# Kingston Safeguarding Adults Board

# ANNUAL REPORT

**1 April 2015 – 31 March 2016**

Kingston upon Thames Safeguarding Adults Partnership Board

# TABLE OF CONTENTS

# Foreword from the Independent Chair of the Kingston Safeguarding Adults Board

Welcome to the Annual Report of the Kingston Safeguarding Adults Board. The Board, in this past year, had 2 Chairs so I would like to start by thanking Simon Williams, the Director of Adult Social Services for Merton, who chaired the Board until September 2015.

I joined the Board as its Independent Chair in October 2015 and it is fair to say that the real work commenced to refresh the Board and the approach to safeguarding in Kingston in January 2016, when the new Head of Service, Julie Phillips joined Kingston. Since then Julie and I have been working together to examine the Board Membership, to ensure we developed, with partners, a new Constitution for the Board and to assure partners that the membership and meetings were able to act strategically, in a positive way and which took account of and enabled improvement of services provided for those who are vulnerable and in need of care and support in Kingston.

In particular, it has been important to assure members that the Board was delivering in accordance with the statutory requirements set out by the Care Act 2014, placing the board for the first time, this last year on a statutory footing.

The commitment of Board members, demonstrated so clearly when we were reviewing the functioning of the Board at its planning and reviewing session in February 2016, was clear and I believe we have a Board which functions at the appropriate strategic level supported by senior managers working operationally who make a difference in each of their constituent organisations. The Board will continue to review its membership as roles change in this ever fluid public sector environment.

So the Board continues its progression and its achievements over the last year are set out in the body of this report. At the Board's planning/reviewing day we began the development of strategic objectives for the forthcoming year. We refreshed the structure and membership of the Board and re-established the Board's sub-groups and their terms of reference. I have always been clear that we need to ensure that we are all reminded about the safeguarding interventions which take place and which protect the borough's most vulnerable citizens. To this end, and at every Board meeting, we examine a person's safeguarding story. In particular we are looking to see if we can demonstrate that professionals from each of our organisations can show that they have "made safeguarding personal". This means that people who are protected are able to identify what outcomes they would prefer to achieve through the safeguarding process.

For the next year (2016/ 2017) clear priorities have been identified.

- Developing greater community awareness about safeguarding and protecting vulnerable people
- Working with care providers to improve the way they can support and protect vulnerable people
- Ensuring that we continue to focus on performance information from all organisations which is relevant and enables the Board to agree and target improvements and also to challenge each other
- Continue to ensure that we embed practice which we term "making safeguarding personal" and which ultimately means that all those citizens who are safeguarded or protected have the opportunity to determine for themselves the outcomes they want to achieve

Our objectives this coming year will build upon these priorities and deliver improved communication to the general public to increase awareness about safeguarding.

It is especially important that all partners continuously audit practice and take forward the lessons learned. We have a way to go with this and are currently re-forming our strategic approach to quality audit.

I would like to thank all those people who support the effectiveness of the Board, but importantly who make a difference to citizens in Kingston, because of their passion for improving services for adults at risk.

Siân Walker
Independent Chair of the Board

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## Introduction

This annual report outlines the progress made during the year in safeguarding adults at risk and is produced on behalf of Kingston Safeguarding Adults Board. This annual report covers the period of 1st April 2015 to 31st March 2016. Each year we have been able to watch and report on the developments of the work carried out by Kingston and its partners to safeguard our vulnerable residents from abuse.

## Who We Are

The Care Act 2014 states that "each local authority must establish a Safeguarding Adults Board (a "SAB") for its area". The Kingston Safeguarding Adults Board (KSAB) was established in 2009 and became statutory on 1st April 2015.

The Board facilitates the drawing together of a wealth of single agency experience from members to allow the Board to tackle more complex, multi-agency issues, ultimately with the aim of helping and protecting adults at risk in Kingston. The KSAB provides opportunities for partner agencies to improve practice to safeguard adults at risk by fostering good interagency relationships and strategic linkages through the Board. The Board also provides opportunities for positive, cross-agency challenge and accountability – which ultimately improves frontline practice.

The Care Act 2014 mandates that SABs should work in consultation with local communities and the local Health Watch; providing partner agencies with the opportunity to shape priorities and improve adult safeguarding responses.

The KSAB has an independent chair. To carry out its role and function the Board needs representatives from each of the main agencies that work with or come into contact with adults at risk. The KSAB is made up of senior representatives from key partner organisations, both statutory and voluntary.

## What We Do

The Care Act 2014 specifies in Section 43 and 44 that the 'SAB' has three core duties and the core duties of the Board is set out in Chapter 14 of the Care Act Statutory Guidance, issued under S78 of the Care Act 2014 which requires the Board to:

- Publish a Strategic Plan for each financial year detailing how it will meet its main objective and what Members will do to achieve this;
- Publish an Annual Report detailing what the Board has done during the year to achieve its objectives and implement its Strategic Plan and what Members have done to implement the Strategy.
- Conduct any Safeguarding Adults Review in accordance with S44 of the Care Act 2014.

The role of the Kingston Safeguarding Adults Board is to lead and co-ordinate the local strategy to safeguard adults at risk of harm or abuse in Kingston. As a partnership, the Kingston Safeguarding Adults Board works to:

- Prevent adult abuse and neglect happening in the community and service settings;
- Promote the safeguarding interests of 'adults at risk' to enable their wellbeing and safety;
- Respond effectively and consistently to instances of abuse and neglect; and
- Learn together.

The safeguarding agenda is much broader than just protecting adults at risk. It is also about allowing adults at risk to stay as much in control of the decision making as possible, whilst taking reasonable measures to ensure that risks of harm are minimised. The right of the individual to be heard throughout this process is a critical element of the drive towards more personalised care and support.

The Kingston Safeguarding Adults Board is proactive in its response to safeguarding adults and aims to promote a broad understanding of safeguarding. This is reflected in a focus on the prevention of abuse as well as a robust response to incidents of abuse. The importance of strong strategic links with other key partners is recognised as essential in order to ensure that all the citizens of Kingston are safeguarded both within the community, and in their homes. Doing this means tackling both the causes of abuse, the processes of dealing with abuse and the prevention of abuse.

## Safeguarding Adults Board Strategy

The KSAB are required to produce a strategy as part of the requirements of the Care Act (2014). The strategy sets out shared priorities and governing principles that continue to guide the way in which the Board works together in order to achieve its priorities. It establishes the shared vision of the partners to create and maintain in Kingston an environment that both safeguards and protects people at risk and in vulnerable situations.

The strategy is not intended to be comprehensive but provides an overview, a sense of direction for safeguarding adults that the Board has agreed. The strategy will be delivered through the KSAB work plan which is reviewed and updated every year.

## Our Structure

Over the year the KSAB has continued to strengthen its partnership arrangements, improve its governance and business arrangements and improve its operational effectiveness in delivery against its priorities.

### Sub Groups

Sub groups have been established to carry out specific functions identified by the KSAB to meet its priorities and/or emerging priorities. The membership of the sub groups reflects the expertise required and involves operational managers, frontline practitioners, commissioners, providers, and representatives from other Boards.

Currently we have re-established three sub groups that sit under the KSAB: Training, Communications and Quality & Performance. A 'Safeguarding Adults Review' sub group will be set up when the Board needs to consider a case for a Safeguarding Adult Review. Task & Finish Groups that report to a sub group are set up when there is a time limited and specific piece of

work to deliver for the Board with a tight focus. An example of this is a Quality Review Task and Finish Group which was asked to review all the safeguarding audits completed by partner agencies to provide a further detailed level of scrutiny.

## Safeguarding Board Achievements

There have been many changes to the membership of the KSAB during the year and early in 2016, the Board came together to review and re-focus its activity. The following objectives were achieved:

- One of the key areas for the board was to respond to protecting adults at risk and the statutory changes that came into effect on April 2015 as a result of the Care Act 2014.
- The KSAB Term of Reference was updated to reflect the board members.
- A KSAB Constitution was developed and agreed.
- KSAB worked to develop a three year strategy although this is still to be finalised.
- Subgroups for quality, communication, and training were re-established and groups began developing their own individual work plans for the coming year.
- We signed up and implemented the new Pan London Safeguarding Adults at Risk policy at the end of March 2016.
- We reviewed Deprivation of Liberty Safeguarding (DoLS) process and are currently working with internal audit to identify and improve process. The outcome of this report will be summarised in the next annual report.
- We started the process of embedding making safeguarding personal across all partners which was a key priority for KSAB. We set up a short term task and finish group consisting of practitioners across agencies to look at developing new safeguarding forms in line with the new Pan London Safeguarding Adults at Risk policy.
- We continue to raise the profile of Adult Safeguarding Board work through regular and annual reporting to Committees, Boards and relevant statutory and governance bodies of all partner agencies.
- The Safeguarding Adults team continues to represent Safeguarding Adults in Kingston through regular attendance of various boards
- We said we will look at enhancing our strategic overview of safeguarding. We have used the NHS Tool and an overarching template for all partners. This template was reviewed at our away day held in March and further challenge sessions will be held in the coming year.

## Feedback from partner agencies on their involvement and work undertaken to protect Adults at Risk in Kingston

## Kingston Clinical Commissioning Group

### Summary of Kingston's Clinical Commissioning Group (KCCG) involvement in Safeguarding Adults at Risk in Kingston

The Kingston Clinical Commissioning Groups safeguarding team work jointly with RBK safeguarding team to promote adult safeguarding and work together when needed on individual and large scale safeguarding investigations. We have recently collaborated to support the safe closure of a nursing home in the Kingston area and we act as lead investigator when there are issues related to health care providers that our organisation commissions.

The KCCG safeguarding team are an active member of the KSAB and its sub groups and monitor standards and quality of adult safeguarding across the Royal Borough of Kingston.

### How has the KCCG worked to prevent abuse occurring?

As a commissioning organisation we seek assurance from our providers that their staff training, policies and procedures are all current and up to date and gain assurance that organisation are reporting on all safeguarding issues.

We receive statistical information from providers on their training figures and information in regards to serious incidents and safeguarding concerns.

There are regular care and quality review groups for commissioned services where safeguarding is discussed and any identified issues and problems have action plans formulated to resolve these and mitigate risk.

### How has the KCCG worked to improve awareness of safeguarding?

The KCCG safeguarding team have been working with our local GP's surgeries and primary care to support and present training on adult safeguarding at the primary care education days, as well as beginning work providing direct training to all staff at GP's surgeries throughout Kingston.

The KCCG safeguarding team has recently trained 81% of its staff team on basic awareness of adult safeguarding and are due to train the KCCG governing body by the end of 2016.

A new adult safeguarding page for the GP team net (which is the intranet service for all Kingston Primary Care) has been set up with useful links contacts and information on adult safeguarding.

### How has KCCG included making safeguarding personal into their safeguarding practice?

The KCCG safeguarding team have worked pro-actively with service users and families to include them as much as possible in the safeguarding process, evidenced when they have been lead investigators for recent safeguarding cases. The KCCG safeguarding team work with service users and families to gain their feedback on the safeguarding process.

During training sessions the KCCG safeguarding team, promote making safeguarding personal and stress the importance of having the person at the centre of the process. The KCCG team are working with commissioners to ensure new contracts include information in regards to making safeguarding personal

### Examples of how KCCG has delivered the KSAB vision for safeguarding Adults at Risk?

The KCCG have senior representation at the KSAB. The KCCG governing body have regular adult safeguarding updates and are made aware of any issues arising. 81% of KCCG staff have now received training protecting adults at risk awareness training. The KCCG is working with providers to train the trainer on Prevent. Training on adults at risk is a regular theme in the primary care education programme. Work has started on training staff in GP's surgeries on safeguarding adults at risk.

## Metropolitan Police (MPS)

The MPS is committed to the protection and safeguarding of adults at risk. At a strategic level the MPS is a statutory partner and contributes to the review of the London Multi Agency Safeguarding Adult procedures. At Kingston representation on the Safeguarding Adult's Board is at Superintendent Level, who has oversight of the required borough delivery for the arrangements.

On a day-to-day practical level, Kingston Police have a team of officers that work alongside other partner agencies in the MASH. Every report of an Adult Coming to Notice (Merlin) that is created by officers is risk assessed by the MASH team. These Merlin's are then ragged on a traffic light system, with RED being the most concerning. Research is conducted within the MASH prior to the reports being sent via secure e-mail to the adult safeguarding team. This is a daily occurrence as Merlin's are created 24/7 by officers within the borough. The MASH team follow up referrals via the safeguarding team to ensure they have been received and allocated to a worker to progress.

**How has the Metropolitan Police worked to prevent abuse occurring?**
Every MERLIN is risk assessed within the MASH unit before it is sent to adult safeguarding. If there are highlighted concerns within the content of the MERLIN, suggesting a crime is likely to take place, or there are concerns that the subject is being exploited, often financially or being taken advantage of by others due to their disability, mental health or lack of mental capacity, then the MASH will create a separate crime report for these concerns if there is not already an open report being investigated by the Community Safety Unit. The MASH will take ownership and contact the safeguarding team directly to establish if the subject is open to services. If this is the case, a meeting is arranged with safeguarding to share the concerns and arrange a joint home visit.

The MASH will also contact the relevant neighbourhood policing team covering the subject to ensure the dedicated ward officer is aware of the concerns and they will often be tasked with extra patrols in the area and provide further reassurance visits to the subject. There will be strong communication between police and safeguarding to ensure the risk to the subject is managed and minimised.

**How has the Metropolitan Police worked to improve awareness of safeguarding?**
Locally, the MASH have recently delivered training to officers within the CID and to Safer Neighbourhood Teams on disability hate crime and the pathway on how to report such concerns. The training package for disability hate crime has also been emailed to staff by way of a power point presentation. Frontline staff have also received mandatory training on the 'Vulnerability Assessment Framework'.

There is also ongoing training which is delivered to probationary officers regarding the creation of MERLIN reports, to ensure the officers realise the importance of recording all the relevant information as well as their concerns so the information can be shared with adult safeguarding.

Corporately, MPS personnel are supported by operational instructions that inform them of their responsibilities under the Mental Capacity Act and have Strategic Support units to provide operational support and advice as required on safeguarding and mental health issues.

The Mental Capacity Act and the role of the Court of Protection feature as part of the Vulnerability and Adult at risk toolkit and the MPS Mental health Toolkit that is currently under development.

**How has Metropolitan Police included making safeguarding personal into safeguarding adults at risk?**
This is an area for further development. Every effort is being made in the MPS at a local and corporate level to improve the awareness, oversight and management of adult safeguarding issues including the implementations of making safeguarding personal.

**Examples of how Metropolitan Police has delivered upon KSAB vision for safeguarding adults at Risk?**

A positive outcome from a recent investigation whereby there were concerns the elderly subject, who was 82 years and diagnosed with dementia, was being exploited financially. Police and safeguarding worked closely on the case, sharing information and conducting home visits on the subject, to ensure she was protected and the relevant safeguarding measures were put in place. Although there were no criminal offences alleged, the perpetrator was identified and given strong words of advice to refrain from making contact with the victim. The desired outcome was achieved, as the perpetrator left the area and stopped all contact with the subject.

A further example is where the proactive unit were investigating a matter of Possession with Intent to Supply (PWITS) drugs at an address being occupied by a vulnerable female. The individuals involved in the drug dealing were arrested and dealt with, and to reduce the risk of further offences being committed at the address and anti-social behaviour in the area, a closure order was applied for at the court by officers, which prevents access to the premises by the criminals.

## Kingston Hospital Foundation Trust

As an acute provider Kingston Hospital Foundation Trust has a duty to respond to concerns of abuse, harm or neglect of adults and children, be responsive to national evidence and local need and provide assurance of compliance with; the local multi-agency guidelines for safeguarding adults, the Care Quality Commission Registration standards and the Care Act 2014. In summary the Trust manages allegations of abuse and neglect and ensures that safeguarding is integral to everyday practice.

Kingston Hospital NHS Foundation Trust (KHFT) has adopted the London Multi-Agency Adult Safeguarding Policy and Procedure, released in December 2015, to ensure there is consistency in practice across London.

Executive Safeguarding leadership is provided by the Director of Nursing and Patient Experience and the Deputy Director of Nursing, as Safeguarding Adults Lead, is responsible for overseeing the delivery and monitoring of policy in practice. The Safeguarding Adults Lead Nurse is responsible for daily delivery and monitoring of safeguarding practice and procedures in collaboration with staff and local agencies.

KHFT have a nominated PREVENT Lead and training is being disseminated across the trust.

**How has your organisation worked to prevent abuse occurring worked to prevent abuse occurring?**

The Safeguarding Adults Lead Nurse has established relationships with all the Borough Safeguarding Leads relating to KHFT. KHFT contributes to complex investigations both on an individual service user basis and from the perspective of whole service reviews.

To support staff in screening all pressure ulcers for cases of abuse and neglect the Safeguarding Lead Nurse works closely with the Tissue Viability Specialist Nurse. Significant improvements have been made, one year into a three-year strategy to reduce pressure ulcers at Kingston Hospital during 2015/16.

KHFT regularly make Deprivation of Liberty Safeguard applications to all local boroughs where patients lack capacity to understand that they need to remain in KHFT for care and treatment.

Learning Disability Specialist Nurses from Your Healthcare Neurodevelopmental Services Specialist Healthcare Teams for Kingston and Richmond provide acute liaison and support for patients with a learning disability who attend KHFT

Female Genital Mutilation (FGM) information recorded by clinical staff is collated by the Trust in order to capture the relevant information for the FGM Prevalence Dataset.

**How has Kingston Hospital Foundation Trust worked to improve awareness of safeguarding?**
The Trust provides safeguarding adults training for every member of staff with a mandatory requirement for a three yearly update; training includes training on the Mental Capacity Act and Deprivation of Liberty in practice.

Training is provided in a variety of formats including; corporate induction and mandatory training via an online training booklet and a rolling monthly programme directed at band 2 and band 5 staff. WRAP training is provided for PREVENT.

Bespoke Safeguarding and MCA training has been provided for specific departments in KHFT for example: The Royal Eye Unit, Palliative Care, Dieticians, and Occupational Therapists.

Training levels are monitored at the Safeguarding Adults and Learning Disability Steering Group and Executive Management Committee.

KHFT has a dedicated internal Intranet page for Safeguarding MCA DoL's and Learning Disabilities. This directs staff to information and all forms relating to these subjects.

**How has Kingston Hospital trust included making safeguarding personal into safeguarding in your organisation?**
Linking into the implementation of the Care Act 2014 and SAPB's led priorities for safeguarding adults, KHFT is committed to the "Making Safeguarding Personal" approach to safeguarding practice and policy. Training sessions focus on the MSP approach to inform and support decision making.

KHFT has secured resources to increase the capacity of the Safeguarding Team to support with Safeguarding and DOL's. This will allow more robust triage of safeguarding concerns and face to face support to aid decision making to become more personal to each individual. It will also aim to assist the boroughs with Section 42 enquiries, thus enhancing the involvement, choice and control for individuals to improve quality of life, well-being and safety.

The Learning Disability (LD) Team provide specific training to staff, both bespoke to the wards/departments and in conjunction with the Education Centre to support best practice for all individuals with LD who attend KHFT.

**Any examples Kingston Hospital Trust has delivered upon our vision for safeguarding adults at Risk (any actions or achievements)?**
KHFT fully supports and upholds the KSAB vision. KHFT's safeguarding work plan for 2016/17 has been updated to reflect recent changes in the above along with a drive to ensure absolute compliance across the organisation.

KHFT have conducted an audit of electronic data related to safeguarding which has enabled the adult safeguarding and children's safeguarding structures to work collaboratively to ensure that governance arrangements are in place to support both services.

The increase in capacity of the adult's team at KHFT will assist with building stronger relationships with all the borough teams and external agencies. It will allow for enhanced data capture and training.

## Your Health Care

Your Healthcare (YH) is a CIC (Community Interest Company). In Kingston YH provides a range of both Adult and Children's community health and social care services. YH is committed to responding to situations which present a risk of abuse and immediate reporting any situation which constitutes a safeguarding concern. In 2015/16 YH raised a total of 112 Safeguard alerts and has supported and contributed to a number of complex enquiries.

YH is an active member of the Safeguarding Adults Partnership Board and has been represented on all sub-groups and is currently the chair of the training sub-group. In 2015/16 YH supported joint training in the borough which was open to all partners and to community providers regarding Pressure Ulcers & Safeguarding and workshops on Mental Capacity.

YH contributes to complex investigations both on an individual service user basis and from the perspective of whole service reviews.

In 2015/16 the IMPACT service in Community Nursing has continued to work with nursing homes to improve the quality and robustness of the services being provided. This commissioned service has supported quality initiatives and contributed to reducing safeguarding risk factors within the nursing homes.

The YH Pressure Ulcer Review Group has evidenced a significant decrease in pressure ulcer grade 3 and above and in so doing has shown improvements in preventative work.

Training is key in prevention and detection of safeguarding and safeguarding, Mental Capacity Act (MCA) training and Prevent are all mandatory training requirements for YH staff.

YH continues to work closely with the local authority to identify cases where the Deprivation of Liberty safeguard apply both in our residential and nursing services and within the community.

Safeguarding awareness training at the time of preparing this report stands at 60% of the workforce, with 63% having completed mental capacity and DOLS training. Adult Safeguarding is now well established in the organisation's induction and mandatory training programmes. Safeguarding is a standing agenda item on all governance groups with reports presented to the Integrated Governance Committee, which in turn provides assurance to the YH Audit and Assurance Board. The investment in training our workforce and raising awareness levels of safeguarding and mental capacity, has ensured our staff are informed and enabled to support services users and partners in the daily working environment.

YH has both Internet and Intranet pages on adult Safeguarding and Intranet information pages on Prevent. The internet page which is public facing has direct links to the surrounding local authority websites and in addition YH has ensured the availability of borough safeguarding leaflets within our service areas.

As our services work alongside many other community providers we actively share our knowledge of safeguarding with our partners.

YH places the individual at the centre of what we do and as an organisation we aim to be the community provider of choice.

However personalisation requires much more than safety and protection and as such YH has also prioritised the promotion of choice, and empowerment.

This is achieved by the application of the Mental Capacity Act (MCA) and in the later part of 2014 the decision was made to re-launch MCA Awareness training. At this time all clinical staff are receiving refresher training in MCA awareness. The aim being that everyone working directly with service users will receive two yearly updates in MCA. The focus of this training being the key principles of the MCA and Best Interest of engagement, empowerment and choice.

Key to the vision within Kingston is the implementation of the Care Act (2014) and the London Multi-agency Safeguarding Adults Policy and Procedure and as such we have worked to review all YH Policies and procedures to ensure care act compliance.

The 2016-17 refresher training for safeguarding focuses on the changes in the safeguarding agenda and highlights the new categories classified under adult safeguarding and the responsibilities we hold as a partner organisation in ensuring that the service user is central to the entire process and that their desired outcomes are key in the reduction or removal of the risk that has been identified.

## South West London and St Georges Mental Health Trust

**Leadership, Governance and Partnership**
The Safeguarding Adults policy was reviewed and updated to align with the Care Act and associated statutory guidance. The policy describes the leadership and governance arrangements in place to maintain the highest standards of practice and performance. Making services safe for service users is fundamental to the provision of high-quality health services. The Trust has made this a top priority as part of a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against statutory, national, and local guidance, policy and standards.

The Trust governance of adult safeguarding is achieved through clearly defined roles with responsibilities for the oversight of governance and operations of adult safeguarding, including line management accountability and reporting lines. The safeguarding governance system is also mapped out in terms of the responsible internal groups and committees.

The policy also describes the responsibilities of the Trust as a provider organisation in its own right and how the Trust works in partnership with Borough-specific Safeguarding Adults policies and procedures.

**How has South West London and St Georges Mental Health Trust worked to prevent abuse occurring?**
The introduction of the Safeguarding Adults Review process provides an opportunity for greater levels of scrutiny of the most challenging cases.

The Integrated Learning Group ensures that appropriate structures, and support processes are in place to identify learning through the review of data and information from Patient Experience, Claims, Inquests, Serious Incidents and Safeguarding Adult Reviews.

In February 2015, the Secretary of State for Health published an independent report - *Themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile* – written by Kate Lampard. The report summarises the findings of the NHS Savile investigations into allegations of abuse by Savile at a number of NHS hospital sites, and identifies themes and lessons to be drawn by the NHS as a whole.

All recommendations have been met by the Trust and all actions are complete, with the exception of the development of a formal relationship with the Leagues of Friends due to constitutional issues.

**How has South West London and St Georges Mental Health Trust worked to improve awareness of safeguarding?**
Workforce development will be prioritised. Comprehensive training plans have been developed that gives detail to the competences and roles within adult safeguarding, including Prevent and the Mental Capacity Act.

The Trust aims to ensure that all its staff have access to the appropriate safeguarding training, learning opportunities and support to facilitate their understanding of the clinical aspects of adult welfare and information sharing.

Current compliance with Safeguarding Adults Level 1 stands at 92%.

A ‘Patient Information’ leaflet entitled ‘Safeguarding Adults’ has been produced and distributed to all teams and services.

**How has South West London and St Georges Mental Health Trust included making safeguarding personal into safeguarding in your organisation?**
In 2014/15 the Safeguarding Adults leadership team initiated a monthly ‘Making Safeguarding Personal Group’. Throughout 2015/16 monthly meetings were held and the group has formulated a number of recommendations that have been presented to the Safeguarding Adults Quality and Compliance Group.

The Trust Care Programme Approach policy was reviewed and updated. Active service user involvement and engagement is at the heart of the approach, and it will focus on reducing distress and promoting social inclusion and recovery. It is based on a thorough assessment of the service users’ individual circumstances. Care plans are developed with full collaboration of the service user and focus on the service user’s strengths and seek to promote their recovery. Care plans recognise the diverse needs and preferences of service users, reflecting their cultural and ethnic background as well as their gender and sexuality.

**Any examples of how South West London and St Georges Mental Health Trust has delivered upon our vison for safeguarding (any actions or achievements)?**
The Trust developed and ratified a Mental Capacity Act (MCA) 2005 Policy

The Mental Capacity Act 2005 (MCA) is one of the main legal frameworks which guides and determines the work of the Trust. It protects the rights of service users, and also enables staff to intervene within a Human Rights compliant framework.

This policy lays out how the Trust implements the Mental Capacity Act (MCA). It describes the processes staff should follow to comply with their professional duties. It also clarifies to whom the MCA applies. It provides the framework for the implementation of Deprivation of Liberty Safeguards. In addition it lays out how the MCA and the Mental Health Act (MHA) fit together in practice in key aspects. It outlines the Trust’s commitment to train staff in key areas of MCA and related practice.

## London Ambulance Service

The London Ambulance Service NHS Trust (LAS) has a duty to ensure the safeguarding of vulnerable persons remains a focal point within the organisation and the Trust is committed to ensuring all persons within London are protected at all times.

The LAS report provides evidence of their commitment to effective safeguarding measures during 2015/16. A full report along with assurance documents can be found on the Trusts website.

**Referrals or concerns raised to local authorities during 2015-16**
The LAS made a total to 17332 referrals to local authorities in London during the year. 4561 children referrals, 4331 Adult Safeguarding Concerns, 8440 Adult welfare Concerns

**Safeguarding Training**
The Trust is committed to ensuring all staff are compliant with safeguarding training requirements. The chart below shows staff directly employed by the LAS as well as voluntary responders and private providers who we contract to work on our behalf.

## Safeguarding Adults Board Objectives 2016/2017

The board has started to plan the work for the following objectives for this year. The away day held in February 2016 helped us to identify further areas that we need to progress and this will be reported in the next annual report**.**

The board is keen to ensure that adults at risks are central to the safeguarding process and we are continuing to embed our new making safeguarding personal forms ensuring that service users are at the heart of all practice.

We are moving to electronic data recording in Kingston Adult Social Care to ensure more robust processes on the collection and management of safeguarding enquiries.

The Mental Health Trust will be implementing an electronic process that is consistent with the data collection by Kingston on Ulysses.

Adult Social Care will be working with the Metropolitan Police to improve process around the sharing of information and tasking as a result of MERLIN's. MERLIN is a database run by the Metropolitan Police that stores information on vulnerable people, found people, missing persons as well as child protection matters which have become known to the police for any reason.

Adult Social Care will be working with Achieving for Children (AFC) to build more robust processes and understanding around safeguarding adults at risk and children at risk of harm. A series of bite size joint training will be rolled out across all adults and children social work team over the coming year.

We will be reviewing our Deprivation of Liberty policy to reflect the changes as a result of the Cheshire West judgement.

## Review of Training

This year we have had a comprehensive training programme designed to provide skills and experience to practitioners across all agencies. The training programme has included basic safeguarding, investigators training and assessing the alert. This has ensured that staff at all levels across the social care sector were able to get the most up to date legislation and guidance on safeguarding practice. Coupled with the safeguarding training, a number of courses relating to domestic violence, forced marriage, Deprivation of Liberty, Risk Assessment and the Mental Capacity Act were run.

The Learning & Development Manager continues to work very closely with the Corporate Training Department to ensure that all training needs are taken into account and that we are aware of the most current issues affecting vulnerable adults in Kingston.

For the coming year we have secured a wide variety of courses specifically aimed at Safeguarding Adults at Risk.

## Summary of Deprivation of Liberty Safeguards Statistics (DoLS)

The Mental Capacity Act (MCA) 2005 was amended to provide safeguards for people who lack capacity. Specifically, to consent to treatment or care in either a hospital or care home that, in their own best interests, can only be provided in circumstances that amount to a deprivation of liberty. This is known as Deprivation of Liberty Safeguards (DoLS). These safeguards came into force on the 1st April 2009. The purpose of this was to provide a legal framework for acting and making decisions on behalf of these individuals. The safeguards cover a particular group of people; these are:

- People who are 18 years and above with significant Learning Disabilities, Dementia, Autism, Brain or Neurological injury/conditions.
- They apply to people who are in a care home (residential and nursing) and acute hospitals. DoLS does not apply to people detained under the Mental Health Act 1983.
- The DoLS assessment incorporates the process for referral, allocation and monitoring which is undertaken by the Adult Safeguarding Team.

In the period of 1st April 2015 – 31st March 2016 there were 729 DoLS requests received, compared to 648 for the same period the previous year. This represents a 13% increase in the number of referrals. The increase in DoLS referrals is in line with national performance. Kingston uses the ADASS priority tool to allocate the DoLs assessments. 82% of authorisations are completed within the statutory timescales, (7 days for an urgent referral and 21 days for standard referrals).

### DoLS Request Received by Month

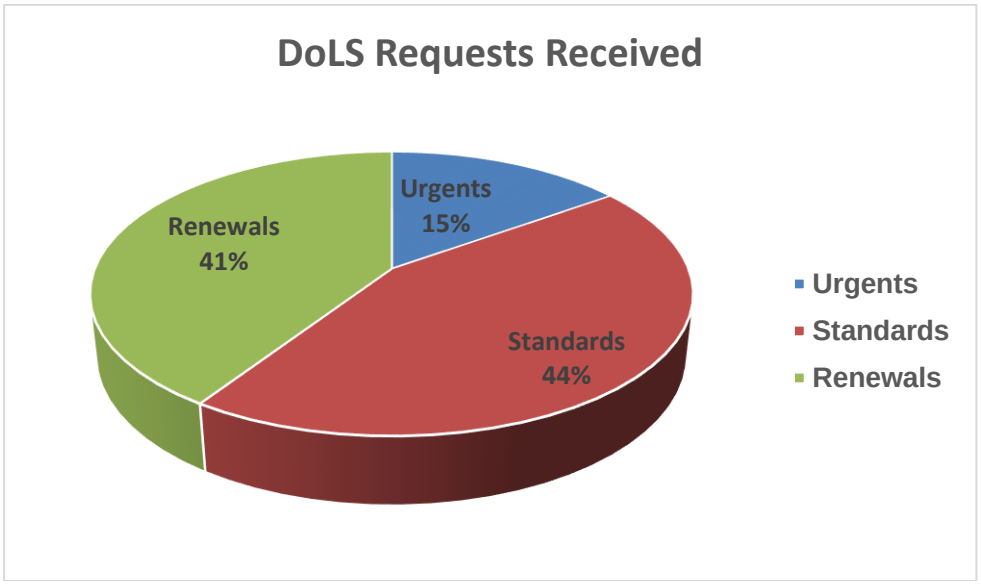
The table below shows the amount of DoLS requests received in each month.

| April | May | June | July | August | September |
|---|---|---|---|---|---|
| 48 | 52 | 78 | 82 | 56 | 45 |
| **October** | **November** | **December** | **January** | **February** | **March** |
| 97 | 31 | 49 | 63 | 87 | 41 |

### DoLS Requests Received

During the period of 1st April 2014 – 31st March 2015 there have been:

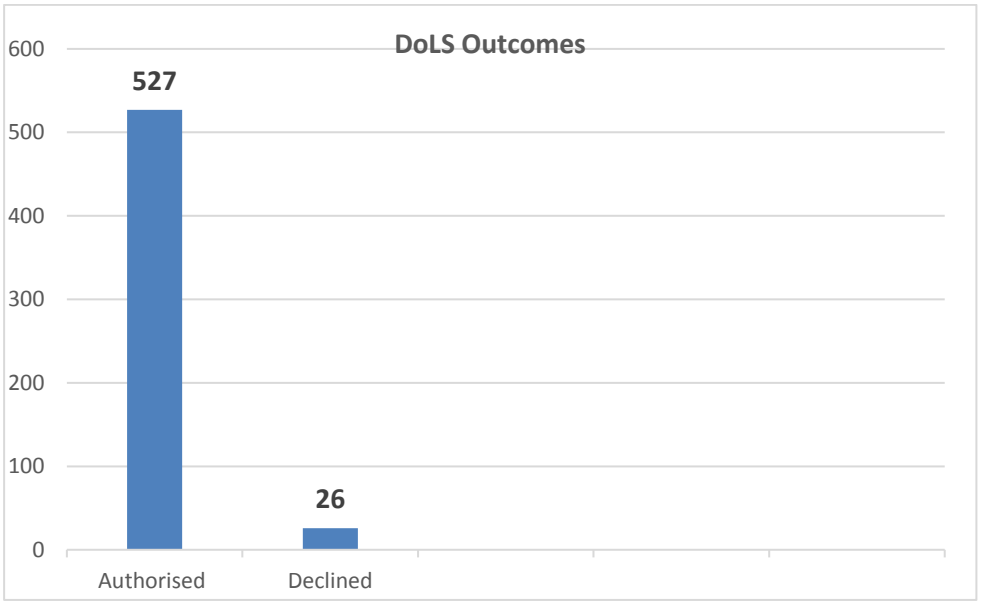
- 322 Standard requests (21 days to complete the 6 assessments)
- 110 Urgent requests (7 days to complete the assessments)
- 297 Renewals (residents already under a DoL that will be expiring)




We have received 297 repeat referrals into the DoLS Team. This is whereby a DoLS authorisation is expiring so a further authorisation has been requested. This represents 41% of the requests for authorisation.

**DoLS Outcomes**

The chart below shows the amount of DoLS that have been authorised and declined.




Applications that are declined are as a result of either the service user dying prior to the DoLs process being completed or as a result of not meeting the criteria for an authorisation.

**DoLS by Care Group**

The table below shows the number of DoLS requests received by client group.

| | |
|---|---|
| Learning Disability | **23** |
| Mental Health<br>*(of which)*<br>Dementia<br>Mental Health other | **192**<br><br>**181**<br>**11** |
| Physical Disability | **76** |
| Not Known | **438** |

As can be seen above, the highest numbers of DoLS requests were for Mental Health (includes Dementia as a category therefore incorporation of older people followed by those with a physical disability.

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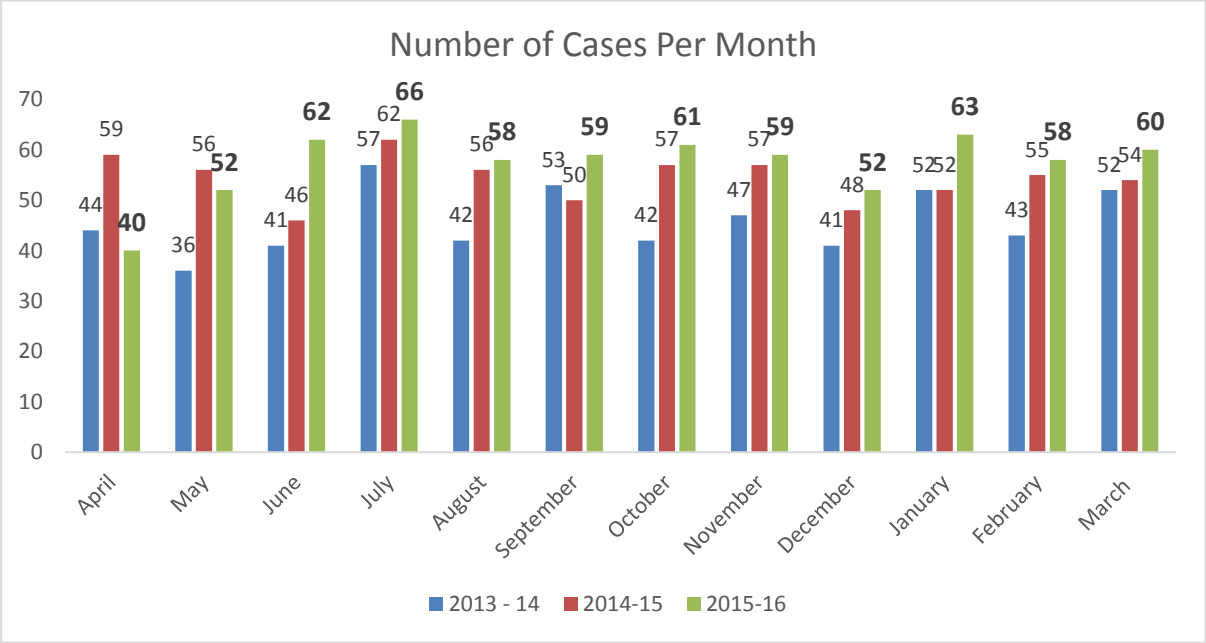
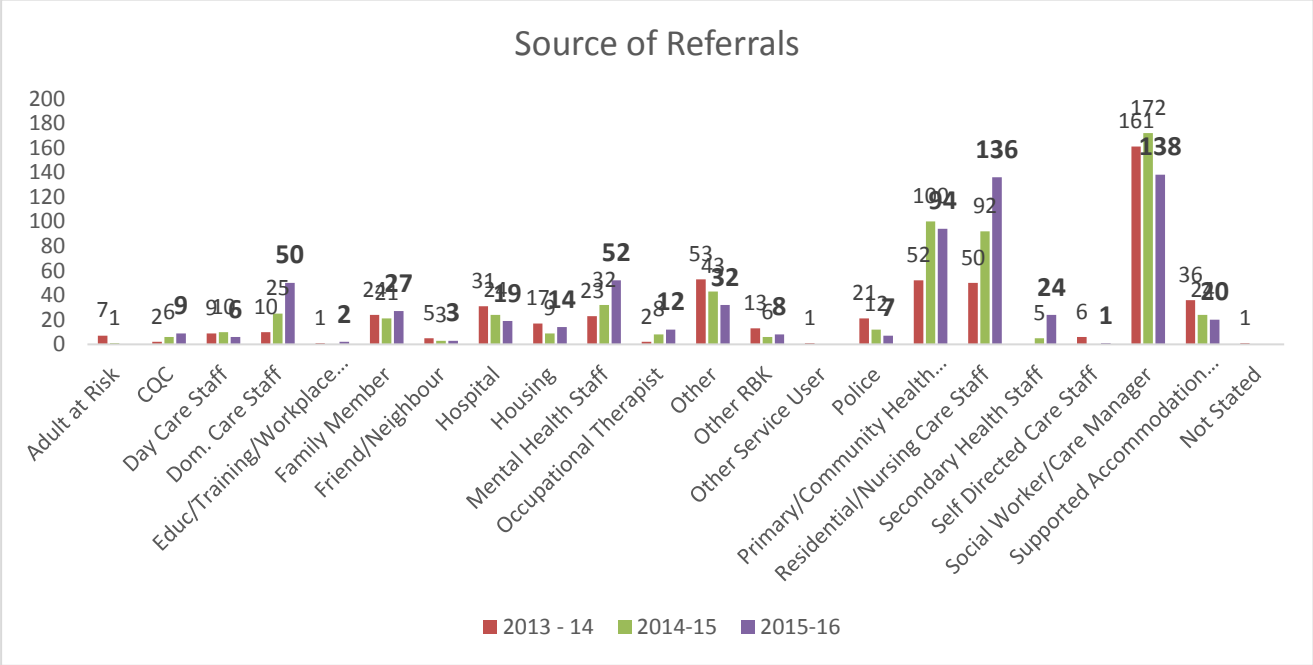
## Summary of Safeguarding Adults Statistics

The number of reported cases of adult abuse (alerts and including those that moved on into referral) received during 1st April 2015 – 31st March 2016 is 690. This is an increase of 6% compared to the same period the previous year, which is seen as a positive as it reflects that our community are aware of safeguarding and know how to report it. Nationally the increase in referrals following the implementation of the Care Act is much higher than Kingston. It is suspected that due to manual recording the data captured does not reflect the local picture. Further work has been planned for the forthcoming year in order to move to a more robust electronic system of recording.

### Number of cases by month

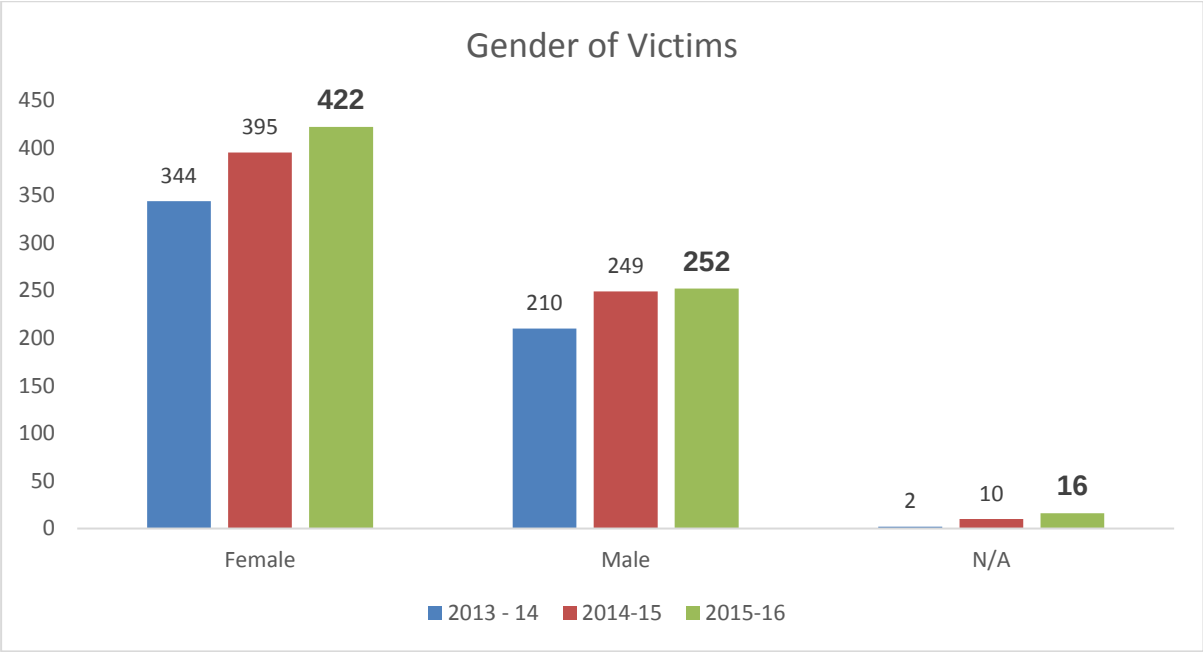



### Source of Referrals



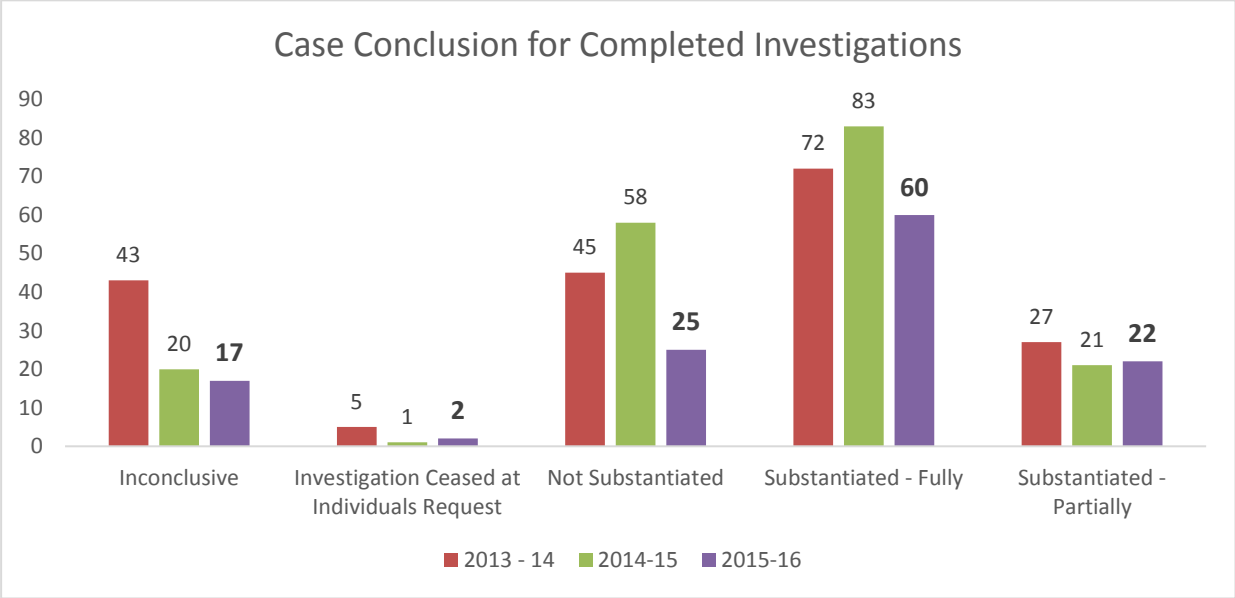
Social care staff are the highest referrer of safeguarding. This is followed by staff in care homes. Referrals from community health staff have remained broadly stable. Referrals from the police have dropped again this year. Work needs to be undertaken to identify reasons for this.

**Gender of Victims**




Females, and in particular single people, are more likely to be abused. The referral rate for males has remained the same as the previous year. This may be as a result of males being less likely to raise a safeguarding alert due to the stigma of being a victim.

**Case conclusion for completed investigations**

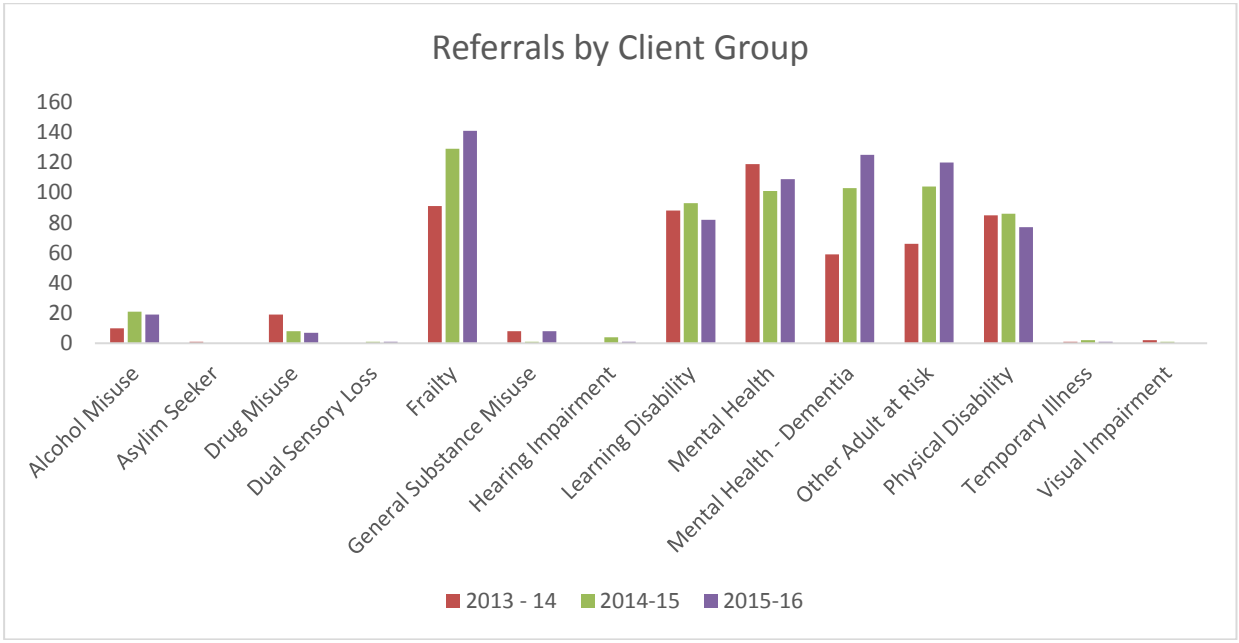



124 reported safeguarding cases went on to investigation. Out of those, 60 were substantiated fully, 22 were partly substantiated, whilst 25 were not substantiated and 17 were inconclusive.

It is important to note that a decision whether a case is substantiated or not is determined on the balance of probability and is a multi-agency decision by the strategy group following review of

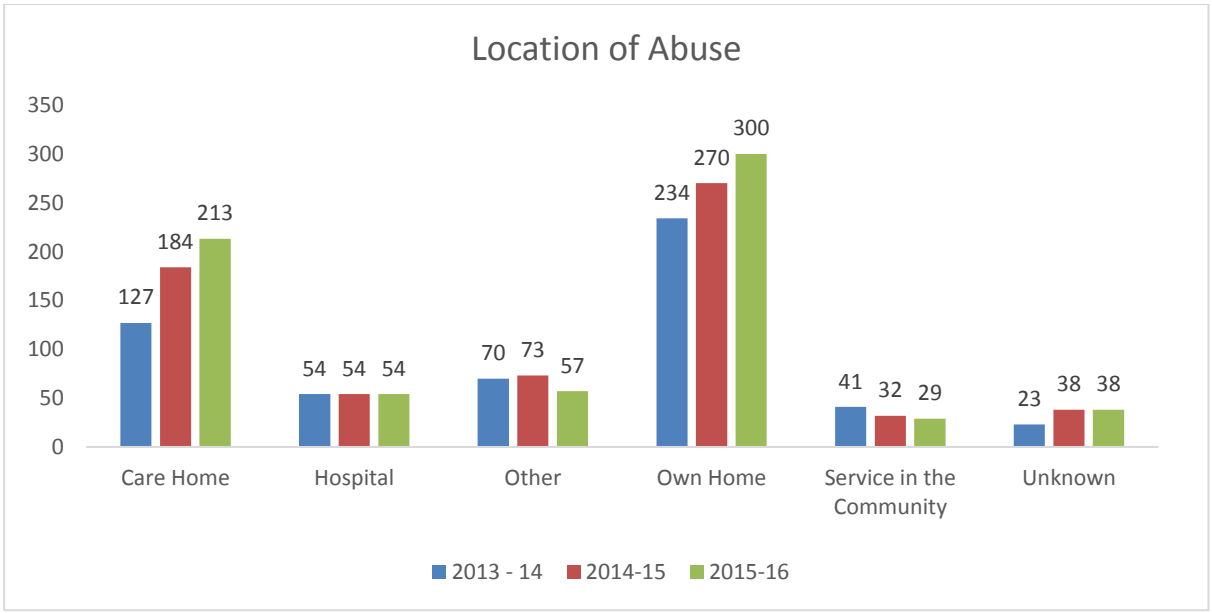
investigation. As safeguarding progresses on from the introduction of the Care Act 2014, the case conclusion will change focusing on customer outcomes from the Making Safeguarding Personal Agenda and decision based on risk to customer following the safeguarding adult's process.

**Safeguarding Referrals by Client Group**




Those listed with frailty as their primary support needs were where the most safeguarding referrals were received. This is consistent with previous data. This connects to the large number of alerts received of people living in a care home as typically it will be older people that reside in care homes (and nursing).

**Location of Abuse**




People living in their own homes is where most of our safeguarding cases occurred. This was followed by those living in a care home. This year saw a rise in multiple alerts regarding customers

in the same care home. These investigations contained more than 5 customers at times so this would inflate the data in relation to safeguarding investigations undertaken in care homes.

**How has this data informed our work?**

- Closer joint working with our contracts team, sharing responsibilities connected to the safeguarding adults investigations within care homes. This has helped sharing information between teams, understanding which team is most appropriate to lead an investigation and further effective liaison with our key agencies such as the Care Quality Commission.

- As this year reported a decrease in alerts, we will need to review our processes and data capturing to ensure that it accurately reflects safeguarding alerts reported in Kingston. To determine when to log as a safeguarding alert and when this should proceed to investigation. Following the introduction of the Care Act 2014 further emphasis on quality of information is key at point of referral in order to make an informed decision as to what is logged as a safeguarding alert.

- Consideration of response to domestic violence and abuse alerts. As the data evidences a rise in females having been victim of alleged abuse, safeguarding adults work need to ensure the involvement of key support services. For example, sharing services such as One Stop Shop and ensuring strong attendance at MARAC.

## GOING FORWARD – WHAT WE PLAN TO DO IN THE COMING YEAR

**Safeguarding Adults Board Objectives 2016/2017**

The board has started to plan the work for the following objectives for this year. The away day held in February 2016 helped us to identify further areas that we need to progress and this will be reported in the next annual report**.**

The board is keen to ensure that adults at risks are central to the safeguarding process and we are continuing to embed our new making safeguarding personal forms ensuring that services users at the heart of all practice.

We are moving to electronic data recording in Kingston Adult Social Care to ensure more robust processes on the collection and management of safeguarding enquiries.

The Mental Health Trust will be implementing an electronic process that is consistent with the data collection by Kingston on Ulysses.

Adult Social Care will be working with the Metropolitan Police to improve process around the sharing of information and tasking as a results of MERLINS.

Adult Social Care will be working with Achieving for Children (AFC) to build more robust processes and understanding around safeguarding adults at risk and children at risk of harm. A series of bite size joint training will be rolled out across all adults and children social work team overs the coming year.

A number of further areas for joint working with AFC have been proposed and will be presented to the Board for approval in 2016-17. These include:

- Mental Capacity Act and Self Neglect
- Sharing learning from Safeguarding Adults Reviews and Serious Case Reviews

The board will continue to work with the Health and Wellbeing Board, Safer Kingston Partnership and the LSCB to identify common aims and align work plans to maximise capacity and avoid duplication. We will continue to address issues identified through local children's Serious Case Reviews, through participation in Kingston Domestic Strategy Board, Safer Kingston Partnership Board and the Health and Wellbeing Board.

We will be reviewing our Deprivation of Liberty policy to reflect the changes as a result of the Cheshire West judgement.

**The Training Sub Group will be focusing on the following objectives:**

- Further joint work with other Boards
- Making Safeguarding Personal
- Mainstreaming Making Safeguarding Personal work
- Evaluating the impact of MSP
- Embedding within all partner organisations
- Improving User Engagement