SAFEGUARDING ADULTS EXECUTIVE BOARD

ANNUAL REPORT 2018/19

mistreated?
bullied?
hit?
neglected?
exploited?
silenced?

COURAGE
COMPASSION
ACCOUNTABILITY

City of Westminster

THE ROYAL BOROUGH OF KENSINGTON AND CHELSEA

SAFEGUARDING ADULTS EXECUTIVE BOARD
ANNUAL REPORT 2018/19

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FOREWORD

I am very pleased to introduce the Annual Report for the Bi-Borough Safeguarding Adults Executive Board 2018/19. As the Interim Independent Chair of the Board during that year, I was very grateful to all partners for their contributions to the Board, and their ongoing support.

During the year, the partnership has reviewed and amended its governance structure and developed and agreed a practical business plan to deliver our shared objectives. The plan includes our commitment to working with all agencies, supporting operational services to prevent abuse from happening, and when and where abuse does happen, be assured that all agencies respond appropriately. The Board also held a development day which provided an opportunity for partners to evidence their work to safeguard vulnerable adults. Partners of the Board have continued to support each other, meet our collective commitment to keeping adults safe across the Bi-Borough, and progress delivery of the business plan to support the shared objectives.

In March 2019 a peer review team was invited, through the Association of Directors of Adult Social Services London (ADASS), to complete a review of safeguarding arrangements within the Bi-Borough. The review was a stimulating and rewarding experience. The quality of the work shared and the conversations with the Peer Review Team demonstrated commitment, hard work and professionalism regarding safeguarding adults from all partners.

We have continued to look at information about safeguarding activity in the Bi-Borough to inform our priorities for improvement. We have considered recommendations and lessons learned from Safeguarding Adults Reviews and where relevant, from Children's Serious Case Reviews and Domestic Homicide Reviews to understand what happened, and what needs to change. This has informed the business plan this year and priorities for the future

We continue to raise awareness of safeguarding in the communities of the Bi-Borough, with the help of our service user, community and voluntary groups, especially the 'Local Account Group' and the 'Safeguarding Adults Reference Group'.

This annual report is important because it shows what the Board aimed to achieve during 2018/19 and what we have been able to achieve. It shows that most of the business plan was completed during the year. The annual report provides a picture of who is safeguarded in the Bi-Borough, in what circumstances and why. This helps us to know what we should be focussing on for the future. It includes the High-Level Statement of Intent 2019/2022, which says what we want to achieve during the next 3 years (see page 10).

There continues to be significant pressures on partners in terms of resources and capacity, so we want to thank all partners and those who have engaged in the work of the Board, for their considerable time and effort. In my role as Interim Independent Chair I would like to acknowledge the value of the work of the subgroups in supporting the Bi-Borough Safeguarding Adults Executive Board (SAEB).

There continues to be a lot to do to reduce the risks and experiences of abuse and neglect in our communities and support people who are most vulnerable to these risks. I sincerely hope that Board partners will continue to work together to achieve the Boards objectives with the support and leadership of the new Independent Chair

I hope that you will find this year's Annual Report a helpful and informative read.

Dr Adi Cooper OBE,

Interim Independent Chair, Safeguarding Adults Executive Board 2018/19

WHAT DOES THE EXECUTIVE BOARD DO?

Our Vision

The strategic objectives and work of the Board is based on the following vision:

People in the Royal Borough of Kensington and Chelsea and Westminster City Council have the right to live a life free from harm, where communities:

- have a culture that does not tolerate abuse
- work together to prevent abuse
- know what to do when abuse happens

Structure and Membership

The Bi-Borough Safeguarding Adults Executive Board (SAEB) is a multi-agency partnership.

The role of the Board is to assure itself that local safeguarding arrangements and partner agencies act to help and protect adults in its area.

This is about how we prevent abuse and respond when abuse does occur in line with the needs and wishes of the person experiencing harm.

The Boards' main objective is to assure itself that local safeguarding arrangements and partner organisations act to help and protect people aged 18 and over in the area who:

- have needs for care and support; and
- are experiencing, or at risk of, abuse or neglect; and
- (as a result of their care and support needs) are unable to protect themselves from either the risk of, or experience of, abuse or neglect.

Our Values and Behaviours

The Board believes that adult safeguarding takes **COURAGE** to acknowledge that abuse or neglect is occurring and to overcome our natural reluctance to face the consequences for all concerned by shining a light on it.

The Board promotes **COMPASSION** in our dealings with people who have experienced abuse and neglect, and in our dealings with one another, especially when we make mistakes. The Board promotes a culture of learning rather than blame.

At the same time, as members of the Board, we are clear that we are **ACCOUNTABLE** to each other, and to the people we serve in the two boroughs.

The Board is responsible for overseeing and leading on the protection and promotion of an adult's right to live an independent life, in safety, free from abuse and neglect across The Royal Borough of Kensington and Chelsea and Westminster City Council.

The Board is a partnership of organisations working together to prevent abuse and neglect, and when someone experiences abuse or neglect, to respond in a way that supports their choices and promotes their well-being.

The Board does not work in isolation, nor is it solely responsible for all safeguarding arrangements as Safeguarding is everyone's business!

THE SAFEGUARDING ADULTS EXECUTIVE BOARD

Section 43 and Schedule 2 of the Care Act 2014 outlines local authorities' responsibilities to set up a Safeguarding Adults Board in their area.

The Act requires a Safeguarding Adults Board to:

1. Develop and produce a 3-year Strategy and an annual Business Plan in order to direct the work of the Board that reflects its priorities
2. Publish an annual report/accountability statement highlighting the Board's progress and achievements in meeting the objectives in the Strategic Safeguarding Plan and ensuring this is widely reported across partner agencies and organisations.
3. Learn from the experiences of individuals, through undertaking Safeguarding Adult Reviews (SAR's) in accordance with the national guidance of best practice and the Board's SAR's protocol.

The Terms of Reference for the board were reviewed in January 2019 and can be found **here**.

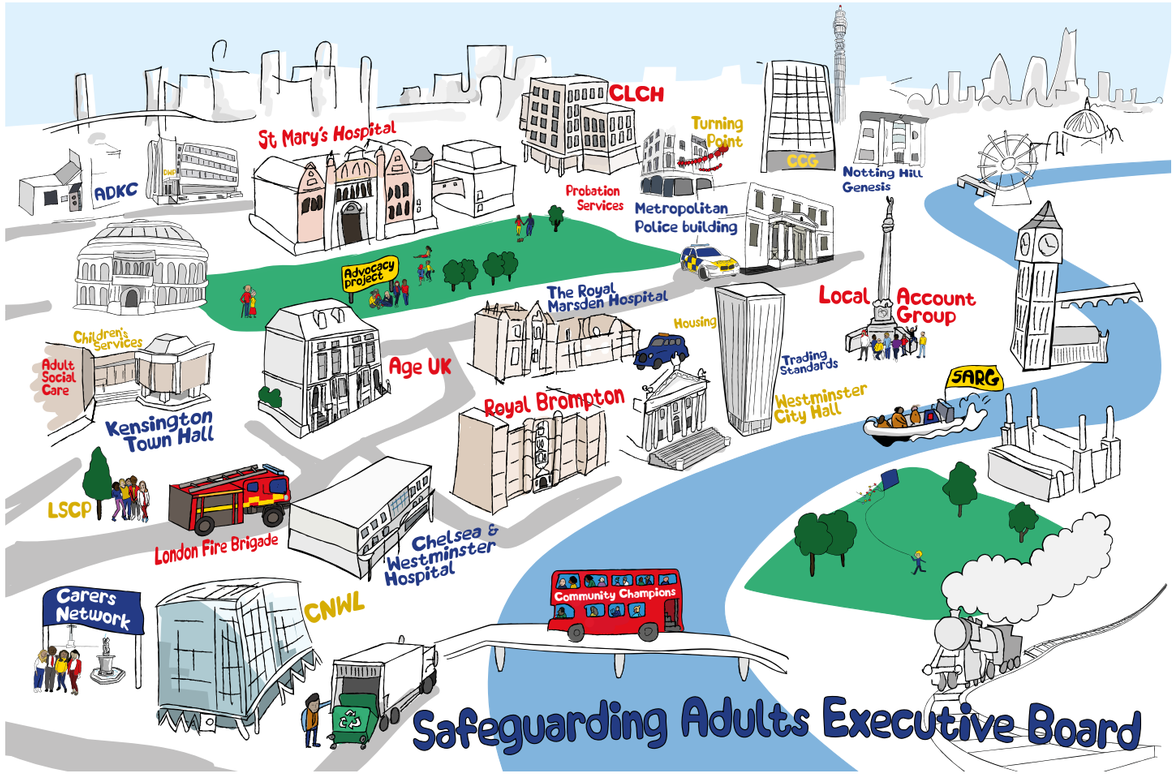
The statutory members of the Safeguarding Adults Executive Board:

- The Bi Borough Executive Director of Adult Social Care and Health
- The Deputy Director of Quality, Nursing and Safeguarding, Central Westminster Hammersmith Hillingdon and Ealing Clinical Commissioning Groups Commissioning Collaborative
- BCU Commander of Central West, Chief Superintendent, Metropolitan Police

The Care Act 2014 states that the Board can appoint other members it considers appropriate with the right skills and experience.

There are senior representatives on the Board, from the following organisations:

- London Fire Brigade
- Imperial College Healthcare NHS Trust
- Chelsea and Westminster Hospital Foundation NHS Trust
- The Royal Marsden NHS Foundation Trust
- Central London Community Healthcare Trust
- Central North West London NHS Foundation Trust
- Community Rehabilitation Company (CRC)
- National London Probation Service
- Children's Services (Local Authority)
- Community Safety (Local Authority)
- Local Councillors
- Housing (Local Authority)
- Mind
- Genesis Notting Hill Housing
- Trading Standards (Local Authority)
- Public Health Community Champions Programme
- Royal Brompton and Harefield HNS Foundation Trust Healthwatch



Adult Social Care (Local Authority)Board members are the senior 'go to' person in each of these organisations or services with lead responsibility for adult safeguarding.

They bring their organisations' adult safeguarding issues to the attention of the Board, promote the Board's priorities, and disseminate lessons learned throughout their organisation.

The Board can use its statutory authority also to assist members in addressing barriers to effective safeguarding that may exist in their organisation, and between organisations.

An even wider group of people, including voluntary sector organisations; housing and homelessness agencies; advocacy and carers' groups; and members of the public all contribute to the Boards various work-streams.

Adult Safeguarding now includes such areas as

- People Trafficking
- Modern Day Slavery
- Self- Neglect
- Domestic Violence

This Agenda is much wider than when Safeguarding Boards were first introduced.

Sub-groups of the Board are chaired by officers from the following organisations:

- Central North West London NHS Foundation Trust
- Imperial College Healthcare NHS Trust
- Central London Community Healthcare Trust
- The Royal Marsden NHS Foundation Trust
- London Fire Brigade
- Metropolitan Police
- Notting Hill Genesis Housing
- The North West London Collaboration of Clinical Commissioning Groups (NWL CCGs)

The North West London Collaboration of Clinical Commissioning Groups (NWL CCGs) is committed to safeguarding the wellbeing of vulnerable adults who access services that are commissioned by the NWL CCGs. The NWL CCG ensures that staff have appropriate policies, procedures, training and access to expert advice to ensure that adults at risk are identified and, where appropriate, a referral is made to adult social care.

"The Care Act 2014 states that local authorities, Clinical Commissioning Groups (CCGs) and the chief officer of the local police must be members of the Safeguarding Adults Board. The CCG is an active member of the Safeguarding Adults Executive Board. Safeguarding is about making sure everyone is treated with dignity and respect and does not suffer abuse. This is particularly important for those who are unable to protect themselves from harm or abuse, possibly because of their age, a disability or because they are unwell. To ensure this, care must be of a high quality in order to prevent abuse happening. It also means there is an effective response if there is evidence or suspicion of abuse."

"Safeguarding is always our top priority. There is a requirement to ensure that safeguarding is embedded throughout the commissioning process. Safeguarding is central to the commissioning strategy in North West London."

"To keep our communities safe from abuse and neglect, it is not enough to simply react when a safeguarding concern arises. Safeguarding principles need to be embedded across organisations' cultures at all levels, and people's safety needs to be considered all the time, whenever a decision is made."

We are committed to embed learning from Serious Case Reviews at a strategic level so that learning is shared across the system. We anticipate that this will improve the experience of patients using the services that we commission and makes our safeguarding processes more robust."

Chief Nurse & Director of Quality
North West London Collaboration of Clinical Commissioning Groups

The Care Act 2014 says members may make payments for purposes connected with the Board. Most of the funding for the Board comes from the Local Authorities. The North West London Collaboration of Clinical Commissioning Groups (NWL CCGs) contribute £20,00.00 per borough.

Mayor's Office for Policing and Crime provides an annual contribution of £5,000 to local safeguarding adult boards.

Also, for the third year running, The London Fire Brigade has contributed £1,000 per borough, to be shared between the Safeguarding Adults Board and the Local Safeguarding Children Board.

The Care Act 2014 guidance states that all members of the Board should have the right skills and experience necessary for the Board to act effectively and efficiently to safeguard adults in its area.

We acknowledge the value of the work of the subgroups in supporting the Board. Attendance is good and members are committed and work hard to progress the Board's priorities and safeguard adults at risk of abuse and neglect.

Putting our "house" in order

Our "House" model has set the scene for our safeguarding adults' journey: it is valued by our service users and experts by experience and is recognised at a national level as a framework built on the wellbeing principle.

Residents across the Bi-Borough told us how important it is to be in control of the decisions they make about their life, even when they have experienced abuse or neglect. Throughout this report you will find examples of what people told us under the headings "you said" and "we did"

"The House strategy has supported the SAEB to ensure that all its safeguarding adults work is focused on making safeguarding personal, prioritising the safety and well-being of all our residents and to ensure they are fully listened to by incorporating the voice of residents in everything we do "

The Safeguarding Adults Reference Group

Putting our “house” in order

However, we are motivated to continue to learn from others how to make safeguarding adults better for residents.

In March 2019 London Adult Directors of Adult Social Services (ADASS) were invited to complete a review of our safeguarding adults’ arrangements within the Bi-Borough.

Local Government Association

“Peer challenge is a proven tool for improvement. It is a process commissioned by a council and involves a small team of local government officers and councillors spending time at the council as peers to provide challenge and share learning”

The outcome of the peer review provided key messages on what is working well and some areas for consideration, which will be taken forward to inform the Board strategy for the next 3 years.

What is working well: Leadership

Strong leadership and the positive changes over the previous 18 months demonstrated that, despite differences in the two boroughs, there were also many similarities in ensuring safeguarding outcomes of residents are met. The Peer Review team feedback was that staff from both boroughs were supported in safeguarding activity. It was acknowledged that service user engagement across the Bi-Borough was very good, and the Peer Review team were impressed with the ambitions of the Local Account Group in supporting the Councils.

Members of the London ADASS Peer review team and the Local Account Group

What is working well: Partnership

There was clear evidence of: a focus on high risk groups, through approaches to hoarding, homelessness, rough sleepers and modern slavery; and a good level of partnership response across council departments and with statutory partners in working with both individuals and at a strategic level. The Quality Assurance Team were noted to be making a positive difference, enhancing market oversight and improvement work.

Areas for consideration

It was noted that it would be helpful to review the governance arrangements of the Board.

Next Steps

The Board held a Development Day with members and the Local Account Group to set the Board agenda for the next 3 years

Information used to inform the development day came from various sources including:

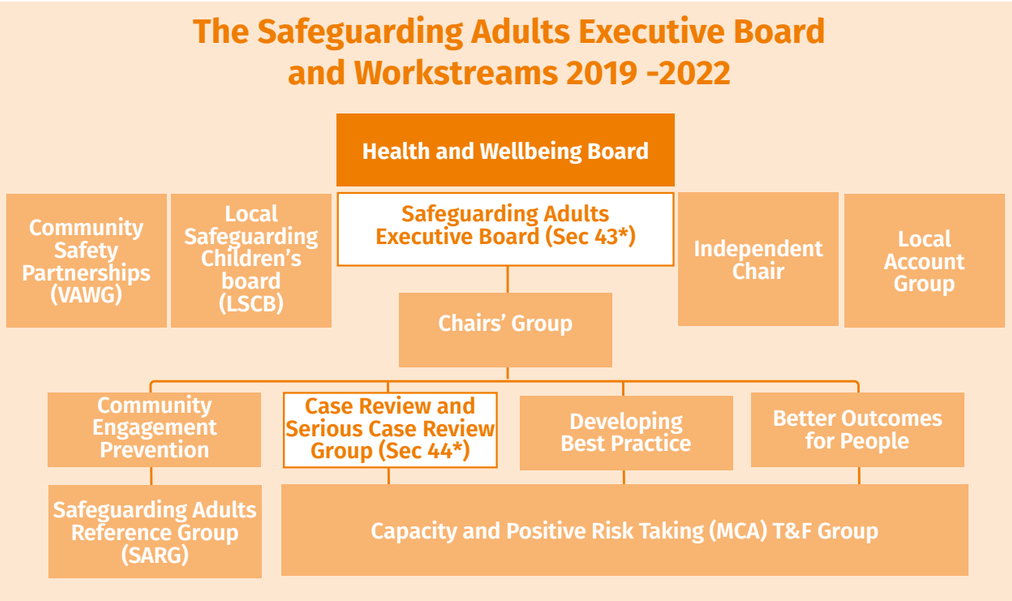
London ADASS Peer Review of Bi-Borough Safeguarding arrangements recommendation: To review the governance arrangements and align the vision and values for safeguarding across the Councils;

The Safeguarding Adults at Risk Audit tool (SARAT) 2018-19, which was completed by all partners, to provide assurance to the Safeguarding Adults Executive Board (SAEB) that all partners are compliant with safeguarding, following the introduction of the Care Act 2014;

Local and National Safeguarding Adult Reviews: The Board commissioned a Safeguarding Adult Review (SAR) in 2018/19. The findings from the SAR gave us the opportunity to explore more closely the areas shared with the Local Children’s Safeguarding Board (LSCB), such as ‘Think Family’, Transitions and Liberty Protection Safeguards.

The outcome of the development day was two-fold

1. A new governance structure with greater emphasis placed on service user engagement in the workings of the Board: **The Safeguarding Adults Executive Board and Workstreams.**



2. The new strategic plan or statement of intent: **Statement of Intent 2019 – 2022**

Statement of Intent 2019 – 2022

Working Together across agencies & between Adults and Children's Services	Capacity and Positive Risk Taking	Awareness and Support	Governance
Think Family: To jointly raise awareness and develop guidance and tools **Transition Group:** Joint workshop with operational staff to develop sound pathways for young adults into adult services which are relevant to need this may mean statutory or voluntary organisations. **SAEB and LSCB:** Joint Board Event to review work and share experiences **Lead group or agency** • Local Safeguarding Children's Partnership (LSCP) • Safeguarding Adults Executive Board (SAEB)	**Liberty Protection Safeguards:** Help prepare the Safeguarding Adults Executive Board Partnership for LPS **Multi-agency Quality Assurance:** Partnership Audit of Mental Capacity Audit practice **Rough-sleeping and Safeguarding** **Partnership awareness of Legal Literacy:** Development of Interagency protocols related to Court of Protection **Developing good partnership practice around managing risk and defensible decision making**	**Prevention "Raising Awareness of Safeguarding":** Increase service users by experience involvement in SAEB activity • Co-designed events for seldom heard service user groups • Multi-agency leaflets -Review • Train the Trainer-Refresh Learning from SAR's and DHR's Raising awareness of usefulness of High-Risk Panels **Lead group or agency** • Community Engagement group • Safeguarding Adults Reference Group • Local Account Group	**Governance review:** • Legal Indemnity Insurance • Membership review • Finance review • Service User Engagement • Review Our Values • Cycle of Quality Assurance function **Lead group or agency** • Safeguarding Adults Executive Board (SAEB)
IT systems and Information Sharing • Statement from the SAEB to reinforce obligations • Focus on best practice in recording **Lead group or agency** • Developing Best Practice Group	**Lead group or agency** • Capacity and Positive Risk-Taking Sub-group	**Advocacy** • Re-commissioning • Workforce development • Public Awareness **Lead group or agency** • Adult Social Care Commissioning • Developing Best Practice Group	**Variability in referral rates across partnership:** Consistency in responses Bi-Borough Board to align local practice and pathways **Workstreams:** • Better Outcomes for People

CREATING A SAFE AND HEALTHY COMMUNITY

Service User Involvement

"I am able to make choices about my wellbeing"

We have had an ambitious year in which we have combined our approaches to working with service users by having a service user by experience group and the Local Account Group. This ensures that there is service user involvement in all areas of the Board's work.

Service users by experience

The Safeguarding Adults Reference Group was re-launched with the support of our community engagement subgroup. The group is now focussed on co-producing safeguarding training and delivering events to raise awareness of safeguarding adults.

This is the groups explanation of how stages of co-production work in practice using the analogy of a cake.

Coercion is telling someone that they will have cake.

Educating or informing is telling someone about the look and flavour of the cake that they will be given, but there is no choice.

Consultation or engagement is about asking people what type of cake they would like and why - but this might be ignored.

Co-design is like people deciding what flavour the cake should be and how it should be decorated… but that is it.

"our views are important, and our voices heard"

Co-production is:

1. deciding whether cake is needed (or would something else be better)
2. deciding on the flavour of the cake and the decoration,
3. working out how to make the cake,
4. baking it,
5. trying it to find out how it is
6. working out what could be done better in the future.

"We are often approached by organisations who say they want to co-produce with us and then they allow us to 'decorate the cake'! This year the Safeguarding Adults Executive Board have worked with members and instilled confidence about what co-production really is...that our views are important and our voices heard"

Chief Executive, Action Disability Kensington & Chelsea

In March 2019 members from the Safeguarding Adults Reference Group delivered a short presentation to the Board on their ideas on what service user events in the community should look like. Their proposals were supported, and these events are now being co-produced with the community engagement group.

The Local Account Group

In July 2018 the Bi-Borough Local Account Group launched their Ambition Plan. Within this plan it was agreed that the Local Account Group will input and support the priorities of the Safeguarding Adults Executive Board. This has meant that feedback from service users and carers groups is heard at every Board meeting and through the subgroups. In 2019/20 the Local Account Group will co-produce a Service User Feedback Form for adults involved in the safeguarding adults process. 12 months after the form has been launched and in line with the Local Account Group Ambition Plan, we will support the Local Account Group to analyse the feedback and present the findings to the Board, with identified learning from a service user perspective.

"The contribution and support from both the Local Account group and The Safeguarding Adults Reference Group has been invaluable. It is inspirational to work such a highly motivated and enthusiastic group"

Head of Service, Safeguarding and Workforce Development Team, Bi-Borough Adult Social Care

Community Engagement

You said:
I want to know how to stay safe in my own home

We did:
This year the Community Engagement Group have commenced a Safe at Home Programme which will include a national universal video accessible to all home care and health agencies. It will be a helpful guide on scams and security and safety issues in the home.

"This year the Community Engagement Group have commenced a Safe at Home Programme which will include a national universal video accessible to all home care and health agencies. It will be a helpful guide on scams and security and safety issues in the home"

Chairs of the Community Engagement Group

As well as putting on awareness-raising events to help people spot scams and creating links with local organisations and community groups to spread the message about how to stay safe, here is the Community Engagements Group message to residents:

Everyone has the right to live in safety, free from abuse and neglect.

Abuse and neglect can occur anywhere: in your own home or a public place, while you are in hospital or attending a day centre, or in a college or care home.

You may be living alone or with others. The person causing the harm may be a stranger but, more often than not, you'll know and feel safe with them. They're usually in a position of trust and power, such as a health or care professional, relative or neighbour.

Far too often this could be someone stealing money or other valuables. Or it might be that someone appointed to look after your money on your behalf is using it inappropriately or coercing you to spend it in a way you're not happy with. Internet scams and doorstep crime are also common forms of financial abuse.

People and organisations worked together to deliver the Community Engagement Group event in February 2019 raising awareness of how residents can stay 'Safe at Home'. The focus of this event was to raise awareness and provide information on:

- Home fire safety
- Home Improvement Agency Services available in Westminster
- Trading standards and scam information

The next page includes example of the information that was provided at the 'Safe at Home' event.

You said:
You are willing to work with me

We did:
In 2018/19 the London Fire carried out 3,334 Home Fire Safety Visits across the Bi-Borough in 2018/19

We were told what happens during a home fire safety visit by a member of the London Fire Brigade

Firefighters or trained staff will visit the home and offer advice based on individual needs, this includes information on how to prevent fires, the importance of smoke alarms to detect a fire and having escape plans in the event of a fire. They will also fit smoke alarms if required.

Prevention:

- Understand the main causes of fire in the home and how to prevent them.
- Identify fire hazards in the home and know how to reduce the risk of a fire happening.
- Reduce the risk of a fire happening at night by having an appropriate bedtime routine.

Detection:

- Identify the function and importance of a smoke alarm in home fire safety, as smoke generated by fire can kill people and is just as dangerous as fire.
- Every home should have at least one smoke alarm fitted on each floor level, and ideally one in every room a fire could start.
- Smoke alarms should be tested once a week
- LFB can provide specialist smoke alarms for people with hearing or visual impairments.
- Understand that the Fire Brigade carry out Home Fire Safety Visits and that they can be requested via the Brigade website

Escape:

- Know that fire should only be tackled by firefighters as they use special equipment and protective clothing.
- Prepare and practice a fire escape plan, making sure everyone in the home knows what to do if there is a fire.
- Understand how to call 999 and when it is appropriate to do so.

Our Trading Standards Lead Officer told us about Door step scams

Doorstep scams take place when someone comes to your door and tries to scam you out of your money or tries to gain access to your home. Doorstep scammers aren't always pushy and persuasive, they may seem polite or friendly. So, if you're not expecting someone it's important to be vigilant when you answer the door, especially if you live on your own.

A victim of Doorstep Crime:

Alfred's Story

Earlier this year Alfred received an unexpected knock at the door from a roofer claiming to be doing some work for a neighbour nearby and who noticed they have some loose tiles on the roof. The roofer claimed that they have some left-over materials and he could do the work quickly and for a discount. He offered to fix the tiles for £50-100 cash. Alfred agreed but once the work started more problems are found with the roof and the bill keeps on increasing. Alfred felt very intimidated and pressurised by the roofer and agreed to them doing more work and the increased costs. Alfred told his Daughter who called the police who opened an investigation into the matter.

The Outcome:

The roofer is now being prosecuted for 3 cases of doorstep crime in the same street.

Financial Abuse, Better Outcomes for People

Financial Abuse is another name for stealing or defrauding someone of goods and/or property. It is always a crime but is not always prosecuted. Sometimes the issue is straightforward, for example a care-worker stealing from an older person's purse, but at other times it is more difficult to address. This is because very often the person alleged to have caused harm can be someone's son or daughter. A common issue that comes to the Boards attention through safeguarding are relatives attempting to justify their actions on the basis that they are simply obtaining their inheritance in advance by the misuse of Lasting Powers of Attorney.

Financial abuse/harm can happen because the older person can be seen as an easy way of getting money, particularly if they are dependent or confused. Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services have recently published a report advising that the police and the Crown Prosecution Service (CPS) need to prepare for the growing challenges of helping and keeping safe an ageing population. Many older people lead active and safe lives. Not all older people are vulnerable, but they are more likely than other groups to be living with some form of physical or mental ill health. Too many older people are socially isolated and lonely and may leave their homes only rarely.

"It's important to remember that these criminals are incredibly sophisticated and prepared to put a huge amount of effort into conning people out of their money. Scams make victims part with their money and personal details by intimidating them or promising cash, prizes, services and fictitious high returns on investment. It's important to remember that no matter what type of scam, all scams are crimes.

- Approximately 3.2 million people (1 in every 15) fall victim to scams each year.
- The average age of a scam victim is 75.
- Scams cost the UK economy between 5 and 10 billion pounds each year.
- Only 5% of these crimes are ever reported.

Trading Standards

Trading Standards Top Tips on how to Stay Safe at Home

- Don't buy at the door
- If you think work needs doing around the home get quotes from other businesses that are members of a Trading Standards trusty trader scheme or use the vetted business on the free online directory from Which? magazine, or from Age UK.
- Use a security chain/ spy hole at the front door when you receive any unexpected calls – many Councils have a Home Improvement Agency Service and for those on certain benefits or pensioners they may be able to have these installed for free
- If the caller claims to be from a utility company to read the meter, ensure you have set up an agreed password in advance and the callers has given this
- Never let anyone into your home unless you are satisfied who they are
- Ask them to show you identification and independently verify they are calling from Company they claim to be
- Never leave valuables, money or bank cards lying around
- Do not donate to alleged charities at the door
- Contact the Citizens Advice Consumer Service if you would like help.

Assisting residents to stay 'Safe at Home'

Age UK Kensington & Chelsea assists residents who are aged 55 and over to maintain their independence, making the tasks of daily living a bit easier. The aim of the 'Safe at Home' service is to reduce the risk of falls in the home, reduce the risk of harm from other hazards in the home, improve health, wellbeing and peace of mind by ensuring that the home environment is safe for the resident.

Our DIY service provides support to clients helping them with those little tasks around the house that can make a huge difference to their quality of life. Those tasks go from changing a lightbulb to assemble a flat-pack so corridors are clear of clutter helping to avoid falls. We also fit spyholes and door chains to help people stay safer at home.

Community Engagement Manager, Age UK Kensington & Chelsea

Better outcomes for People

The main purpose of the Better Outcomes for People (BOP) sub-group is to provide evidence that gives the Safeguarding Adults Executive Board (SAEB) assurance that it is delivering its prime responsibility of preventing abuse and increasing the safety and well-being of adults who have experienced harm across the Bi-Borough.

The BOP identifies outcome measures for the SAEB's strategic priorities; identifies sources of information; collects and analyses relevant information; and reports to the Board and member agencies, as required.

In 2018/19 the Board tasked the BOP Better to complete a local analysis of safeguarding and crime.

We wanted to know, under our restorative justice agenda:

- What percentage of safeguarding concerns were crimes?
- How many were reported to the police?
- How many resulted in prosecutions?

The group established that:

- About 1 in 3 Safeguarding concerns were classified as crimes / potential crimes;
- These concerns differed from others, not so much in terms of the personal characteristics of the adult at risk, as in the type of harm or abuse alleged as in the type of harm or abuse alleged. Financial abuse featured more highly and the source of risk was more likely to be from non-professionals;
- The majority (74%) of these concerns were raised with the police (some later in the pathway);
- The majority of safeguarding enquiries were completed in under 90 days but those raised with the police were slightly less likely to have been completed in this time (70%:79%)

- There was little difference between the groups in terms of the identification of risk and the impact of the enquiry on risk, but those raised with the police were slightly more likely to have ended at the individual's request and slightly more likely to have ended with the risk remaining;
- We were unable to identify the number resulting in prosecutions.

CHART DEMONSTRATES ABUSE TYPE

	Crime / Potential crime	Other (Not crime / Don't know)	Total
% financial abuse*	60%	18%	33%
% physical abuse*	42%	20%	28%
% sexual abuse*	10%	2%	5%
% domestic abuse / violence*	10%	5%	7%
% neglect / omission*	7%	58%	40%
% source of risk: ASC / NHS provider	22%	42%	35%
% source of risk: family/stranger/not known	69%	42%	52%
% met s42 enquiry criteria	52%	43%	46%
Number of concerns	136	245	381

*On own or in combination with other(s). Differences between groups more marked in terms of type and source of risk, rather than personal characteristics

Financial abuse occurred in 60% of cases in a number of ways, including:

- Taking cash / bank card / belongings directly;
- Taking money from cashpoint;
- Taking money via bank transactions / bank transfers (including scam calls);
- Taking money from post-office account;
- Blackmail;
- Burglary;
- Being asked for money by care worker (and paying); and
- Overcharging (at local restaurant).

"The abuse that vulnerable adults can suffer is often hidden from view. In the Bi-Borough we work closely together with our multi-agency partners and external organisations to identify and support those who may be victims. When incidents or concerns are reported to us, we endeavour to conduct a thorough investigation and where possible, bring those who abuse and mistreat vulnerable people to justice".

Safeguarding Lead
Metropolitan Police Service
Co-Chair of the Better Outcomes for People subgroup

METROPOLITAN POLICE

Working together for a safer London

MAKING SAFEGUARDING PERSONAL

Financial Abuse, Dementia Friends

You said:
I want to be able to make choices about my well-being

We did:
Here are two case examples of how the work of the Board is helping to protect residents from Financial Abuse

How we supported Elsie to maintain her financial independence

"I have lived on my own since my sister died last year. We lived together for over 60 years, we went through everything together, including the blitz. I remember those days when we ran hand in hand to the underground tunnels in Bethnal Green to stay safe in from the raids. We moved to west London after the War, we had lost our home and had relatives here.

I have carers who come to help me about 2 times a day as I have difficulties getting to the bathroom as my sight is rather poor nowadays. I have a neighbour who has been helping me to pay my bills since my sister died. My neighbour is my only friend and I trust her, so I let her take my bank card to withdraw money the pay my bills and then she pays it all through her account for me.

I told my social worker about this and she seemed concerned that my bills were high. I gave her all my paperwork to look at and she said that my neighbour withdraws more money than the bills cost.

I was very upset about this. I may have poor sight but I'm not a bad judge of character and I can't believe that my neighbour would steal from me. I always tell her to take a little extra to buy a treat for the kids as she does all my shopping as well, I never have to worry about what I need, and I depend on her.

Over the next few weeks I had many visits from my social worker who talked to me about safeguarding. I explained to her that I always tell my neighbour to keep any change from the bills and that I wanted to keep my friendship with her as she visits me regularly and makes me lovely cups of tea and we sit down and chat for hours most evenings and the children visit me too. They call me Aunty Elsie.

My social worker supported me to set up my direct debits for all my bills and set up regular online shopping which includes some treats that I like to buy for my neighbour and her children. "

The outcome:

"My social worker listened to what I wanted to happen next and helped me to sort out everything I needed"

Here is the Voice of another resident:

"My care workers were not supporting me properly and some of the residents I lived with were always borrowing money from me and causing me problems. My social worker helped me to sort out my problems in a way that suited me and helped me to maintain relationships that were important to me"

No Decision about me without me

This story demonstrates how Making Safeguarding Personal put Mohammed's best interests at the heart of discussions

"My family have always helped to manage my finances. I came from a very wealthy family, we never needed to worry about money, so I was surprised when my family kept telling me I didn't have enough money for the things that I liked. I like to have afternoon tea and my grand-daughter used to take me to the Ritz every Sunday but she says we can't always afford to go, and she is always arguing with my family about wanting to take me there. They have ramps in place for my wheelchair and they all know me there as I have been a regular there for years. I told my social worker when she visited who then had a safeguarding meeting about this and introduced me to another lady who is now my advocate. My social worker told me she completed a mental capacity assessment and said

"I lacked capacity to make informed decisions regarding my money and where I live due to my dementia"

The police came to see me to execute a warrant as part of an investigation into allegations of financial abuse made by my grand-daughter. My grandson had Lasting Power of Attorney over my finances and welfare decisions, but the investigation showed that he was spending all my money. This made me very sad at first, but I am now on holiday in a lovely care home following something called a best interests decision meeting."

The outcome:

"With the help of my social worker, the police and my advocate I am changing my will and getting everything back into order. I get confused sometimes, but they help me to understand and I don't have to worry about not having money any more. My grand-daughter now visits me regularly and takes me out shopping once a month and to the Ritz for afternoon tea."

Dementia Friends

As part of Mental Health Awareness Week, the Adult Social Care (ASC) and Public Health team staff conference: 'With Health in Mind' took place in 2019. The focus: to raise awareness of mental health issues in the workplace and community and to de-stigmatise mental health issues and encourage open discussion. Linda O'Sullivan from the Alzheimer's Society conducted a Dementia Friends training workshop.

Watch the team's video

Dementia Friends is open to anyone of any age to join. A Dementia Friend learns about how dementia affects a person and uses that understanding to make a real difference for people affected by dementia. To find out more and get involved, visit www.dementiafriends.org.uk

Dementia Friends
An Alzheimer's Society initiative

Creating a Safe and Healthy Community

Rough sleeping and Safeguarding

The last 3 years have seen a significant increase and change in profile of deaths of people across the 'rough sleeping pathway', which includes rough sleepers on the street through to those in hostels and supported accommodation. The Safeguarding Adults Team in Westminster have supported a review of all individual deaths in 2018 and agreed that, given the increase in deaths there was a need for a more comprehensive and standardised approach to reviews following deaths of rough sleepers, to keep track of trends and to look for and share lessons learned, with a multi-agency approach and within a clear governance structure.

The circumstances in which the Safeguarding Adult Board might arrange a Safeguarding Adult Review are set out in the Care Act 2014 and apply equally to someone who was sleeping rough. Safeguarding Adults Services in Westminster takes all deaths of people on the street seriously. Our responsibilities under the Care Act 2014 ensure that we will make enquires irrespective of the persons 'ordinary residence'. We agree that it is important that the risks of living on the streets are not compounded by agencies failing to provide a timely and appropriate service response in the locality where a person is sleeping rough and is at risk of harm or abuse.

Safeguarding Adults Services in Westminster have been working closely with the Rough Sleeping commissioning team to develop a new pathway to support people who are rough sleepers and those who are in hostels and supported housing who may be at high risk and eligible for safeguarding under the Care Act 2014. All deaths are reviewed within this new pathway to see if they meet the referral criteria for a safeguarding adult review under Section 44 criteria of the Care Act 2014.

The Enhanced Vulnerabilities Forum

The enhanced vulnerabilities forum in Westminster was set up in August 2018 to discuss rough sleepers and clients accessing the rough sleeping pathway, that present with high risk health and mental health concerns. The principal focus is on people who have "fallen through cracks" and/ or been very resistant to change.

These monthly meetings review actions taken by practitioners, propose and track solutions, as well as escalate cases that are deemed to require further review or that may need statutory decisions appealed. In addition, specific trends and/or risks to the wider cohort of people who are rough sleeping are reviewed and escalated, including a review of deaths across the rough sleeping pathway.

Making Every Adult Matter (MEAM)

This year Making Every Adult Matter (MEAM) was launched in Westminster

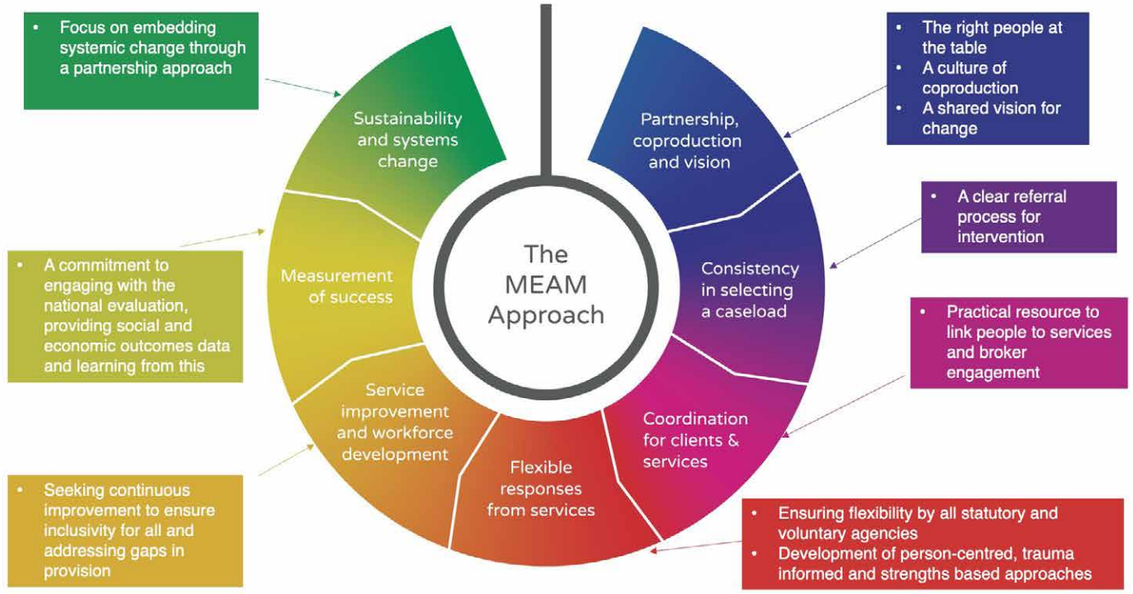
The Making Every Adult Matter (MEAM) coalition is made up of the national charities Clinks, Homeless Link and Mind. People facing multiple disadvantage face a combination of problems including homelessness, substance misuse, learning disabilities, contact with the criminal justice system and mental ill health. They can 'fall through the gaps' between services and systems, making it harder for them to address their problems and lead fulfilling lives.

The MEAM Approach is a framework to help local areas develop effective, coordinated services for people facing multiple disadvantage, and promote lasting, embedded change to local systems.

What are the benefits of being in a MEAM area:

Westminster applied to become a MEAM area and were selected in Nov 2018. Four strands of project work have been identified so far:

- Improving support for adults with autism in Westminster facing multiple disadvantage;
- Improving join up between probation and homelessness services;
- Improving join up between council and partner agencies in relation to treatment resistance alcohol users; and
- Improving psychiatric hospital discharge planning for homeless patients.



Community Safety – Violence Against Women and Girls

You said:
My recovery is important

We did:
The Angelou Partnership support women and girls affected by domestic violence and abuse

Making the transition to adulthood is difficult for everyone but can be especially challenging for young people who are vulnerable or leaving care.

Maria had a difficult transition into adulthood and found stability in a co-dependent relationship and had been the subject of physical and emotional abuse by her partner for several years. Following a safeguarding adults enquiry, which was undertaken in conjunction with a police investigation, Maria was able to remain in her own home and feel safe from abuse from her partner. The case was very complicated and overwhelming for Maria at times, as there were interviews, care and support assessments with social workers, legal advice, advocacy, court actions and several meetings with the police.

The outcome:

As a result of the above, Maria's partner was prosecuted for assaults on her and he left their home with an injunction to prevent his return. Maria was able to remain in the home she loved and, once she was convinced that her partner could not return to abuse her, she felt safe and was able to develop her own relationships and interests.

Violence against women and Girls (VAWG) is a strategic priority for the Royal Borough of Kensington and Chelsea and Westminster City Council. VAWG is a form of discrimination and a violation of human rights and links strongly to adult safeguarding.

Data shows that 17 referrals were made to the Multi-agency Risk Assessment Conference and 13 referrals from Adult Safeguarding were made to the Angelou Partnership, the main commissioned VAWG service in the Bi-Borough.

It is estimated that 1 in 4 women in the Royal Borough of Kensington and Chelsea will experience domestic abuse. 1 in 5 will experience stalking and 1 in 3 will experience sexual violence. Additional vulnerabilities mean that this number is likely to be higher for some groups, such as those with care and support needs who may require safeguarding adult services. With this in mind, work is being done to strengthen the adult safeguarding response to Violence Against Women and Girls.

Joint working protocols were reviewed this year between the Violence Against Women and Girls (VAWG) Strategic Board and the Safeguarding Adult Executive Board. The joint working agenda is driven by seven strategic priorities which include ongoing communication, prevention and awareness-raising activities, creating a menu of options for survivors and their children and continuing to strengthen the coordinated community response. Joint working is focused on ensuring there is preventative, immediate and long-term support for survivors and their children.

Modern Slavery and Exploitation is a key area for the VAWG Strategic Partnership and the Safeguarding Adult Executive Board and work in this area took place throughout 2018-19.

Modern Slavery and Exploitation

RAISING AWARENESS FOR STOP THE TRAFFIK
PEOPLE SHOULDN'T BE BOUGHT & SOLD

Modern Slavery is an umbrella term for human trafficking and servitude. It is used when somebody is forced or coerced into doing something and another person gains from this exploitation. It affects an estimated 40 million men, women and children worldwide. 136,000 individuals are estimated to be in modern slavery here in the UK.

Tackling Modern Slavery is a priority for the Bi-Borough and is a vital part of our Violence Against Women and Girls strategy, while acknowledging it affects men and boys as well.

We have a multi-agency partnership group, whose objectives are to raise awareness of modern slavery and exploitation, resulting in an increase of victim identification; to provide necessary support to enable survivors of trafficking to recover; to build communities, which are resilient to human trafficking; and to ensure perpetrators are brought to justice.

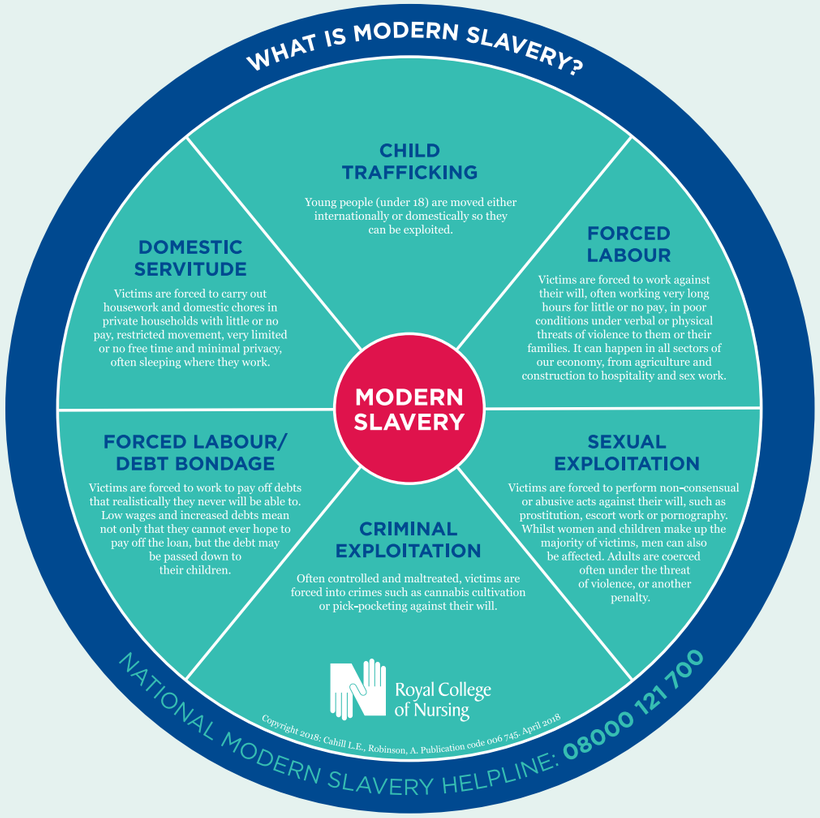
In June 2018 we partnered with the charity **STOP THE TRAFFIK** to employ a Modern Slavery and Exploitation Partnership and Community Coordinator. One of the roles of the Coordinator is to deliver training to raise awareness of modern slavery and the support available for victim/survivors. 300 multi-agency staff were trained in the period between April 2018- March 2019. Prior to the training, 47.8% of attendees agreed with the statement, "I am confident I could respond appropriately if I suspected a case of modern slavery". Following the training, 96.7% agreed with the statement. This increase of over 100% demonstrates that front-line professionals are better equipped with skills to identify and report.

In order to support staff to do this, we developed a Modern Slavery Adult Referral Pathway. The pathway sets out the roles and responsibilities of staff if a victim/survivor of modern slavery is identified, along with the **National Referral Mechanism (NRM)** process. 52 professionals across Adult Social Care and Housing were trained on how to sensitively conduct NRM interviews and complete the forms ahead of the launch of the pathway.

Since the development of the pathway, we have seen an increase in referrals to the National Referral Mechanism. By knowing the options available to victim/survivors of modern slavery and understanding the process, we can help them access the support they deserve. Data collection is in its infancy but will be provided in next years report for 2019-20

"We cannot stop what we cannot see"

Modern Slavery & Exploitation Partnerships and Community Coordinator, Community Safety Team



The vision of safeguarding

Imperial College Healthcare NHS
NHS Trust

"is to achieve the best possible outcomes for children and vulnerable adults through ensuring that their voices are heard, and that early intervention ensures their safety and wellbeing. This will be achieved through effective, united multi agency team working and engendering a culture where safeguarding is at the forefront of our care"

Modern slavery is a crime and a violation of fundamental human rights. It takes various forms, such as slavery, servitude, forced and compulsory labour and human trafficking, all of which have in common the deprivation of a person's liberty by another in order to exploit them for personal or commercial gain.

We are committed to improving our practices to combat slavery and human trafficking.

LEADING, LISTENING AND LEARNING

Safeguarding Adult Reviews (SARS)

The Care Act 2014 states that the Board must conduct a Safeguarding Adults Review in accordance with Section 44 of the Act

The Care Act 2014: SARS - what they are and what they aren't

They should not:	They should be:
• Reinvestigate or apportion blame	• About 'learning lessons'
• Only focus on finding out what happened	• Understanding why the incident happened

You said:
We want you to listen

We did:
We did: The Safeguarding Adults Case Review Group considers the recommendations and lessons learned from Enquiries and Safeguarding Adults Reviews (SARs) and where relevant, from Children's Serious Case Reviews and Domestic Homicide Reviews.

Safeguarding Adult Reviews are about learning together and improving how adults are protected from abuse of all kinds.

This year we have been working on:

1. Local Improvements for referral with a focus on fatal fires, deaths of people who are rough sleeping or homelessness, to ensure that:

- there is a clear process for referral;
- Triaging of cases for potential referral takes place at organisational level; and
- Partnership support is available to organisations in the referral process with clear rationale if the referral is not accepted.

2. Embedding Learning from SAR's into practice: A series of workshops were launched aiming to:

- Raise awareness of the Safeguarding Adults Review process;
- identify opportunities to draw on what works and promote good practice;
- sustain and embed learning into ongoing service improvements such, as the 7 mins briefing model.

7-minute briefings are based on a technique borrowed from the FBI. This is based on research, which suggests that seven minutes is an ideal time span to concentrate and learn. Learning for seven minutes is manageable in most services, and learning is more memorable as it is simple and not clouded by other issues and pressures.

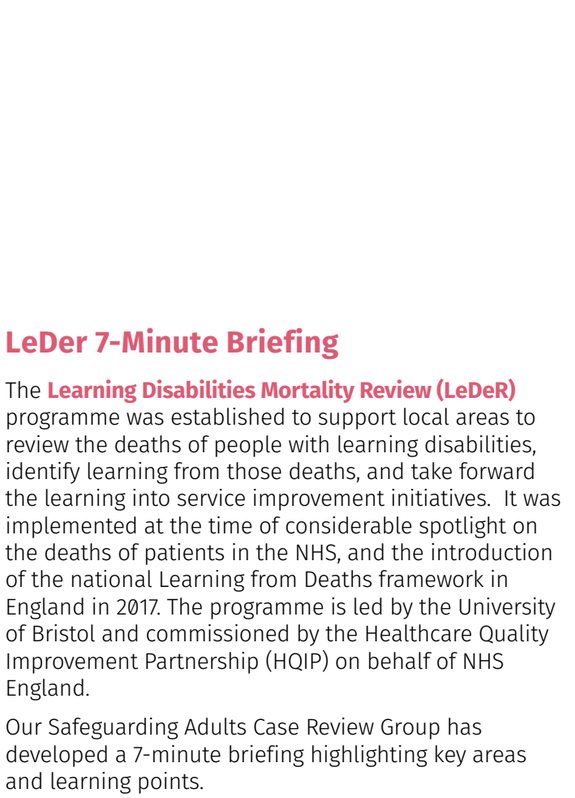
7-minute briefings have been created as a learning aid for use in supervision, team meetings, or just as a reminder of the key issues around a theme or current issue.

The following page describes 2 examples of how the 7 -minute learning is being used to aid learning .

LeDer 7-Minute Briefing

The **Learning Disabilities Mortality Review (LeDeR)** programme was established to support local areas to review the deaths of people with learning disabilities, identify learning from those deaths, and take forward the learning into service improvement initiatives. It was implemented at the time of considerable spotlight on the deaths of patients in the NHS, and the introduction of the national Learning from Deaths framework in England in 2017. The programme is led by the University of Bristol and commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England.

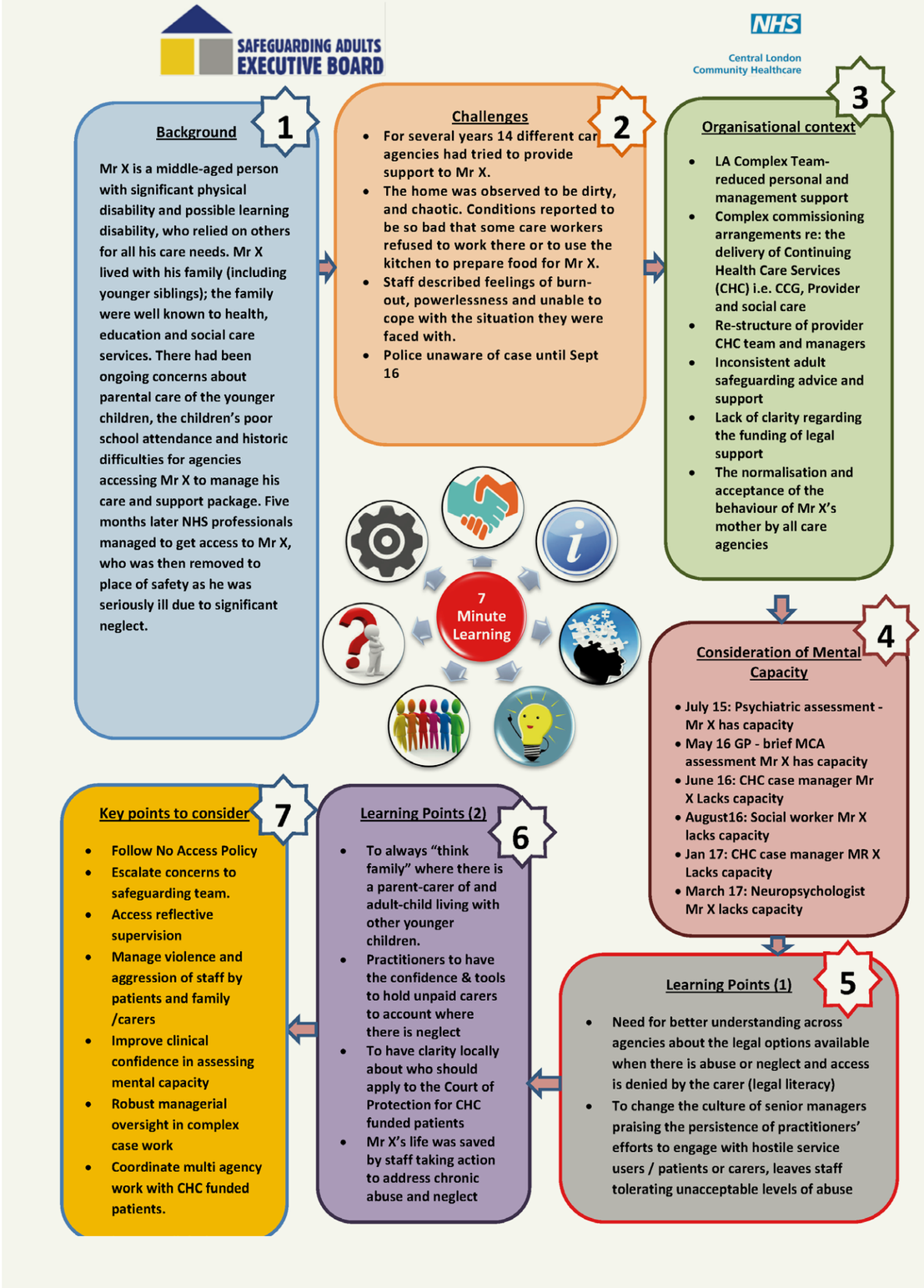
Our Safeguarding Adults Case Review Group has developed a 7-minute briefing highlighting key areas and learning points.



In 2018-19 2 cases were accepted by the Group as meeting the Section 44 Safeguarding Adults Review criteria.

An Appendix of the cases presented and reviewed by the group is found at the back of this report in APPENDIX 1.

We used the 7-minute learning model to share learning from a recently commissioned Safeguarding Adults Review for the case of Mr X.

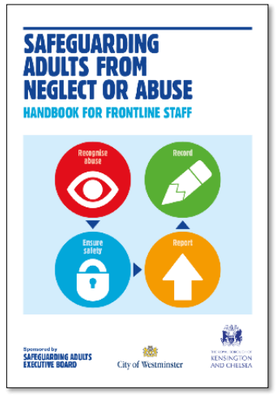


WHAT HAS THE BOARD BEEN DOING?

Adult Safeguarding in Action 2018/19

The Board has been working this year to ensure that we can demonstrate Adult Safeguarding in Action and the impact this has on our partnership.

- The following section provides examples of specific work our partners have been engaged with to include: Think Family within a community health setting
- Person centred care for learning disabilities patients in a hospital setting
- Dignity Champion project work in which the experiences of patients , staff are collected to provide insights to help improve quality of care being delivered



Developing Best Practice

The Developing Best Practice subgroup has produced a guidance booklet to help people working directly with adults at risk of abuse or neglect to understand how to raise concerns. This booklet supplements the London Multi-agency Safeguarding Adults Policy and Procedures.

It is the responsibility of everyone to recognise suspected or actual abuse and to take appropriate action in line with the procedures in this document.

"Staff have found this handbook to be both an essential and effective aid to all safeguarding work"

Deputy Director Patient Experience Imperial College Healthcare NHS Trust

Think Family

The Central London Community Healthcare NHS Trust Safeguarding Team supports the Trust in fulfilling its statutory duty to safeguard children, young people and adults at risk from experiencing harm or abuse. We encourage our staff to take a personalised and 'think family' approach when assessing risk, planning safe care and acting on or escalating concerns.

In August 2018 we introduced a single point of contact (SPOC) with 'duty' safeguarding staff available to ensure frontline staff and managers have access to timely advice and support in managing urgent or complex safeguarding cases.

Associate Director of Safeguarding, Central London Community Healthcare NHS Trust

Person Centred Care

The Royal Marsden NHS Foundation Trust *works hard to ensure that all adults are cared for in a safe, secure and caring environment; that all services have safeguarding at their core, and that staff are supported and trained appropriately to manage safeguarding issues where they arise.*

During the last year, we have launched our new Learning Disabilities policy and pathways, which supports to identify and flag patients with learning disabilities coming into the Trust and the pathways of care to ensure reasonable adjustments can be made to meet their health and support needs.

Head of Adult Safeguarding
The Royal Marsden NHS Foundation Trust

The ROYAL MARSDEN
NHS Foundation Trust

Making Safeguarding Personal

To safeguard individuals in a way that supports them in making choices and having control in how they choose to live their lives is a core objective and key priority for all members of staff who work with adults within the Trust. All staff are given training to help them to identify adults who may require safeguarding and work with other highly experienced colleagues to share information as needed and make referrals to other agencies – such as Social Services – to ensure those adults are protected. As a Trust we are committed to ensuring that all patients, are cared for in a safe and secure environment.

We do this by having named professionals in post who lead on issues relating to safeguarding and ensuring staff are trained in safeguarding – including at director level – and this is annually refreshed.

Director of Nursing, West Middlesex Hospital

NHS
Chelsea and Westminster Hospital
NHS Foundation Trust

Healthwatch Central West London's Dignity Champion project

continues to be an essential part of our local engagement with health and care services in the boroughs of Kensington and Chelsea, and Westminster City Council. Using our statutory power as a local Healthwatch, we collect the experiences of patients, staff, carers and relatives in publicly funded health or care services. These insights help us to develop recommendations that improve the quality of care being delivered.

Chief Executive Officer, Healthwatch Central West London

healthwatch
Central West London

London Ambulance Service (LAS)

In 2018/2019 the London Ambulance Service NHS Trust (LAS) has continued to ensure the safeguarding of children and "adults at risk" remains a focal point within the organisation and the Trust is committed to ensuring all persons within London are protected at all times.

The Safeguarding Team have worked hard to support staff, monitor and review safeguarding practice and raise the profile of safeguarding during 2018/19 and have undertaken a number of audits and established several review groups to assure practice. The Trust serves a population of 8.78 million, covering 8,382 square miles and is made up of 32 boroughs. The Trust responds to over 5000, 999 calls every day and in 2018/19 we raised safeguarding concerns for an average of 2.1% of incidents received. The Trusts 111/ Integrated Urgent Care services in SE and NE London also raised safeguarding referrals and concerns via the Trusts reporting process

All staff have a duty to be alert to potential safeguarding concerns and are expected to be aware of and implement the Trust's safeguarding policies and procedures and work in partnership with other agencies to help safeguard those at risk.

Associate Director of Quality, Safeguarding & Safety and Security

COMPASSION RESPECT EMPOWERMENT PARTNERSHIP

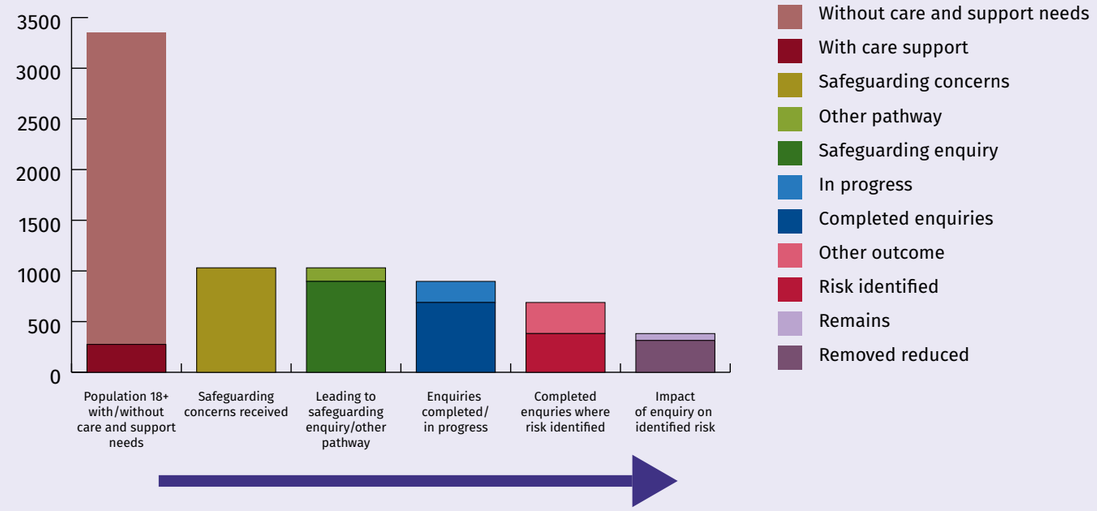
NHS
London Ambulance Service
NHS Trust

Central North West London NHS Foundation Trust *is committed to making sure that safeguarding and promoting the welfare of adults at risk is embedded across every directorate and in every aspect of the Trust's work*

WHAT ARE THE NUMBERS TELLING US?

This section brings together information on the safeguarding concerns that were received by the two boroughs in the period 1 April 2018 to 31 March 2019. The table and charts below highlight key statistics and show what happened to the concerns after they had been received, from the follow-up enquiry, where appropriate, to outcome

The Safeguarding Journey – from raising of safeguarding concern to outcome of safe guarding enquiry



The safeguarding journey

Raising of safeguarding concern

- In 2018-19 we received across RBKC and WCC a total of 1,031 concerns about cases of potential or actual harm or abuse. This is equivalent to three concerns for every 1,000 adults in the general population, or, we estimate, 38 for every 1,000 adults with care and support needs
- The great majority of concerns (897) met the threshold for a safeguarding enquiry. They involved 789 adults at risk; 69% were aged 65+ and 62% were women. Those concerns that did not meet the threshold were followed up in other ways for example by referral to the social care management team, the customer services team, trading standards offices, domestic abuse support agencies, or the police

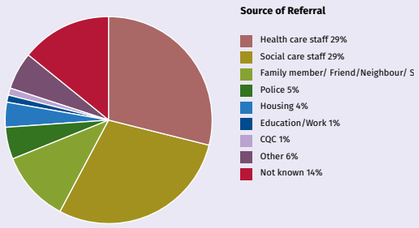
Resulting safeguarding process

- Of the concerns that met the threshold for a safeguarding enquiry over half (518, or 58%) were classified as s42 enquiries in that the person was experiencing or at risk of harm or abuse and had care and support needs which prevented them from protecting themselves
- The focus of all safeguarding enquiries is to establish what the adult at risk would like to happen in relation to the risk and what needs to be done to achieve this

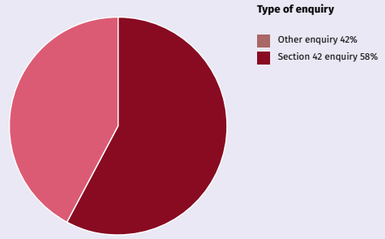
The outcome of the safeguarding process

- In over half (382, or 55%) of the enquiries which were completed in 2018-19, a clear risk of harm or abuse was identified. In the great majority of these cases (82%) the risk of harm was assessed by the social worker as having been removed or reduced by the end of the enquiry. This may have involved actions such as increased monitoring of the adult at risk or disciplinary action
- In the remaining cases the risk was judged to have remained. Commonly this was when the inquiry involved a family member and the adult was accepting of the risk and did not wish any specific action to be taken.

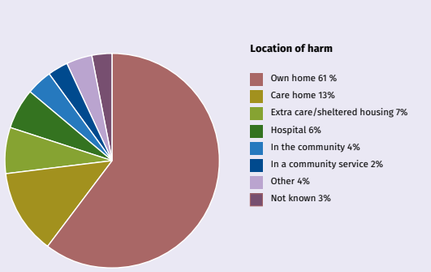
Data set for 2018-19 looking at who makes a referral ,threshold, location of harm and outcomes for the adult at risk



The majority of incidents (61%) occurred in the adult at risk's own home. About a quarter occurred in care settings



Just over 40% of concerns were followed up under safeguarding even though they did not meet the threshold for a s42 enquiry



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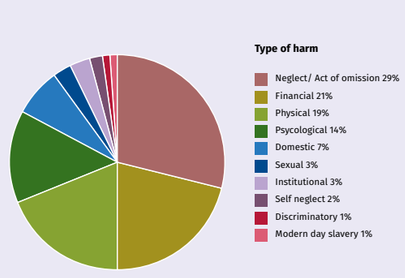
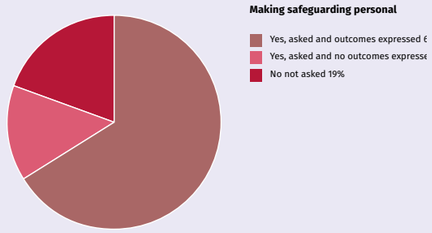
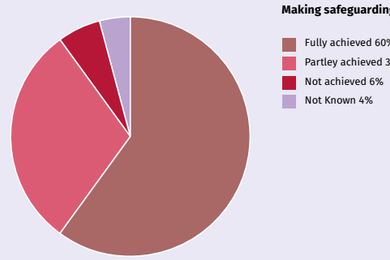


Self-neglect is under-represented among the allegations of abuse raised as this is followed-up under a separate pathway



In about 80% of completed enquiries the adult at risk, or their representative, was asked about the outcomes they wanted to achieves but in 14% of cases no desired outcomes were expressed



Where the adult at risk, or their representative, expressed a desired outcome, in nine out of ten cases the outcome desired was assessed as having been fully or partially achieved

APPENDIX

The Safeguarding Adults Board must arrange a Safeguarding Adults Review when an adult in its area dies or there is a near miss as a result of abuse or neglect and there is concern that partner agencies could have worked more effectively to protect the adult .

The Safeguarding Case Review Group reviewed the 2 cases below and determined that they met the statutory criteria for a SAR.

	Date case to SACRG	Emerging themes from Safeguarding Adults Reviews
1	**27 July 2018**	This is a 'near miss' case involving a person (Mr O) who was discharged from hospital. This review highlighted that Mr O presented well in terms of his functioning. While there were underlying tendencies to self-neglect, these were not always apparent, and it would have been helpful if services that supported Mr O had a greater awareness of his vulnerabilities and tendency to self-neglect. The safeguarding investigation identified the need for greater communication between agencies. The learning for organisations included the importance of creating robust handover and information on specific cases prior to staff changing or leaving their role. Early learning from this case has helped to develop clearer lines of communication between adult social care and housing. This review also highlighted the need for closer working between agencies and people, who may not require formal care services, but would benefit from some monitoring in the community to safely support their choices, rights and freedoms. **Outcome:** It was agreed a Learning Lessons Review (LLR) was the most appropriate methodology review to promote effective learning and improvement action to explore the way organisations are working together. The review will be completed in 2019 and the learning will be disseminated to all members of the SAEB. This Safeguarding Adults Case Review Group will ensure that a seven-minute learning briefing is disseminated, and practice changes are embedded by the relevant agencies.

	Date case to SACRG	Emerging themes from Safeguarding Adults Reviews
2	**21 November 2018** **Mr P**	This case concerned a man (Mr P) who had complex care and support needs, complex physical co-morbidities. Mr P exhibited challenging behaviour and had fluctuating mental capacity. Challenging behaviours impacted upon carers ability to support Mr P . He would self -neglect, increased is alcohol intake making him susceptible to falls and started to self medicate and overuse pain killers .This led to an increase in hospital admissions on at least 6 occasions in 1 year. **Outcome:** A Learning Lessons Review was undertaken to consider how agencies worked together to safeguard a man with complex care and support needs. The key focus of the review was to consider if there were 'checks and balances' in the planning and delivery of care to assure safe systems are in place and if not to explore risk to address systems issues or unsafe practice. Professionals worked closely to produce an Action Plan. The action plan includes new guidance and escalation policies for local nursing homes, promotion of joint working and changes to bariatric pathways in community care settings.

JARGON BUSTER

This is Our Safeguarding Jargon Buster using plain English definitions of the most commonly used words and phrases in this annual report.

Abuse

Harm that is caused by anyone who has power over another person, which may include family members, friends, unpaid carers and health or social care workers. It can take various forms, including physical harm or neglect, and verbal, emotional or sexual abuse. Adults at risk can also be the victim of financial abuse from people they trust. Abuse may be carried out by individuals or by the organisation that employs them.

Accountability

When a person or organisation is responsible for ensuring that things happen, and is expected to explain what happened and why.

Adult at risk

An adult who is in need of extra support because of their age, disability, or physical or mental ill-health, and who may be unable to protect themselves from harm, neglect or exploitation.

Advocacy

Help to enable you to get the care and support you need that is independent of your local council. An advocate can help you express your needs and wishes, and weigh up and take decisions about the options available to you. They can help you find services, make sure correct procedures are followed and challenge decisions made by councils or other organisations.

Autonomy

Having control and choice over your life and the freedom to decide what happens to you. Even when you need a lot of care and support, you should still be able to make your own choices and should be treated with dignity.

Best interests decision

Other people should act in your 'best interests' if you are unable to make a particular decision for yourself (for example, about your health or your finances). The law does not define what 'best interests' might be, but gives a list of things that the people around you must consider when they are deciding what is best for you. These include your wishes, feelings and beliefs, the views of your close family and friends on what you would want, and all your personal circumstances.

Carer

A person who provides unpaid support to a partner, family member, friend or neighbour who is ill, struggling or disabled and could not manage without this help. This is distinct from a care worker, who is paid to support people.

Challenging behaviour

Challenging behaviour may cause harm to the person or to those around them, and may make it difficult for them to go out and about. It may include aggression, self-injury or disruptive or destructive behaviour. It is often caused by a person's difficulty in communicating what they need - perhaps because of a learning disability, autism, dementia or a mental health problem. People whose behaviour is a threat to their own wellbeing or to others need the right support. They may be referred by their GP to a specialist behavioural team. The specialist team will work on understanding the causes of the behaviour and finding solutions. This is sometimes known as positive behaviour support.

Deprivation of liberty safeguards

Legal protection for people in hospitals or care homes who are unable to make decisions about their own care and support, property or finances. People with mental health conditions, including dementia, may not be allowed to make decisions for themselves, if this is deemed to be in their best interests. The safeguards exist to make sure that people do not lose the right to make their own decisions for the wrong reasons.

Dignity

Being worthy of respect as a human being and being treated as if you matter. You should be treated with dignity by everyone involved in your care and support. If dignity is not part of the care and support you receive, you may feel uncomfortable, embarrassed and unable to make decisions for yourself. Dignity applies equally to everyone, regardless of whether they have capacity.

Human trafficking

When someone is dishonest to you about the job you are interested in and you travel to a place and find out that you have been lied to. But you have paid money to get there and find out you now need to pay this money back before you are allowed to leave.

Learning Lessons Review

Safeguarding Adults Boards must arrange for there to be a review of a case involving an adult in its area with needs for care and support if there is reasonable cause for concern about how the SAEB, members of it or other persons with relevant functions worked together to safeguard the adult, and the adult is still alive, and the SAEB knows or suspects that the adult has experienced serious abuse or neglect. Each member of the SAEB must co-operate in and contribute to the carrying out of a review under this section with a view to identifying the lessons to be learnt from the adult's case, and applying those lessons to future cases.

Liberty Protection Safeguards

In July 2018, the government published a Mental Capacity (Amendment) Bill, which passed into law in May 2019. It replaces the Deprivation of Liberty Safeguards (DoLS) with a scheme known as the Liberty Protection Safeguards (although the term is not used in the Bill itself).

Making Safeguarding Personal (MSP)

It means that you are asked what you want to do about the incident of abuse and how you may be supported in making yourself safe. It helps you to take control and it gives you choice.

Mental Capacity Act 2005

A law that is designed to protect people who are unable to make decisions about their own care and support, property or finances, because of a mental health condition, learning disability, brain injury or illness. 'Mental capacity' is the ability to make decisions for yourself. The law says that people may lose the right to make decisions if this is in their best interests.

Near miss

Something that is not supposed to happen and is prevented before serious harm is caused.

Outcomes

In social care, an 'outcome' refers to an aim or objective you would like to achieve or need to happen - for example, continuing to live in your own home, or being able to go out and about. You should be able to say which outcomes are the most important to you, and receive support to achieve them.

Proportionality

Doing what is needed, without intruding into people's lives any further than is necessary to meet their needs or keep them safe. It is an important principle in the Care Act 2014

Prevention

Any action that prevents or delays the need for you to receive care and support, by keeping you well and enabling you to remain independent

Think Family

A Think Family approach is the steps taken by practitioners to identify wider family needs which extend beyond the individual they are supporting.

Transitions

This Term relates to the transition between children's and adults' services. Young people, who receive social care, often still need support when they turn 18. 'Transition' is the period of time when young people are moving from childhood into adulthood.

Council services for adults are different from those for children, so it's important that young adults get the services they need to live a full life. This is a very important stage in a young person's life because they need to make plans for their future care arrangements which will help them live as independently as possible.

WHAT THE BOARD WILL BE WORKING ON IN 2019/2020

The Board will continue to be guided by what people are telling us is important to them, as contained in the “house”.

We continue to work in the coming year on the three key areas:

- **Making Safeguarding Personal**

Working alongside our service user groups to develop further ways to hear the voice of the adult at risk on the Board and at a local level:

1. Service user feedback form implementation and audit
2. Marketing of Safe at home videos at a local and national level
3. Review of Train the Trainers programme delivered by service users and Community Champions

- **Creating a safe and Healthy community**

1. Preparation for implementation of the Mental Capacity Act (Amended) 2019 Liberty Protection Safeguards across the Partnership
2. Feedback from joint working group with safeguarding and community safety partnerships on prevention of repeat victimisation of older people
3. Understanding what good Quality Assurance looks like at Board Level

- **Leading listening and Learning**

1. Programme of workshops jointly developed with the Local Safeguarding Children’s Partnership to include: Transitions & Think Family
2. Launch of learning programme from safeguarding adults review and other reviews and exploring ways to better embed learning into front line practice
3. Partnership response and evaluation of Safeguarding Adults Risk Assessment Tool

mistreated?
bullied?
hit?
neglected?
hurt?
exploited?
silenced?

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