Kingston upon Thames Safeguarding
Adults Partnership Board

Adult Safeguarding Annual Report 2016-17

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Foreword from the Independent Chair

I am again delighted to introduce the Kingston Safeguarding Adults Board Annual report for 2016/17. In the previous year we began by identifying the considerable work which needed to be carried out to ensure, that as a Board, we are accountable to the citizens of Kingston for Safeguarding people with care and support needs who are unable to protect themselves.

This last year has been one of consolidation and this report sets out the considerable work which has been undertaken by people from all the partner organisations.

A key remit for the Board is to provide assurance that all partners are effectively delivering services which safeguard and protect people from abuse. To do this effectively we must all ensure that citizens are clear about the quality services they can expect. To enable us to do this, we are currently working on improving effective communication with the wider public.

We must also ensure there is a culture of continuous learning and improvement in all organisations; that there is a transparent culture where staff and importantly people who use services know when they need to report a concern and how to do this. The Board has responsibility for holding partners to account for the training provided to their staff, and importantly will also be the lead in learning from significant events and incidences where services quality should have been better or where a number of organisations providing support for someone did not communicate well. In this Annual Report we have set out two safeguarding stories which explain a serious concern in relation to a person and we have identified, as a Board the improvements which needed to be made following the safeguarding enquiry.

When I started my role in 2015, I set out that I am personally committed to making the experience of people who are safeguarded, a good personal experience. We have done much to begin to achieve this and the subject of 'Making Safeguarding Personal' is mentioned in this Annual Report.

We have more to do and especially, if we are to support and promote the ability for people to live as independently as they can; we need to ensure that this goal is well understood by our citizens and all organisations which support and assist people in need. This further requires us to communication better with the general public and I hope to be reporting next year, that we have started to improve the conversation about safeguarding in the wider public arena.

Siân Walker

Independent Chair, Royal Borough of Kingston upon Thames Safeguarding Adults Board

Executive Summary

The Safeguarding Adults Board Annual Report 2016-17 provides an overview of the Board's achievements over the last 12 months and its priorities for the year ahead.

The Board, its sub-groups and all partner agencies have worked hard through 2016-17 to ensure safeguarding adults continues to be a priority across the borough. As partners we are committed to working together to keep people safe from abuse and to continue improving our practice including making safeguarding more personal.

During 2016-17 we made significant steps forward as a Board and achieved:

- Following a review of all processes and activity in relation to the Care Act 2014 we successfully implemented all the changes required
- Adoption of new Pan-London Policy & Procedures and publication of revised and complimentary local procedures
- Publication of the Board's Vision and 3 year Strategy
- Establishment of a process and robust governance for Safeguarding Adult Reviews
- Full self-assessment audit of most partner agencies on the Board
- Implementation of an enhanced person-centred safeguarding process which means we really do ensure the person is at the centre of everything and all their wishes are taken into account
- Establishment of a Vulnerable Adults Multi-Agency Panel to examine criteria for those people who are considered to be at high risk
- Publication of a Safeguarding Adults leaflet
- Further development of the Board with improved engagement of Board members, some of whom now chair/lead some of the Board's sub-groups
- An Education Grant for Mental Capacity Act 2005 (MCA)/Deprivation of Liberty Safeguards (DoLS) education with NHS Clinical Commissioning Group

Looking forward to 2017-18, all agencies across the partnership are committed to continue to deliver on our vision and strategy and work towards achieving the priorities set out in our 3 year business plan, including:

- Continuing to develop our role as the strategic lead for safeguarding, building on our leadership responsibilities with our statutory partners
- Supporting local care and health providers to improve the quality of care and support, with "zero tolerance" for providers who put people at risk
- Finding innovative ways to undertake Safeguarding Adult Reviews and ensuring learnings are shared appropriately
- Continuing to improve our practice and making safeguarding more personal
- Improving awareness of adult safeguarding through a variety of channels and ensuring there are improved links with the Safer Kingston Partnership as well as continuing links with the Kingston Safeguarding Children's Board
- Developing a performance framework which better informs the success of our collective actions and shows where we need to make other improvements

About Kingston Safeguarding Adults Board

What is a Safeguarding Adults Board?

Kingston Safeguarding Adults Board was established in its current form in 2011. It is comprises senior strategic leaders from a number of organisations which provide services in Kingston and is led by an Independent Chair.

From 1 April 2015, the Board became a statutory body with specific duties and functions. These requirements are set out in the Care Act 2014.

The Board leads the strategic oversight of adult safeguarding arrangements in Kingston for adults with care and support needs who may be suffering from or are at risk of abuse or neglect. The Board does this by:

- Making sure that local arrangements are in place and that the safeguarding work of all the partner agencies is effective
- Improving the way partner agencies and services work together to respond when abuse or neglect has occurred and to prevent abuse and neglect from happening
- Making sure that people are always placed at the centre of any investigation where abuse or neglect has occurred
- Ensuring continuous improvement, development and learning which will improve our shared practice
- Having a strategic plan to ensure we deliver on our objectives

How we work

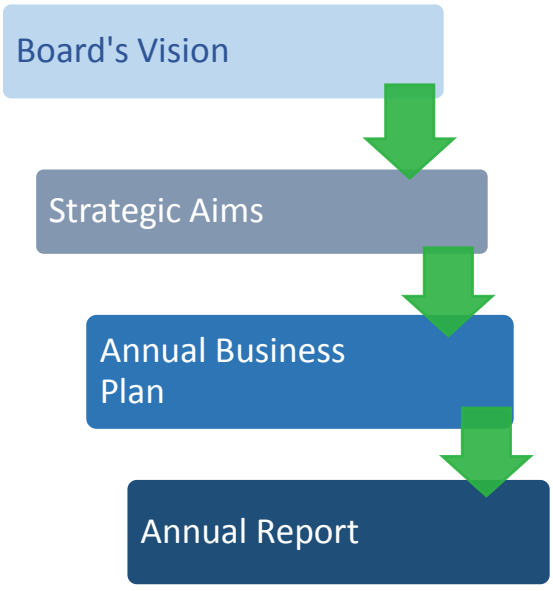
The Board has a core membership of statutory organisations, including Royal Borough of Kingston, NHS Kingston Clinical Commissioning Group (CCG), and the Police as well as other partners. The Board is led by an Independent Chair and meets four times a year with most of its business delivered through its sub-groups.

Board's Vision and Principles: Sets the overall vision of the Board and the outcomes it wants to achieve for the citizens of the Royal Borough of Kingston upon Thames

Strategic Aims: Establishes strategic aims and 3 year objectives required to achieve the Board's Vision; providing direction and continuity to each year's Business Plan.

Annual Business Plan: Provides a detailed plan of specific key actions, and target timescales required to achieve the Board's Strategic Plan.

Annual Report: reflects on the previous year's activity and reports process towards the Strategic and Annual Business Plan.



Our Vision and Principles

Our vision is for Kingston to be a place where everyone lives in safety, free from abuse and the fear of abuse with the rights of citizenship

This means that as a Board, we will continue to work in partnership to ensure mutual co-operation and work with our local communities to:

- Take all actions in our power to actively prevent abuse and neglect from happening
- Identify, report and remove the risk of abuse and neglect
- Support people who have experienced abuse, in ways that they wish to be supported and enable them to recover and regain trust in those around them
- Place the person at the centre at all times throughout our interventions and support
- Improve community awareness
- Share information and intelligence
- Learn from safeguarding enquiries and safeguarding adult's reviews to improve our practice and preventative strategies
- Ensure that we give our communities reassurance.

"No-one should have to tolerate or be exposed to abuse, neglect or exploitation"

In 2016, we set out our priorities as a Board in our two-year Business Plan:

- **Aim 1:** To have in place strategic leadership, governance and the widest possible partnership to deliver on all of our lawful safeguarding responsibilities.
- **Aim 2:** To improve levels of engagement and knowledge of safeguarding by raising awareness with the public, vulnerable people, their carers and supporters and also 'hard to reach' communities and high risk groups

The Six Safeguarding Principles

1. Empowerment
2. Prevention
3. Proportionality
4. Protection
5. Partnership
6. Accountability

- **Aim 3:** To ensure the requirements and the spirit of the Care Act 2014 are fully implemented by all agencies that hold statutory and non-statutory responsibility for safeguarding, through best practice.
- **Aim 4:** To develop a safeguarding culture which promotes adults at risk as being central to and fully involved in safeguarding arrangements, plans, process and any intervention.
- **Aim 5:** To ensure our aims, objectives, plans and service interventions are appropriately and proportionately reviewed so we can monitor progress, take corrective actions and ensure that continuous learning, improvement and quality outcomes are achieved.

Our Priorities

What we wanted to achieve:

- Enable strategic leadership of the safeguarding agenda in its widest sense
- Agree future annual funding arrangements from relevant partners and Board support arrangements
- Reviews the Board's group learning and development offer, revising the training strategy and competency framework to comply with Care Act 2014 requirements and Making Safeguarding Personal
- Measuring and reporting on the effectiveness and multi-agency safeguarding training, and other training that makes people feel safe
- Improve public awareness of safeguarding adults and the work of the Board in the community
- Work with providers to increase understanding of neglect
- Work with adults at risk, particularly those with a learning disability to increase awareness of the risk of financial exploitation
- Develop a performance framework for safeguarding that can be used by partners to measure effectiveness
- Review referral routes for raising safeguarding concerns to enable alignment across the partnership
- Consider how adults at risk are engaged in a meaningful way as part of the Board's decision making
- All partners to undertake self-assessment audits to determine areas of development
- Work with the police and providers to increase referrals
- Improve our practice through the deployment of senior lead practitioners for social work practice

What we did in 2016-17

Key achievements

We have written and published a Vision & Strategy document.

We have revised and published our local safeguarding procedures in response to the Care Act 2014 and have developed a local protocol for Safeguarding Adult Reviews. All our policies and procedures dovetail with the revised Pan-London Safeguarding Policy, which was launched in February 2016.

As a Board, each partner organisation has completed a self-assessment and evaluation process to get a better understanding of how they are doing in terms of implementing their respective safeguarding arrangements.

We have participated in a joint learning event hosted by the London Borough of Sutton in respect of learning from the closure of several residential care homes for older people.

Training

Each partner has a safeguarding training plan focusing on changes in relation to safeguarding procedures. This drives effective and safe practice.

We have trained staff in the Council (as Managers and investigators of the safeguarding arrangements) so they can work in this new way to meet Care Act requirements.

All staff involved in the safeguarding process receive regular supervision to ensure that standards are maintained and we continue learning and improving our practice.

Public Information

We have produced new safeguarding leaflets and cards to raise awareness about safeguarding in the community.

We have started the process of redeveloping new webpages to help public and professionals identify when someone may be at risk and make it easier for them to raise a concern.

Making Safeguarding Personal

We have incorporated Making Safeguarding Personal into our safeguarding processes to make sure that the person at risk is always at the centre of practice and decides what outcome they want at the end of the process.

As part of the Board lead self-assessment audit we obtained a better understanding of how all partners are doing in relation to making safeguarding more personal.

We only share information on a need to know basis. This is in line with the Data Protection Act

What our sub-groups did in 2016-17

Training Sub-group

During 2016-17 individuals were trained on a range of courses:

- Safeguarding Adults Awareness (Level 1)
- Safeguarding Adults (Level 2)
- Deprivation of Liberty Safeguards Introduction
- Mental Capacity Act Introduction
- Safeguarding Adults Enquiry Officer
- Safeguarding Adults Manager
- PREVENT
- Safeguarding Annual conference
- Safeguarding Masterclasses

A range of Introductory and Specialist Domestic Abuse courses were made available to Royal Borough of Kingston Council staff through the Local Safeguarding Children Board (LSCB).

Our Safeguarding Adults Awareness (Level 1) classroom-based training was updated in order to reflect changes as a result of the Care Act and the implementation of a way of working known as "Making Safeguarding Personal". A new Safeguarding Adults Awareness (Level 1) and additional Safeguarding (Level 2) e-learning packages, reflecting these changes, were implemented. The Level 2 training is aimed at specific staff groups as defined in the Safeguarding Training Strategy.

Quality Assurance Sub-group

The focus of this sub-group in 2016-17 has been to deliver the self-assessment process across the partnership. This work was undertaken using the Safeguarding Adults at Risk Audit Tool and occurred as a two part process:

- Completion of a self-assessment audit
- A Safeguarding Adult Board Challenge and Support event, which was completed jointly with statutory partners

The Safeguarding Adults at Risk Audit Tool was developed by the London Chairs of Safeguarding Adults Boards (SABs) network and the London office of NHS England. It reflects statutory guidance and best practice. The audit tool gives organisations a consistent framework to assess, monitor and/or improve their Safeguarding Adults arrangements.

The purpose of this exercise was to provide the Board with an overview of the Safeguarding Adults arrangements that are in place across Kingston identifying:

- Strengths, in order for good practice to be shared

- Common areas for improvement where organisations can work together with support from the SAB
- Single agency issues that need to be addressed
- Partnership issues that may need to be addressed by the SAB

Following the completion of the self-assessment and challenge sessions, the sub-group collated the results and reported on the findings.

Findings from the Audit

Of the partners organisations that were asked to complete the self-assessment audit tool, six completed it. Each organisation received brief confidential feedback notes reflecting the views of panel members. Organisations were then able to use the findings to target their own plans for delivering effective safeguarding services.

The individual contributions and quantity of work undertaken was valued and appreciated by panel members. However, there was variation between organisations in how senior leaders were involved in both the challenge sessions and in validating the individual written submissions. Overall, it was encouraging that across the partnership most organisations had robust and effective safeguarding processes in place and relatively few development areas. The following themes emerged from the audit:

- Some organisations provide services across several local authorities and consideration should be given to the best way of involving these organisations balancing efficiency, reducing the need for them to duplicate actions across different Safeguarding Adults Boards and Kingston Board's statutory duties.
- Developing an understanding and utilisation of the Mental Capacity Act and the Deprivation of Liberty Safeguards; and the PREVENT strategy; and embedding these in staff training and organisation policies, procedures and contracting was identified as a key priority for all organisations within 2016-17.
- Consideration to be given to making the next audit more of a SAB peer exercise – where the activity of the whole Board and the outcomes it achieves across partner organisations are challenged by another Board.

Safeguarding Adults Review (SAR) Sub-group

A SAR is an investigation into the circumstances where a person was not safeguarded from harm as a result of multi-agency failure. It is the responsibility of the Board to commission a SAR in certain circumstances, as set out on the Care Act. Each Board must consider the recommendations and outcomes from Safeguarding Adult Reviews, identify the learning and determine the necessary practice and interagency improvements that must be made to prevent similar incidents from happening again. Learning from SARs should always be proportionate and involve staff from various agencies in learning from the incident. The

learning should not only deliver the actions, but build on how communication and interagency working must be improved.

The focus of the Safeguarding Adult Review Sub-group in 2016-17 has been to agree the methodology for considering referral and managing Safeguarding Adult Reviews.

The Sub-group considered two (2) cases. Neither of the cases were recommended for a Safeguarding Adults Review. Both cases related to people known to Mental Health services who had taken their own life.

Additionally, Kingston participated in a learning review hosted by Sutton. The summary of the learning from this review can be found on their website www.sutton.gov.uk.

Communications Sub-group

The KSAB communication sub group is made up of members of the board with the aim of producing and action a communication and engagement strategy.

The KSAB sets its strategy by the aims and objectives of the KSAB. There are 4 strategic priorities:

1. Sharing information and Engaging with the people of Kingston
2. Supporting and Empowering. Providing quality safeguarding services when abuse and neglect is identified and putting adults at risk at the centre of what we do.
3. Prevention, ensuring agencies work together to prevent abuse or neglect and take the appropriate action when its needed
4. Prepare, holding agencies to account for the services they provide.

The group was set up early this year and have had two meetings.

Current outcomes

The group so far have worked on the design and production of safeguarding leaflets and credit card sized document that contain safeguarding information and information on how to report a safeguarding concern. These leaflets have been launched as part of the communication and engagement strategy and will be available at GP's surgeries, Kingston Hospital reception and clinic areas, libraries and other public areas as well as being given out by social workers and community nursing when they make visits.

The group have also developed the "Kingston Safeguarding Adults Pledge" and are calling on local organisations to help combat adult abuse across the borough with the launch of a new pledge initiative. The group has put together a pack for businesses containing information for sharing with their staff at team meetings, along with definitions of what constitutes abuse, and importantly how to report concerns of abuse.

The group have now completed the communication and engagement strategy and the top priorities are to raise awareness and the profile of adult safeguarding amongst the population of Kingston, as well as giving people clear information on how to report concerns and where to get advice and support.

The Story of Doris

Doris is a 70 year old woman who had been diagnosed with Multiple Sclerosis. Doris was in receipt of a personal budget which she use to employ private care workers to support her at home during the day and night and provide daily physical care. Doris was also supported by the Community Nursing Service. She had significant mobility impairment, history of pressure ulcers and was at high risk of skin deterioration. Doris had mental capacity and was able to make decisions regarding her health and social care. She was an intelligent, independent lady who liked to have control of her care which included declining GP screenings and offers by care workers to call a GP prior to a hospital admission. In November 2013 Doris was assessed as having a grade 4 (serious) pressure ulcer which required surgery and she was eventually admitted to hospital with a high temperature and episodes of chest pain. Doris received palliative (end of life) care and died 10 days later. The cause of death was recorded as peritonitis, a duodenum ulcer and a perforated bowel.

Safeguarding concerns were raised by the hospital regarding the severity of the pressure ulcer and the care Doris received in the community. The Community Nursing Team had also raised concerns in relation to Doris's pressure ulcer and queried why the Care Workers had not escalated their concerns about the wound prior to Doris's hospital admission. The Safeguarding concerns were investigated and the Board commissioned an Independent Review to identify any system problems which could help improve practice in similar circumstances in the future and identify if such a death could be prevented.

The Independent Review highlighted that the health care provider had taken learning from the safeguarding referral and had taken significant steps to address the identified issues and continue to improve their services.

Further recommendations from the review were that:

- Individuals with personal budgets in receipt of a social care and a health care service should have joint social care and health assessment and reviews.
- There must always be a Named Case Manager for individuals with long term poor health conditions.
- Individuals with personal budgets to be fully supported to understand their responsibilities as an employer.
- There must be robust oversight of training for care workers on how to provide adequate care in similar circumstances and in the use of equipment provided.
- The GP service is highlighted as there is currently no enhanced service commissioned for people with long term conditions.
- There is acknowledgement that in the initial process leading up to the Independent Review there were communication difficulties across health and social care organisations. These have been successfully worked through and positive learning has been taken from all aspects of this case.

The Story of Mary

Mary, 80 years old woman was known to social care since 2012 and offers of social care services were always declined. Mary experienced high levels of anxiety, memory loss and depression and would not agreed to any GP/professionals to visit. Medication had been prescribed in blister packs however Mary did not want to take them and a Community Matron was assigned to assist with medication for Asthma and Blood Pressure. A recommendation for an Outreach Service was made in order to set up a package of care to encourage and support Mary with medication, meals and personal care. Again, Mary was not engaging with Outreach or with social care, and her behaviour also changed towards her friends and neighbours. Mary was easily angered/upset and wanted to be left alone. Mary's neighbours continued to cook meals for her and tried to assist her with shopping and collecting her pension. However, Mary had lost her confidence and often refused to go out.

Mary eventually accepted a package of care (once a day) though this did not continue as she was not happy with the care. There was no communication between teams that the care had stopped. Joints visits by professionals were made to Mary, though there was no answer at the door and neighbours became concerned for her safety. The Police and Ambulance Service were contacted and attended promptly, and called to Mary through the letterbox. Mary responded and told everyone to 'go away'. The Police Officer deemed that Mary had capacity to decide if she wanted to open the door or not and agreed that they would visit the following day and force entry if Mary does not respond. The following day, again there was no response, and entry was forced by the Police. LAS were called and Mary was admitted to hospital as it was felt she may have suffered a stroke. Mary died that evening from abdominal sepsis and a cardiac condition.

Following an investigation, it was felt that despite multi-agency involvement there was a query as to whether partner agencies could have worked more effectively together to protect Mary. Some professionals had expressed their belief that Mary lacked capacity to understand the risks and their involvement was specifically because of Mary's withdrawal and self-neglect, her lack of nutrition/fluid intake and lack of mental capacity in some aspects of her care. The Police stated they were unable to take action if an individual's capacity was not assessed by the GP or Community Mental Health Team.

It is unknown and hard to establish whether, if Mary had been admitted to hospital earlier, this would have saved her life. At the time of attending the property, the legal limitations of the Police were fully understood, however the professional's views were not enough to be taken into consideration.

It was recognised that:

- Better communication between services sharing the same IT system could have happened and that there needed to be clarity on guidance on the "No Reply/Response Policy" for all professionals regarding an individual with eligible care needs.
- Clearer guidance was needed for all partner agencies about acting in the best interest of a vulnerable adult and safeguarding the person according to the Care Act 2014.

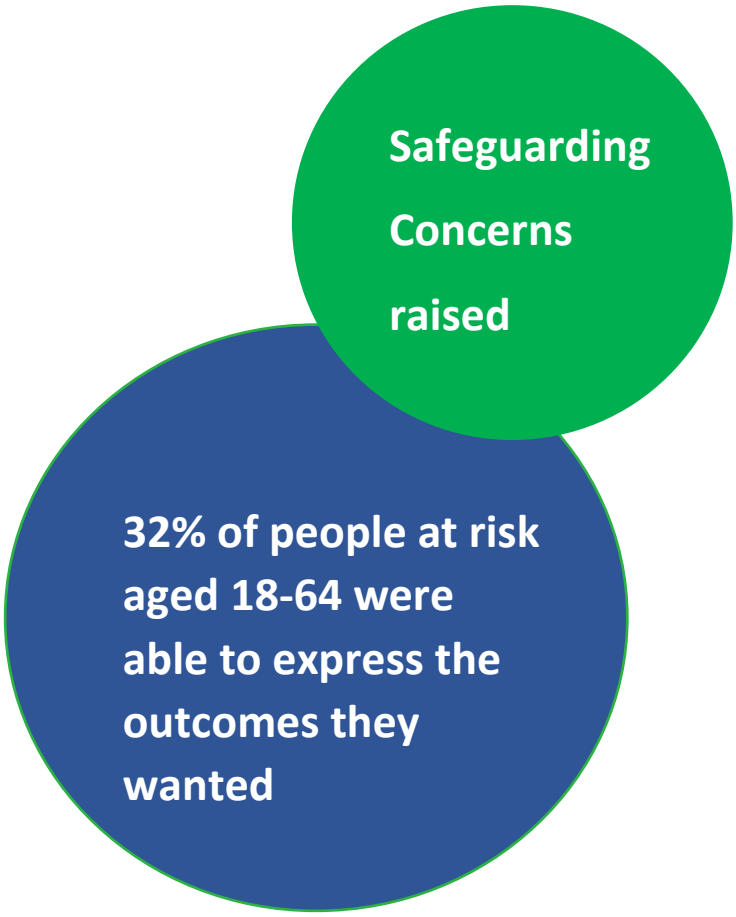
How Board Members are making a difference

Kingston Adult Social Care

The Care Act 2014 introduced a broader definition of adult safeguarding, new requirements for Safeguarding Adults Boards (SAB) and significant changes to safeguarding terminology. A safeguarding concern occurs when a safeguarding issue is first raised with the Council. Every concern received is reviewed, considered and risk assessed. Concerns will either progress to the next stage of the safeguarding process for fuller investigation and formal intervention (this is called a Section 42 Enquiry) or the matter will be dealt with through another route if not considered to be a safeguarding matter.

Within Kingston we have seen the highest ever number of safeguarding concerns in the last year. In response to the 1042 concerns raised, 419 enquiries were undertaken under Section 42 of the Care Act 2014. This marks a 34% increase in the number of concerns and a 61% increase in enquiries. While we have seen an increase across the board, the biggest increase is in relation to older people, aged 65 and over.

Most reported allegations of abuse were Neglect & Acts of Omission (180) and Physical abuse (123).



Police

At a strategic level the Metropolitan Police Service (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.

Kingston Police has a team of officers that work alongside other partner agencies within the Multi-Agency Safeguarding Hub (MASH). Every report of an Adult Coming to Notice (ACN) that is created by officers is then risk assessed by the MASH Team. These ACN's are then assessed on a traffic light system, with RED being the most concerning and GREEN the least. Research is conducted within the MASH prior to the reports being sent via secure email to the Adult Safeguarding Team. This is a daily occurrence as ACN reports are created 24/7 by officers within the borough. Each ACN report is quality assured by the MASH prior to being sent and any gaps in learning are identified and addressed.

The number of reports created by officers are as follows:

Q1	01/04/2016-01/07/2016	520
Q2	01/07/2016-01/10/2016	560
Q3	01/10/2016-01/01/2017	590
Q4	01/01/2017-31/03/2017	554

The total number of reports for the last year (2,224) is significantly larger than the previous year (1,731). This is reflective of the training programme that was rolled out to frontline staff last year on the 'Vulnerability Assessment Framework' (VAF) demonstrating an increased knowledge and experience in identifying the VAF factors correctly.

Prevention

Every ACN report is risk assessed within the MASH unit before it is sent to adult safeguarding. If there are highlighted concerns within the content of the report, suggesting a crime is likely to take place, a crime report will also be created and an investigation undertaken by the Community Safety Unit. If there are concerns but no obvious offences a non-crime report will be created and progressed by the Safer Neighbourhood team who are best placed to offer ongoing support within the community. Extra patrols in the area and reassurance visits are routinely undertaken in such cases.

There is good communication between Police and adult safeguarding to ensure the risk to adults are managed and minimised. The MASH is the single point of contact for safeguarding and are able to co-ordinate slow time response and investigation, in addition to assisting with ongoing enquiries.

The Missing Person Co-ordinator for Kingston is also integral in the identification of vulnerable adults. This person quality assures the Missing person Reports and ensures that correct reports are created in all cases involving vulnerability.

Local monthly multi-agency risk management meetings (Community MARAC) are held to ensure appropriate o-ordinated and protective measures can be taken and managed on a local multi-agency basis. The criteria includes both vulnerable victims and either vulnerable perpetrators or perpetrators that pose a risk to the community. It may also include cases where the community maybe affected by the perpetrators behaviour. This is a multi-agency panel whose aim is to develop risk management plans where appropriate. All subjects are referred via an agreed protocol. The remit for the MARAC has expanded over the last year and is looking to expand further to include GP referrals. Several excellent outcomes have been achieved through this process where agencies have worked in partnership to safeguard adults.

Improvements

In the first half of 2016 the MASH delivered training to CID Officers and 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 PowerPoint presentation. Frontline officers have also received mandatory training on the 'Vulnerability Assessment Framework'. Further training will be implemented through Personal and Professional Development days anticipated after September 2017.
There is also ongoing training which is delivered to all probationary officers regarding the creation of ACN reports, to ensure a high standard of referral.

Corporately, MPS personnel are supported by operational instructions that inform them of their responsibilities under the Mental Capacity Act and have Strategic Central Units to provide operational support and advice as required on safeguarding and mental health issues. The MPS Vulnerability and Adult at Risk toolkit is utilised as best practice.

Achievements

Within the last year a new full time post has been created within Kingston, The Borough Mental Health Liaison Officer. This Officer is the Single Point of Contact for mental health across the board and has been expanding this role throughout the last year.
Our Community MARAC grows from strength to strength offering practical solutions to risk areas including adult safeguarding.

Officers are starting to use less traditional powers as part of the problem solving process. Two closure orders have been obtained within the last year, one which solved the problem of a vulnerable adult being exploited by local drug users and being the victim of ASB. The other remains in place and is policed daily by officers to ensure its effectiveness, again to prevent a vulnerable adult from falling victim to local drug dealers and criminals.

A notable good result from Kingston CID was the arrest, charge and conviction of a suspect who preyed on vulnerable adults within Kingston. The female was convicted of 17 offences, mainly burglary and theft, and was sentenced to 4.5 years in prison.

The MASH is co-located with Children's Services (SPA), however, they are not co-located with Adult Services. Going forward this would be a positive step and would ensure further joint working and enhanced risk management.

NHS Kingston Clinical Commissioning Group (KCCG)

The KCCG continues to work very closely with the Safeguarding Adults Board to deliver on the Board's Business Plan, identify safeguarding risks posed by providers and the Safeguarding Lead continues to chair the SAB Communications Group. Within the CCG, the Quality Team continue to deploy the 2016 Quality and Safeguarding component of the Kingston CCG Operational Plan which is aligned with Kingston CCG's Governing Body Assurance Framework requirements.

Over the past year the safeguarding adult's team's objectives have been set on the recommendations from the "Deep Dive" audit that was conducted by NHS England in late 2015, which involved all CCG's across London.

Objectives were set around the following:

- Having clear lines of accountability and governance arrangements for adult safeguarding across the CCG.
- Having up to date clear policies.
- Having a staff team that are all trained and up to date on adult safeguarding and know how to refer issues relating to adult safeguarding.
- Safeguarding leads having regular professional supervision to support them in their role and competencies.
- Having effective interagency working with the local authority and other partner services and being engaged in the local safeguarding board.
- Safeguarding lead working with commissioners to ensure contracts contain requirements of services with regard to adult safeguarding Deprivation of Liberty Safeguards and Mental Capacity Act requirements.
- Safeguarding lead being assured that commissioned services are compliant with safeguarding requirements with regard to staff training, policies and procedures and reporting of safeguarding incidents.
- Working with the safeguarding board to support the safeguarding self-assessment audits.
- Being fully engaged in the domestic abuse forums and work streams.
- Engaging local dentists, pharmacists and opticians in understanding contemporary adult safeguarding and being up to date with training on the subject.

Over the past year the safeguarding adult's team have been able to achieve these set objectives. We have ensured that all KCCG staff have achieved their national requirements for understanding and reporting on adult safeguarding as well as providing training and support to the Kingston Commissioning Service.

The team has also worked with partners to provide regular training and updates to Kingston GP's and surgery staff on adult safeguarding and related issues.

The KCCG safeguarding adults lead has set up and chairs the Health Leads Forum with the purpose to support all health service safeguard leads in working together to identify at an

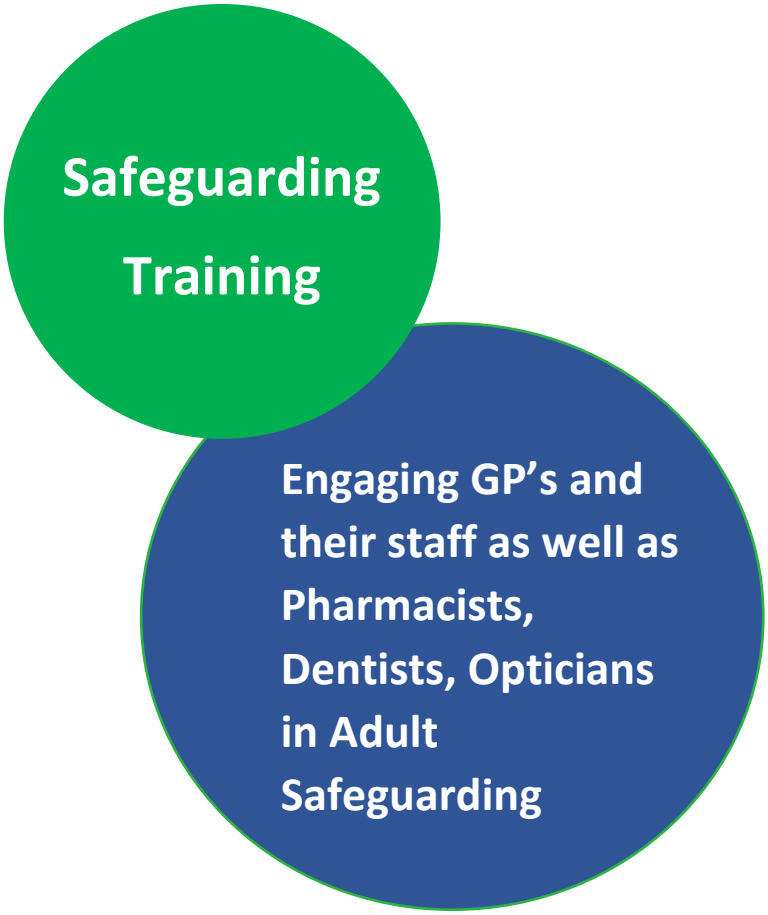
early stage any potential safeguarding issues and concerns at a service level and to work to address these as rapidly as possible.

The safeguarding team are also responsible for leading on the 'Prevent' Counter Terrorism strategy and supporting information and training to partners and commissioned services as well as being a resource for advice and support.

The safeguarding team lead on issues and work related to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

In 2017-18, the focus of the CCG's Safeguarding Adults Strategy will be on the three following priorities:

- To raise the profile of understanding domestic violence and offering support, guidance and signposting for our primary health care partners and colleagues
- To increase focus on the promotion, understanding and support with the Mental Capacity Act (MCA 2007) and Deprivation of Liberty Safeguards.
- To raise awareness and understanding of adult safeguarding in the general population of Kingston.



London Fire Brigade

- The London Fire Brigade worked very closely with the Safeguarding Adults Board with the Borough Commander or a Deputy attending all safeguarding Board meetings.

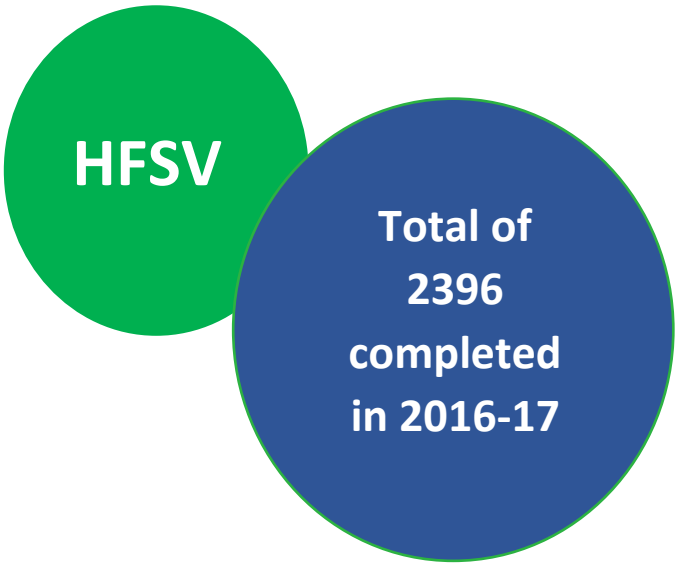
- London Fire Brigade were very proactive in the community, within the Borough of Kingston upon Thames firefighters regularly highlighted vulnerable individuals to the councils Access team where there are signs of self-neglect.

- All Firefighters and Officer in the Borough are trained and familiar with London Fire Brigade safeguarding policies. This training is part of the Borough Training Plan to ensure new Firefighters and Officers to the Borough receive this training. Safeguarding Training and reporting process also forms an important part of Firefighters continual professional development. This year they have also received additional specific training regarding vulnerable adults and children, the signs to look out for and actions that can be taken including the safeguarding reporting process.

- The firefighting crews carry out numerous Home Fire Safety Visits (HFSV) throughout the year and in 2016-17 a total of 2396 HFSV's were completed in the Royal Borough of Kingston upon Thames. During these visits firefighters will review the safety of the property and will supply and fit smoke alarms free of charge if they are required. Firefighters will also talk through escape plans. These visits are tailored to the resident and the property to ensure the advice given is relevant and up to date.

- The Fire Brigade targets HFSV's to those most in need and at least 80% of all our HFSV's are for people who have high risk factors associated with fire. In 2016-17 the number of HFSV was 1914.

- In 2017-18 the London Fire Brigade will continue with it very successful community fire programme carrying out HFSV and will look to forge closer working with all partners on the Adult Safeguarding Board.



Kingston Hospital NHS Foundation Trust

Kingston Hospital continues to work very closely with the Safeguarding Adults Board to deliver on the Board's Business Plan and to identify safeguarding risks posed by providers. The Safeguarding Adults Lead or Deputy attends all board meetings. The Safeguarding Adults Lead Nurse participates in relevant SAB sub groups which include training and communication.

Kingston Hospital formally adopted the London Multi-Agency Policy and Procedure and its policies and guidelines are compliant with The Care Act (2014). All safeguarding training provided references the additional forms of abuse that are now included in the safeguarding agenda.

The Trust has defined its culture as one that is patient centred which puts safety first and where all staff take appropriate responsibility. To support this, the Trust has four values which are: Caring, Safe, Responsible and Value. The Trust has endorsed the six principles of adult safeguarding and promotes the Making Safeguarding Personal approach to supporting and advocating for patients involved in safeguarding concerns.

Safeguarding Concerns for RBK

The Trust has raised 88 formal safeguarding concerns to Kingston Adult Safeguarding Team and participated in Section 42 enquiries where appropriate. It also raised 251 informal concerns to Kingston Social Services which were triaged through the trust safeguarding team and referred for appropriate care management support or community assessments.

DoLS

The awareness of the DoLS process and the requirement to safeguard patients without the capacity to understand their need for care and treatment in hospital has been promoted extensively this year. The Trust made 214 DoLS applications in total (to all boroughs) in 2016/17 compared to 50 applications in 2015/16

Training:

86% of staff have completed the statutory mandatory level 1 training. The target was 85%. Bespoke training on Safeguarding MCA and DoLS has been provided throughout the year to clinical and nursing staff and to specialist departments.

The Trusts Safeguarding objectives and achievements for 2016 / 17 have been:

Development of Adult Safeguarding Link Nurses

To enhance department level knowledge and awareness of adult safeguarding, all wards and departments have identified link nurses to support each area with Adult Safeguarding and DoLS. The link nurses receive half day training from SCIE on Safeguarding, MCA and DoLS in February 2017. This included looking at the training tools available through SCIE with the aim that the link nurses can use these resources to train staff in their specific areas.

Increased knowledge of the issues facing patients with Learning Disabilities

The Trust hosted a half-day learning event for supporting LD service users and their family and carers. This was very well attended and discussed positive and negative experiences during care episodes at the hospital. The learning from this event will be addressed by the newly established LD Steering Group.

Improved Electronic Documentation

The Adult Safeguarding triage assessment on the Clinical Record System (CRS) has been redesigned and upgraded. It includes all the categories of abuse with added guidance for staff. It will also directly link staff to incident reporting and the Safeguarding Intranet webpage. MCA assessment templates designed by the Adult Safeguarding Consultant Lead are now available for all clinicians to use on CRS. This standardises the documentation and sharing of MCA assessments.

Improve access to PREVENT training

In February 2017 the Trust hosted a half day event on PREVENT in conjunction with Kingston CCG. The objective of this was to train trainers to be able to deliver training to their staff. The attendees received the full WRAP training and presentation regarding the role of the Channel Panel and the role of the Police in PREVENT.

Establish Trust Leadership and Oversight for Mental Health

The Trust has formed a Mental Health Steering Group for adults, children and young people in collaboration with SWLSTG Mental Health Trust, CAMHS and community partners. The Trust have recognised the need to raise awareness and ensure staff within the organisation understand the full scope of their responsibilities in supporting individuals with mental health difficulties. This is in accordance with the national framework to improve mental health and wellbeing.

Recruitment

The Safeguarding Adults team have recruited a part-time Band 6 nurse whose immediate responsibilities are to support the DoLS process and applications.

Strategic objectives

In 2017-18, Kingston Hospital's Safeguarding Adults Strategic aim is to:

- Continue to ensure all patients are given the opportunity to voice their concerns under the MSP agenda.
- To continue to deliver improvements in the application of MCA and DoLS to drive up the quality of assessments. An audit is planned for July 2017.
- To shape and improve the patient information provided to guide patients of their rights. This needs improving in line with the Accessible Information Standard. This will need to be achieved through collaboration with SABs
- Continue to promote and deliver PREVENT training
- To focus service improvements on 2 key areas; self-neglect and self-harm/suicide; driven through a new Mental Health forum.
- Trust Policies and procedures will be revised in line with outcome of the pending Law Commission Report.

Your Healthcare

Your Healthcare (YH) is a Community Interest Company (CIC) based in the Royal Borough of Kingston. YH is an active member of the Kingston Safeguarding Adults Board and is currently represented on its Communications and Training Sub-groups.

In Kingston, YH provides both inpatient, residential and multi-disciplinary community health services for Kingston residents who are registered with a Kingston GP. YH also provides specialist Neuro Disability Services (NDS) and diagnostic services for Autistic Spectrum in adults.

YH has formally adopted the Pan London Procedure and its policy and procedures are compliant to the Care Act (2014). In 2016/17 the Care Act was included YH's safeguard refresher training. This included training around the additional forms of abuse that have now been included in the safeguarding agenda.

In 2016/17, YH raised a total of 143 safeguarding concerns which includes both self-reporting, and concerns of abuse or neglect by others.

Prevention

YH has well established adult safeguarding governance and training, frameworks clear leadership and a firm commitment to working with our local partners. The adult safeguarding agenda is of the highest priority and feeds into every level of the organisation with the aim of both preventing, and responding to abuse and neglect. YH has worked closely throughout the year to support the work of the Training and Communication Board Sub-groups, and has participated in joint learning events.

YH has contributed to Section 42 Delegated Enquiries and complex enquiries both on an individual case level and from the perspective of service reviews. YH is currently engaged in a cross agency working group looking at the thresholds for safeguarding and the delegated enquiries.

YH continues to work closely with Kingston Council to identify Deprivations of Liberty Safeguards (DOLS). Robust DOLS procedures are in place within all inpatient services. Two potential community DOLS have been highlighted under the YH Shared Lives Scheme, and all residents were considered under the DOLS criteria.

Training continues to be a key to prevention: Safeguarding Awareness, MCA, and PREVENT training are mandatory requirements for all YH staff.

Improving Awareness

YH is represented on the Communication Board Sub-group. YH also has a specific internet page related to Adult Safeguarding which links with Kingston council sites in order to support those who are looking for information. All YH staff are aware of their responsibility to support people to recognise and report abuse or neglect. There are also close links with other services through our community provision where we are able to support other service providers make improvements in care which can prevent safeguard concern or implement changes following safeguard concerns.

Making Safeguarding Personal

Mental Capacity Act (MCA) training has been key in supporting the personalisation agenda for YH. Where staff have safeguarding concerns, the primary objective is to share these with the person and gain an understanding of their views and wishes.

Our 2016/17 safeguarding refresher training included details on our responsibilities as an organisation in ensuring that the person is central to the entire process, and that their desired outcomes are key in the reduction of the risk that has been identified.

South West London and St. George's Mental Health NHS Trust

Training

Safeguarding Adults is included in Trust induction for all staff. Level 1 training is available through e-learning and face to face sessions and is monitored through the Executive Safeguarding Meeting (ESM). The E-Learning for Health package for Safeguarding Adults Level 1 is up to date with latest policy and is now available on in-house Learning System.

Current Compliance

Within The Trust, 93.3% of staff are compliant with Safeguarding Adults Basic Awareness training.

Reflective Practice

A monthly classroom based session has been provided throughout the year. It focusses on applying policy to practice and is focussed on case studies and practice examples.

Organisational Update

The Trust received confirmation from the Care Quality Commission that the Trust has been rated as 'Good' following the focussed re-inspection that took place in September. This is one of only four mental health trusts in the whole of London to be rated 'Good' by the CQC. This has only been made possible by the hard work and dedication of all the staff providing high quality services for the patients.

CQC praised caring staff across all services that were inspected saying 'staff were enthusiastic, passionate and demonstrated a clear commitment to their work and that care was delivered by hard-working, caring and compassionate staff'. The Inspectors said that they 'saw many examples of where staff really knew the patients and their carers well and were attentive to their individual needs'.

Executive Safeguarding Meeting

The new Director of Nursing and Quality has established a monthly Executive Safeguarding Meeting that will provide comprehensive executive oversight of all safeguarding activities. Both CCG and local authority representatives will be welcome to attend the 'open' quarterly meetings.

Making Safeguarding Personal Group

A co-production project was started in July 2015 that involved MH service users from two boroughs and Trust representatives – it named itself the Making Safeguarding Personal Group (MSP Group). The MSP Group started by looking at ADASS and Local Government guidance on MSP.

How did it work? The Trust has a long established set of systems and structures for listening to, and engaging the people who use our services. We want to hear what they have to say about our services, and we do this at every level of service: from frontline in our in-patient

and community services and up to most senior level on the Quality and Safety Assurance committee (QSAC).

The MSP Group was focussed on co-production, and that was key to the success of the group. It was the group that owned the pro4ject. The trust was a member of the group, it was not the lead, and it was undertaking consultation. This was not a reference group; it was co-production. That is what underpinned the whole project. It involved a group of people talking about a difficult subject: their own very personal and distressing accounts of being abused and neglected. Some of the accounts dated back 30 years, some very recent. Some required formal referral to local authority and the police. Some may have initially appeared trivial but revealed hurtful failures to show respect and up hold dignity.

The MSP group wanted to learn from those experience and try to prevent anyone having to go through the same thing again. The MSP Group highlighted the following key messages:

- *Learn from what happened*
- *Promote 'zero tolerance' everywhere*
- *Promote social justice*
- *Uphold rights and dignity*
- *Show respect*
- *Challenge discrimination*

Priorities 2017/18

Service Line Management

From April 2017 the trust moved into a new service line management (SLM) structure. We have been working with other mental health trusts across the country for some time and believe the move to SLM will universally improve the quality of care our patients receive. The structure, which will move from borough, to a service focus, will enable our clinicians to take the lead on service developments and drive improvements in patient care. Service will therefore be delivered in a consistent way which benefit our patients and help us to be more effective and efficient.

The principle objectives we aim to deliver through SLM are:

1. Leadership be clinicians: driving improvement to patient care
2. Quality-focussed healthcare: delivering better services for every patient
3. Greater efficiency and productivity: guaranteeing good value for money
4. Devolved decision-making: judgements made by our best health professionals

Making Safeguarding Personal

The trust will:

- Review its Safeguarding Adult policy and embed the MSP Group recommendations into practice and its workforce development plans
- Promote Recovery college educational sessions for service users on: 'How to Keep Yourself Safe'

London Ambulance Service NHS Trust

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.

How we are performing

The LAS is Care Act compliant. The Trust operates a hub whereby the central Safeguarding Team manage workload, reports and local managers attend meetings and Boards across London. Learning from these events is fed into the Central Team to consider any Trust wide learning.

The Trust has Safeguarding Adults at risk Policy and procedures in place which are Care Act compliant, promotes making safeguarding personal, wellbeing and references the relevant legislation and statutory guidance.

Policy and procedures in place reflect the Trusts duty to report all forms of abuse including modern slavery, domestic violence and Prevent. The Trust has a standalone Prevent policy and procedure. The trust has made 9 Prevent referrals in the last year and reporting processes are in place for FGM (Female Genital Mutilation). All staff are aware to clear document and report case of FGM referrals.

93% of clinical staff undertook safeguarding training in 2015-16; training for 2016-17 is currently underway which includes domestic violence, hoarding and self-neglect. Modern Slavery training is planned for 2017-18.

Key Achievements

The Trust engages with 32 Adult Boards or sub groups.

The Trust produced 4 short films on Dementia this year which has been shared nationally; these included:

- Language of Dementia
- Communication over the phone
- Assessing challenging behaviour
- Safeguarding concerns

Easy read materials on abuse and neglect are available, also a communication booklet to use with patients who may have difficulty communicating. Staff are also issued with pocket book on MCA and Care Act.

Board learning this year

One of our priorities as a Board is to continue learning from our collective experience of safeguarding. We do this by reflecting on practice through regular audits and practice discussions with staff. Safeguarding Adult Reviews (SARs) were introduced by the Care Act 2014. The Board participated in a Safeguarding Adult Review hosted by Sutton SAB.

The purpose of the SAR is to learn lessons from the case and for those lessons to be applied to future cases to prevent similar harm from occurring. The aim is not to apportion blame on an organisation or individuals for any failings that may be discovered.

Learning from Safeguarding Adult Reviews (SAR)

What did we learn?

- Having the right staffing levels in place to meet the complexity of needs of the person is crucial, including managers on duty out of hours.
- For complex reasons, families are prepared to tolerate low standards of residential care for their relatives and are unlikely to provide professionals with early warning of worsening standards, with the consequence that local systems need both to predict this and compensate for it.
- Further work to be done on the interface between the CQC and Commissioners around the inspection/review of provider settings, otherwise the consequence is that inspections of linked providers remain more likely to be conducted in isolation, without awareness of the implications of concerns
- To use increasingly well-developed Provider Failure protocols, but at the point when failure occurs, there is no mechanism for making sure that sufficient messages are getting passed back to the originating authority of those in placements - with the consequence that adults at risk may be left too long and moved too late.
- Coordination of multi-agency networks at time of care home closure could be further developed, because current reliance on a small group of committed practitioners has the consequence that future closures might not be so well supported
- There is a lack of clarity about what can be communicated to relatives and residents at a time of enforced care home closure with the consequence that a very stressful time is made more so, unnecessarily, and options insufficiently discussed

What did we learn? What we have done?

Improving practice and people's experiences of the process

During 2016, we changed our safeguarding process to ensure that anyone conducting a safeguarding enquiry or following up a concern is more person-centred and finds out what outcomes the person wishes to achieve. This meant a significant change in the way meetings are run and the way practitioners gather the person's feedback on their experience and enables the person to determine whether they feel safer as a result of the safeguarding process.

We now collect this information at the beginning and at the end of the process. This method is a more sophisticated way to ascertain a person's sense of safety after going through the safeguarding process. It also helps practitioners to ensure people are at the centre of the safeguarding process at all times.

Our Priorities for 2017-18

As a Board we will continue to work together to deliver on our vision to keep people in Kingston safe from abuse and neglect. We will do this by delivering on our business plan. Here are some of our priorities for the next year:

Leadership, Governance and Partnerships

Continue to develop our role as the strategic lead for safeguarding and build on our existing partnerships.

We will work with providers to improve quality of care to prevent or reduce incidents of abuse and neglect.

We will show tolerance of organisations who put people at risk of abuse or neglect through their own failings.

We will work effectively in partnership with other agencies to support people who self-neglect and place themselves and others at risk.

Policy, Practice and Staff Development

We will find innovative ways of undertaking Safeguarding Adult Reviews including involving families in the process.

We will arrange two multi-agency learning events focusing on two key areas important to our practice, such as good quality provision and effective involvement of people and families in adult safeguarding.

A new website for the Board

We will continue to improve public awareness of the Board through a variety of channels.

We will develop a new website that is easy to access and use and provides more information about our work to safeguard adults at risk.

Making Safeguarding Personal

We will work with our partners to embed Making Safeguarding Personal in every day practice across the partnership.

We will pilot independent safeguarding surveys of people and families who have gone through the safeguarding process to identify areas to further improve our practice.

Accountability, Performance, Quality and Achievement

We will develop a performance framework to monitor the impact of the partnership on keeping people safe in Kingston

Appendix 1: Board Membership and Sub-groups

The core membership of the Board is:

Independent Chair

Director of Adults and Social Services (Royal Borough of Kingston)

Adult Safeguarding Lead (Your Healthcare)

Deputy Director of Nursing (Kingston Hospital NHS Foundation Trust)

Adult Safeguarding Lead (Kingston Hospital NHS Foundation Trust)

Community Engagement Officer (London Ambulance Service)

GP Representative (Kingston Clinical Commissioning Group)

Director of Quality & Governance (Kingston Clinical Commissioning Group)

Clinical Director (South West London & St. George's Mental Health NHS Trust)

Superintendent (Metropolitan Police)

Borough Commander or their assigned representative (London Fire Brigade)

LSCB Independent Chair or their assigned representative (Achieving for Children)

Director of Public Health (Royal Borough of Kingston)

Relationship Manager, Safer Kingston Partnership (Royal Borough of Kingston)

Head of National Probation Service Hounslow, Kingston & Richmond

Chair (Kingston Healthwatch)

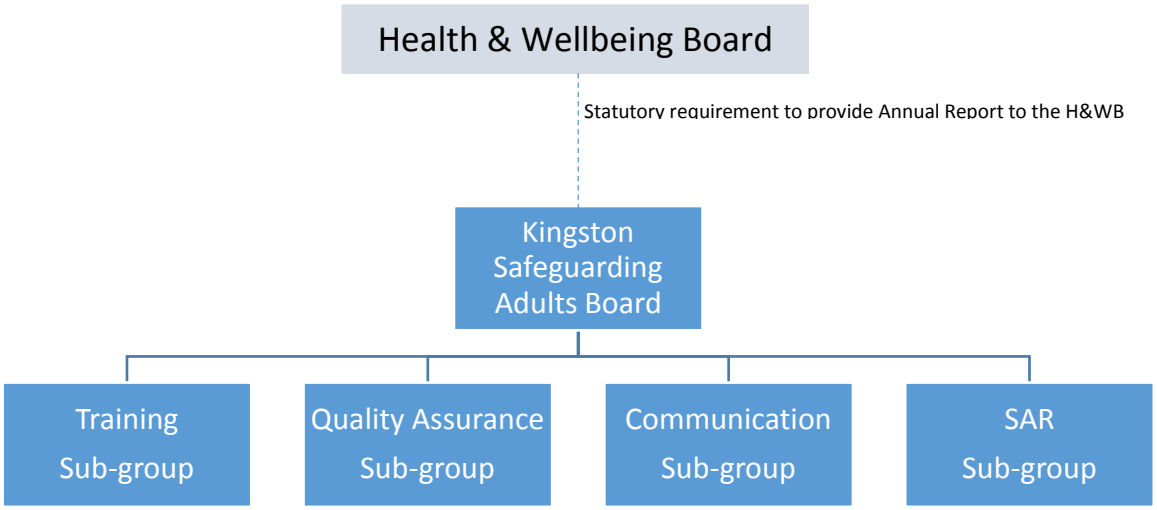
Director of People (Royal Borough of Kingston)

Advisors to the Board:

Head of Adult Safeguarding (Royal Borough of Kingston)

Adult Safeguarding lead (Kingston Clinical Commissioning Group)

Board Governance Structure



Appendix 2: Adult Safeguarding Performance Information and Summary Data 2016-17

1. Safeguarding Information

1.1 Safeguarding Concerns

With the introduction of the Care Act on 1st April 2015, and introduction of significant changes in terminology and safeguarding requirements; for the purposes of this report, we are comparing Concerns and Enquiries in 2016-17 to alerts and referrals in previous years. Although a different definition, it allows some comparison to previous performance.

A safeguarding Concern occurs when any safeguarding issue is first raised with Adult Social Care. After a Concern is received it is reviewed, considered and risk assessed. It will either be dealt with through another route if not considered to be a safeguarding matter, or it will advance to the next stage of the safeguarding process for fuller investigation and formal intervention. This is called a Section 42 Enquiry.

In the 2016-17 year, 893 safeguarding Concerns were raised, leading to 369 Enquiries. This is the highest number received in Kingston and a 77% increase in the number of safeguarding Concerns raised when compared to alerts in the previous financial year. 41% of Concerns progressed to Enquiry in 2016-17 compared to 61% in 2015-16 and 56% in 2014-15 respectively.

1.2 Safeguarding Activity by Month

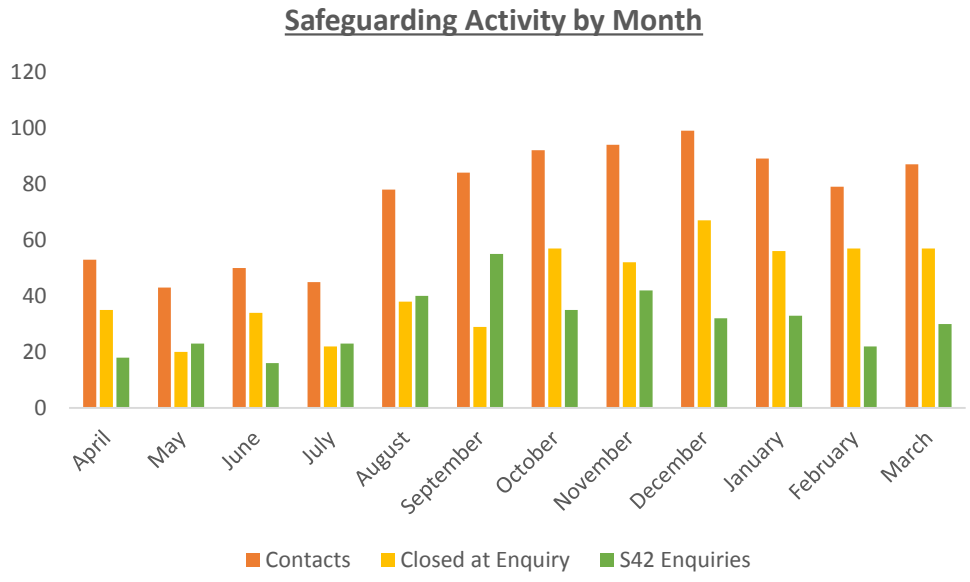


Chart 1: Number of Concerns/Enquiries received by month in 2016/17

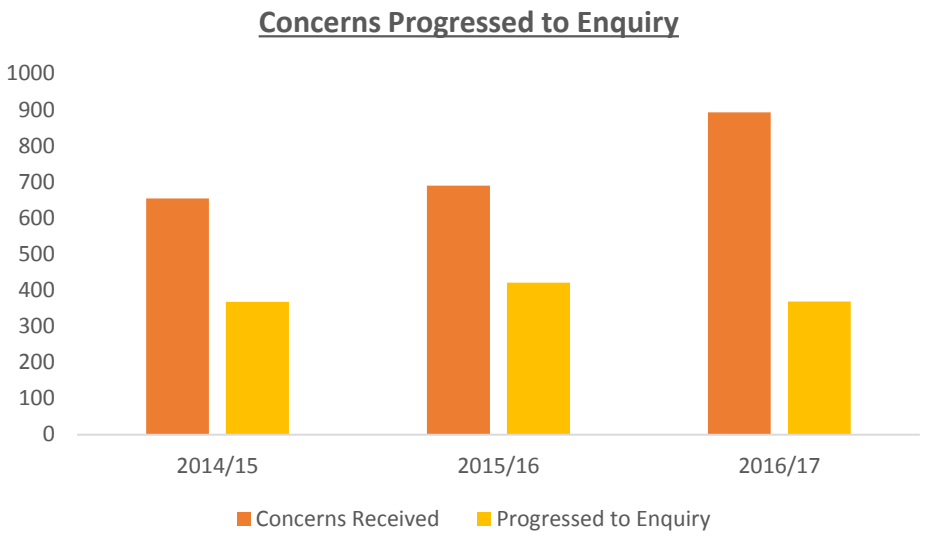
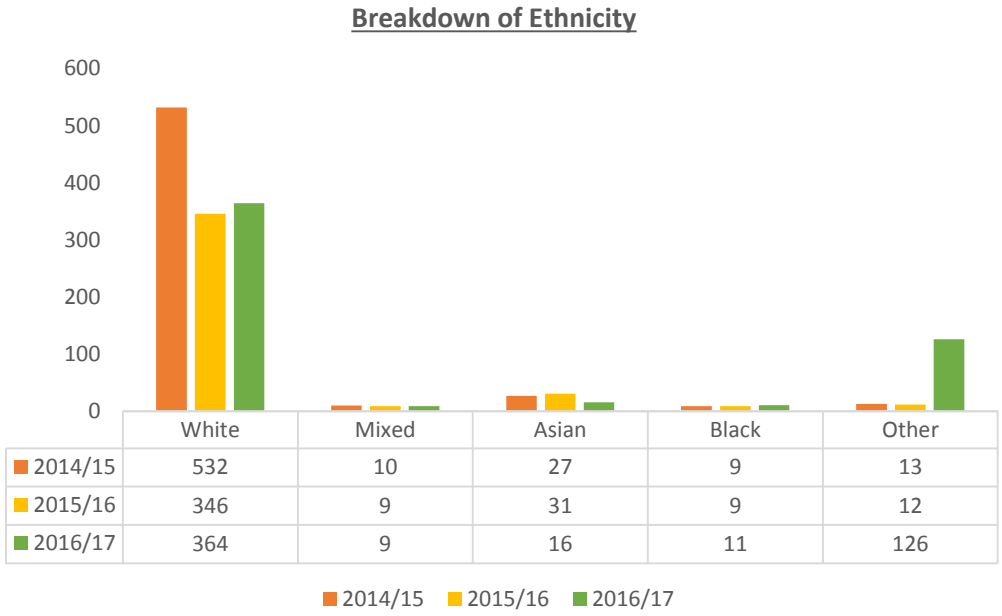


Chart 2: Number of Concerns progressed to Enquiry in 2016/17 and in comparison with the previous 2 years.

1.2.2 Demographics

Ethnicity: The majority of safeguarding enquiries were received in relation to residents with a white ethnicity origin in 2016/17. Of these enquiries, only 44% (160) of the enquiries progressed, compared to 69% (238) in 2015/16.

Chart 3: Breakdown of Ethnicity



	White	Mixed	Asian	Black	Other
2014/15	532	10	27	9	13
2015/16	346	9	31	9	12
2016/17	364	9	16	11	126

Gender: The percentage of Enquiries relating to males has been consistently lower than females over the last 3 three years (Chart 5). The proportion of Enquiries relating to women is reflective of the higher population of women in receipt of services (Chart 4).

Chart 4: Gender of people with safeguarding Concerns/Enquiries

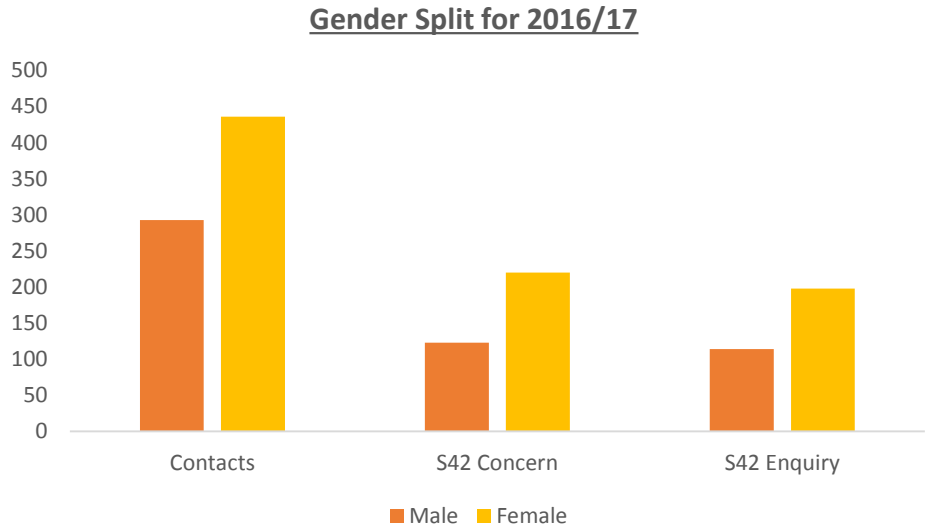
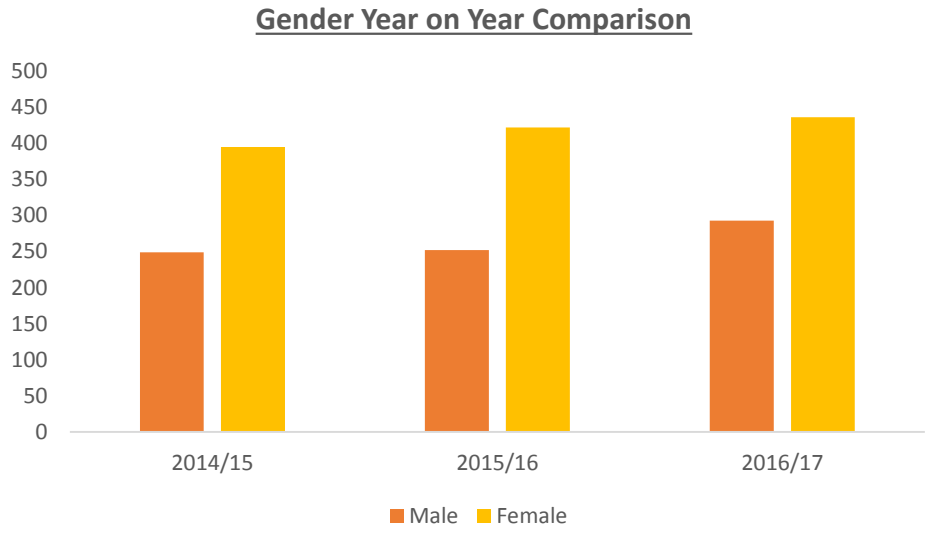


Chart 5: Gender of people with safeguarding Concerns/Enquiries in 2016/17 and in comparison with the previous 2 years.



Age: The number of Enquiries across the age ranges has increased during 2016/17 (Chart 7), indicating that we are seeing a high proportion of vulnerable older people.

Chart 6: Age of people with safeguarding referral enquiries in 2016/17.

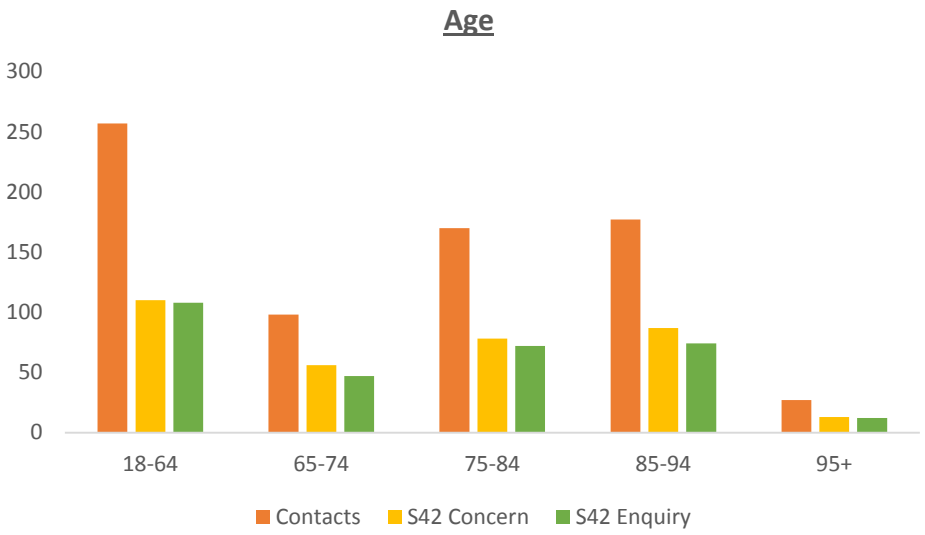
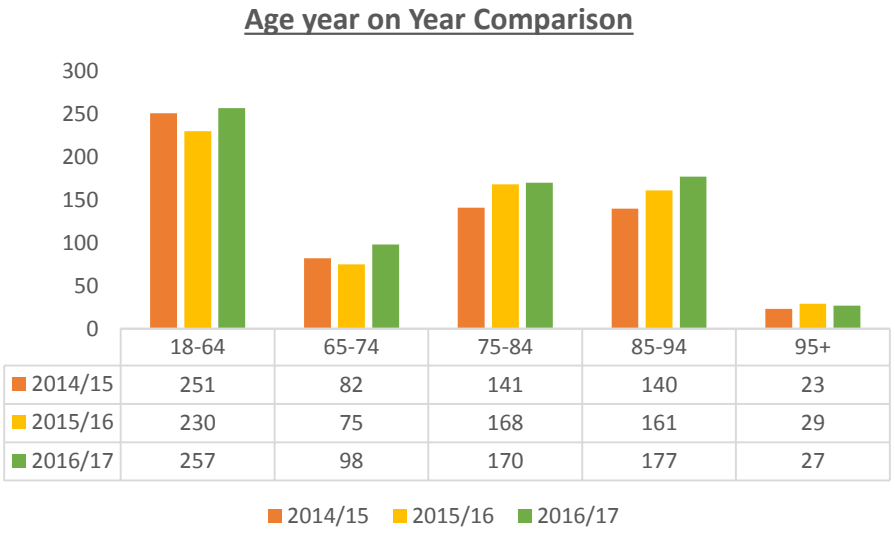


Chart 7: Age of people with safeguarding referral enquiries in 2016/17 and in comparison with the previous 2 years.



	18-64	65-74	75-84	85-94	95+
2014/15	251	82	141	140	23
2015/16	230	75	168	161	29
2016/17	257	98	170	177	27

For those clients aged 85 and above, 30% lacked capacity, with 34% of this age group being supported by an Advocate, family member or a friend during the safeguarding process. For the 18-64 group, 30% lacked capacity and 33% were supported during the safeguarding process.

1.3 Source of Concerns/Enquiries

Sources of Concerns/Enquiries in 2016-17 (Chart 8) indicates a high number however not all concerns are progressed to Enquiry. Concerns raised by Police and Independent Providers indicate an increased number of referrals however only a small percentage are progressed. However, concerns raised by Primary Healthcare Professionals indicate a better understanding of appropriate safeguarding referrals i.e. increased number of referrals progressing to Enquiry.

Chart 8: Alerts/Concerns by source

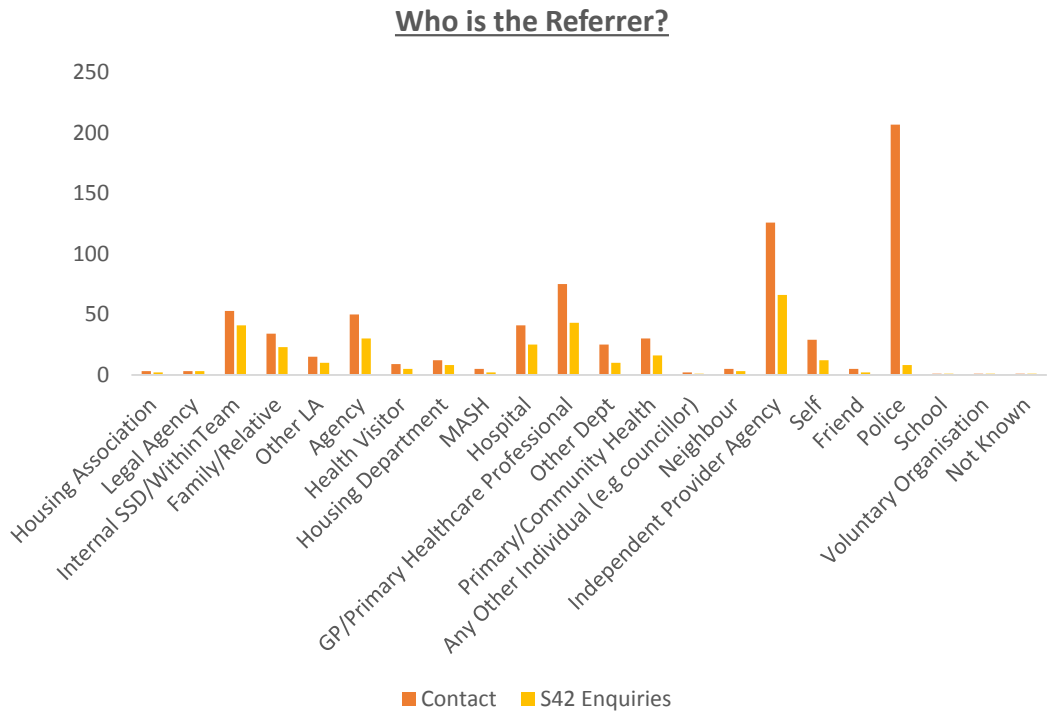
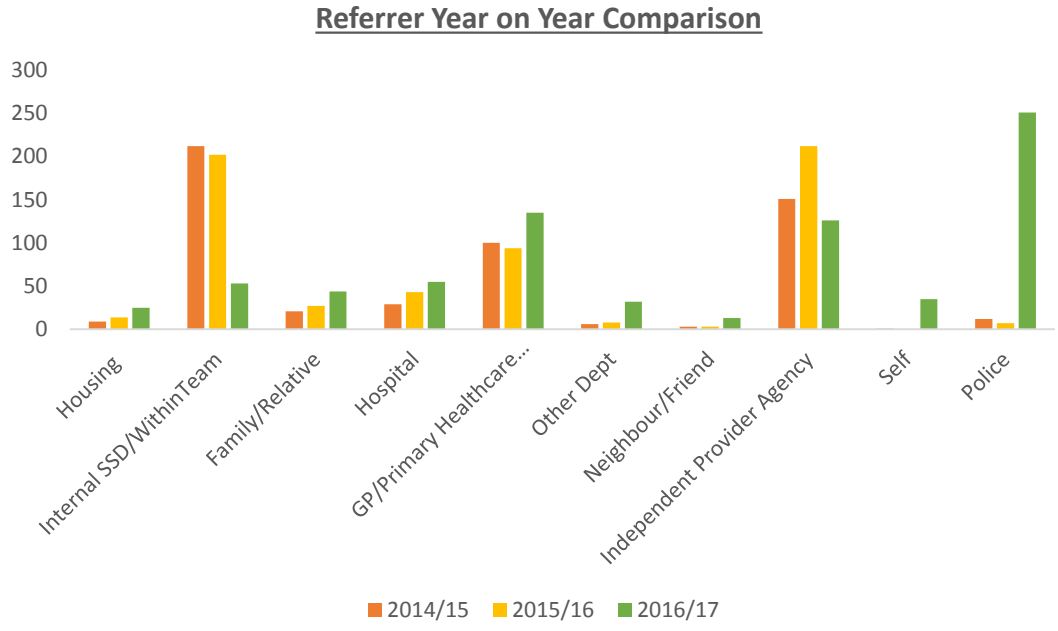


Chart 9: Concerns by source in 2016/17 and in comparison with the previous 2 years.



1.4 Locations of Alleged Abuse of Concerns/Enquiries

As with previous years, adults at risk are more likely to be abused in their own home (Chart 10). Although there are a higher number of adults in care homes; year on year the proportion abused within their own home continues to grow (Chart 11).

Chart 10: Location of concerns/enquiries for 2016/17

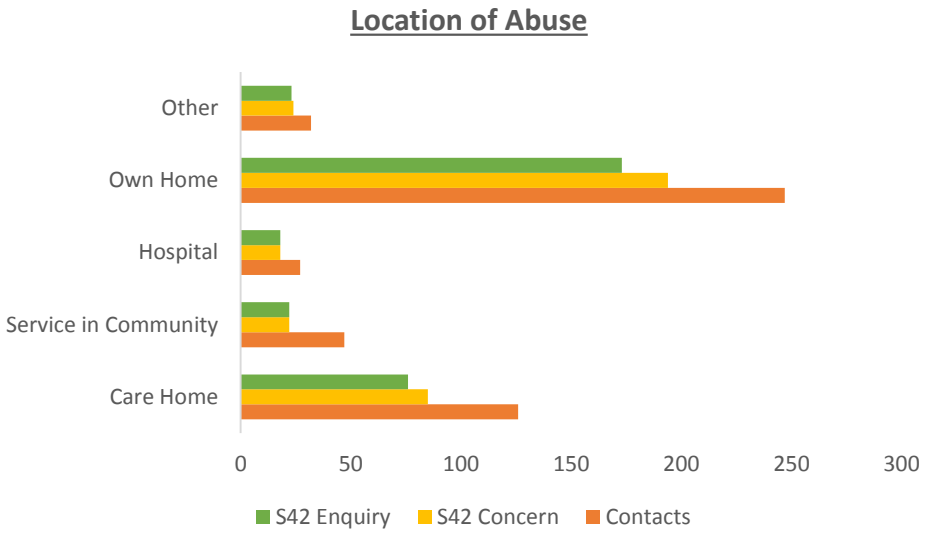
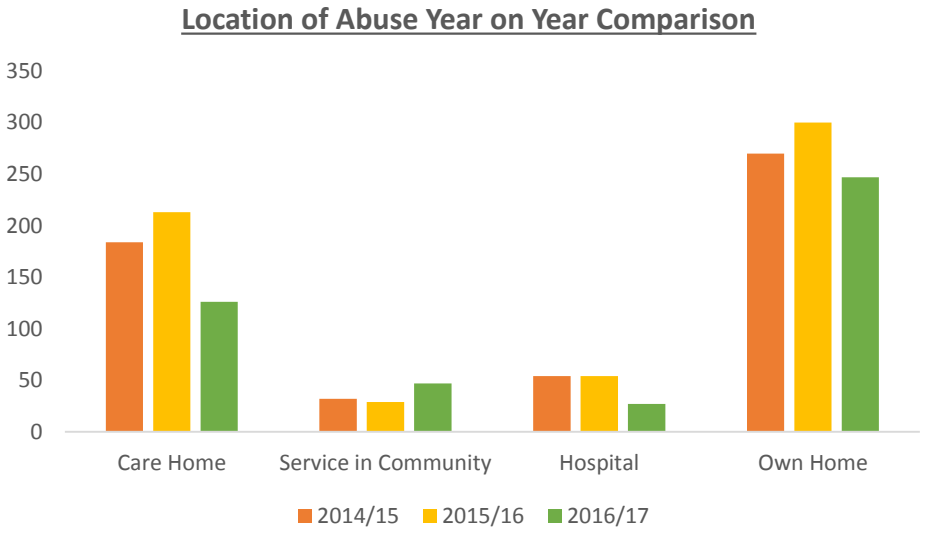


Chart 11: Location of concerns/enquiries – comparison to previous 2 years

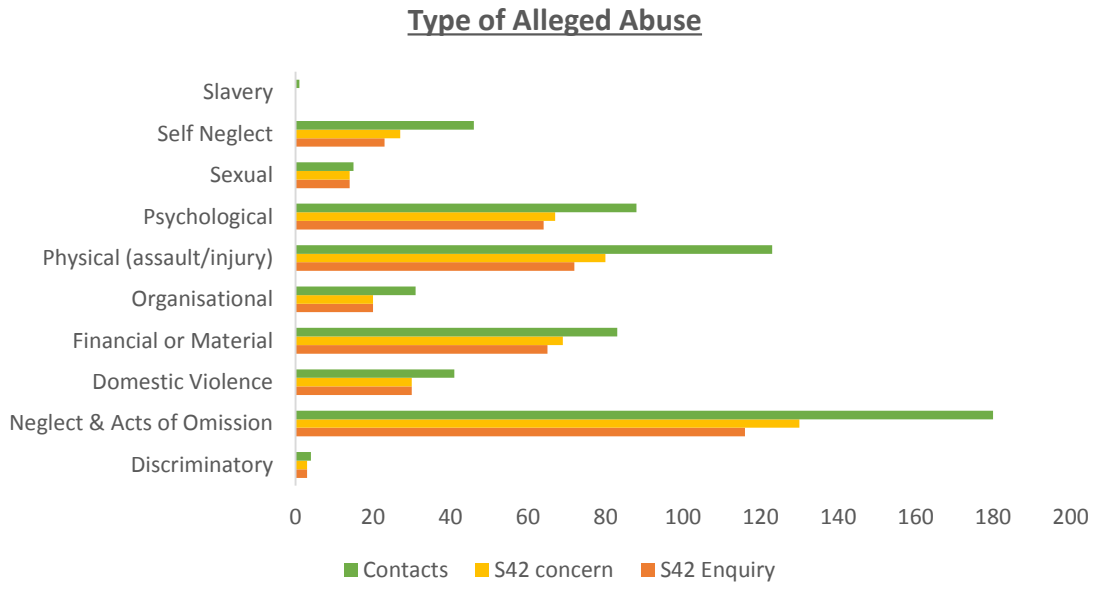


1.5 Type of alleged abuse

In 2016-17, Neglect and Acts of Omission, with 180 cases, and physical (assault/injury) abuse, with 123 cases, were the most highly reported allegations of abuse. Both of these types of abuse are most prevalent for older people and this is consistent with the increase in Concerns for older people.

In line with the Care Act 2014 requirements, self-neglect is now being reported as a type of alleged abuse. There were 46 cases reported during 2016-17 which has significantly increased from the previous year, 27 cases.

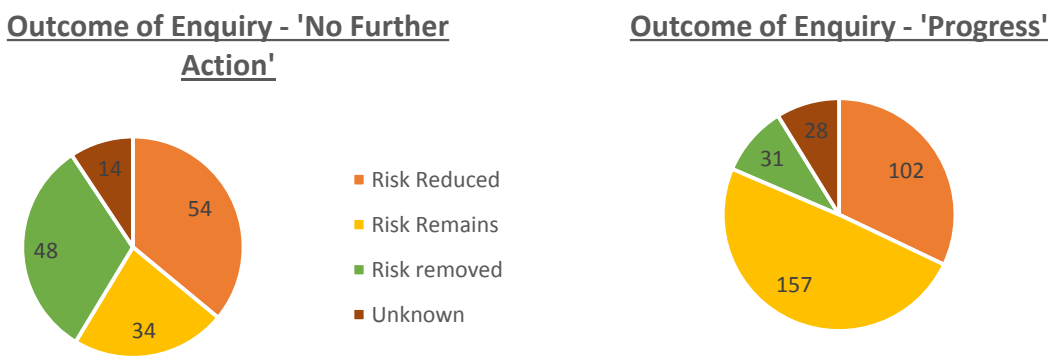
Chart 12: Nature of alleged abuse for safeguarding contacts/enquiries



1.6 Case Outcomes

Under the Care Act new case outcomes were introduced. We no longer report that a case is substantiated, inconclusive etc. The outcomes recorded following Safeguarding Enquiries are now 'Risk Removed', 'Risk Reduced' or 'Risk Remains'. The outcomes for 2016/17 are detailed in Chart 13.

Chart 13: Case conclusions by year, 2016/17, for those triaged as no further action and those progressed.

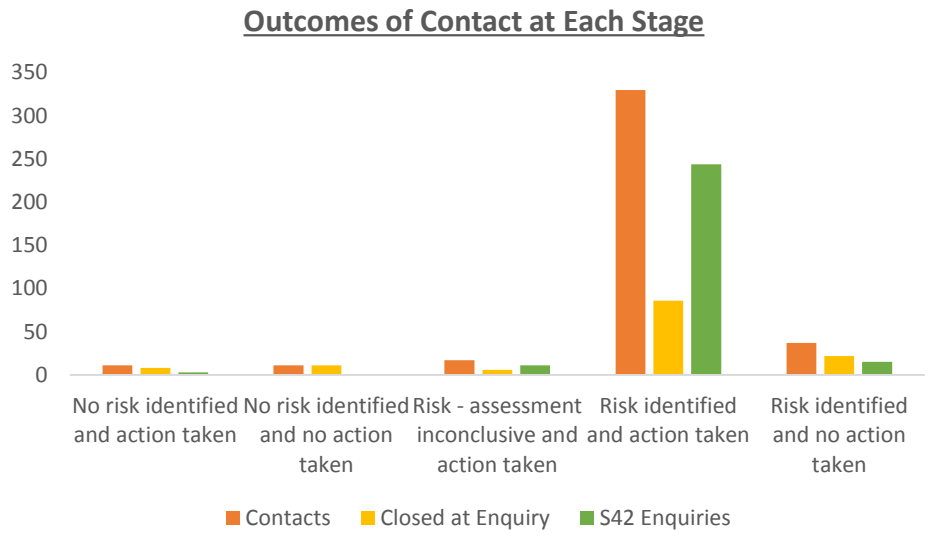


1.7 Outcomes for Adults

1.7.1 Risk

Chart 14 denotes outcomes for the adult at risk showing that the majority have 'Risk Identified and Action Taken'. This could be explained by effective triaging of Duty Workers assessing the information and taking the appropriate action.

Chart 14: Result of safeguarding actions



1.8 Making Safeguarding Personal Data

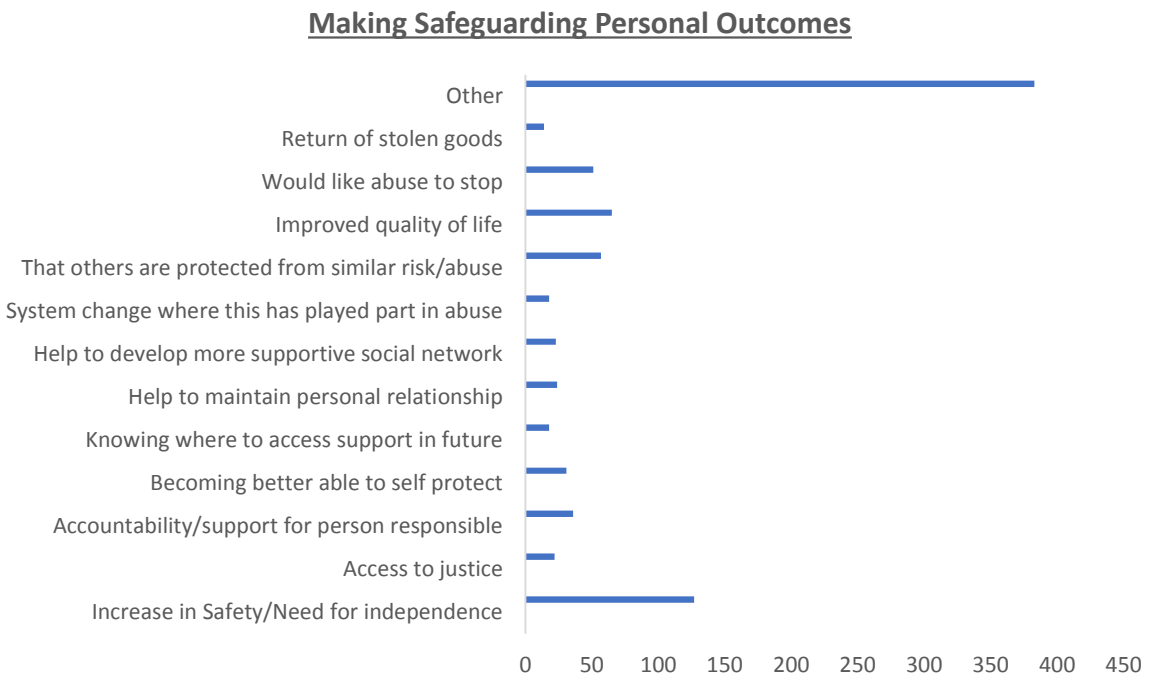
1.8.1 Personal outcomes achieved

Gaining both qualitative and quantitative understanding of outcomes remains central to our work. We have streamlined our process to embrace a making safeguarding personal approach to safeguarding. These are captured at each stage of the safeguarding process.

Chart 15 shows the outcomes indicated by the adults at risk, with the majority wanting an 'increase in safety/need for independence' (127) and an 'improved quality of life' (65).

These outcomes are part of the new terminology within this reporting year, 2016/17. Chart 15 has an overwhelming majority (383) within the 'other' category outcome. From July 2016 all back safeguarding data received from April 2016 onward was uploaded to the new recording system. This category will be audited with a view to improving our recording processes.

Chart 15: Making Safeguarding Personal Outcomes



The adult at risk and other representatives involved in the safeguarding felt their outcomes were achieved. Nearly 36% of the adults at risk over 85 years of age felt they achieved the outcomes they wanted; 35% partially achieved their outcomes however, 22% did not feel their outcomes were achieved.

Safeguarding Overview

During this period there were increases across all abuse categories with 2 categories continually leading the way - Physical (20%) and Neglect & Acts of Omission (29%).

During the period there were no serious case reviews, however Kingston participated in a learning review lead by Sutton Council and full details can be found on their website www.sutton.gov.uk

Appendix 3: Deprivation of Liberty Safeguards Performance Data

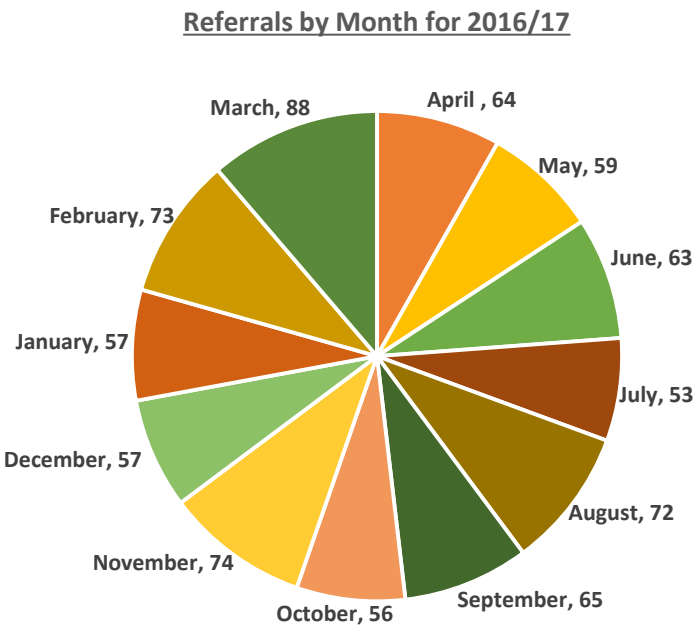
3. Deprivation of Liberty Safeguards Information

3.1 Referrals

From 01/04/2016 to 31/03/17 a total of 781 requests were received, compared to 729 for the same period last year. This represents a 7.1% increase. Chart 1 shows a breakdown of the number of referrals received per month.

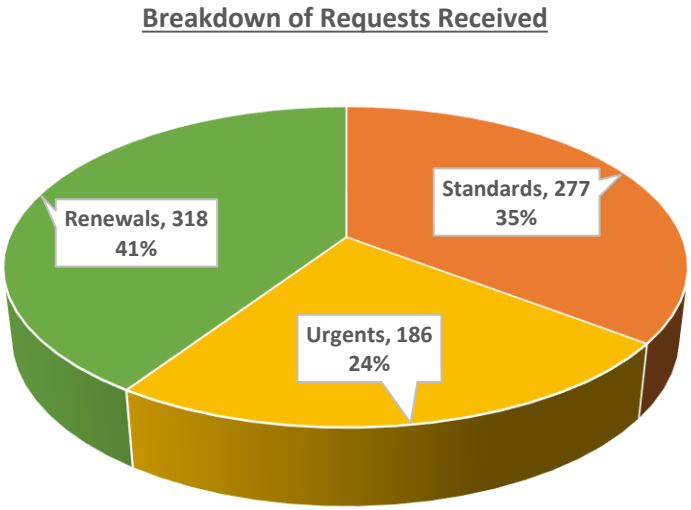
90.3% (705) of referrals were from care/nursing homes with 9.7% (76) coming from hospitals. For residents residing in the borough in hospital or care homes 642 requests were received (83.6%) compared with 16.4% (128) of requests for Kingston residents residing outside of the borough.

Chart 1: Referrals received per month.



During the reporting year 2016/17, 277 Standard requests, 186 Urgent requests and 318 Renewal requests were received. Chart 2 shows the breakdown of the requests received by percentage. The 318 Renewal requests received were for repeat referrals. Of the 186 (24%) Urgent requests, 115 (62%) were from care/nursing homes and 71 (38.2%) received from hospitals.

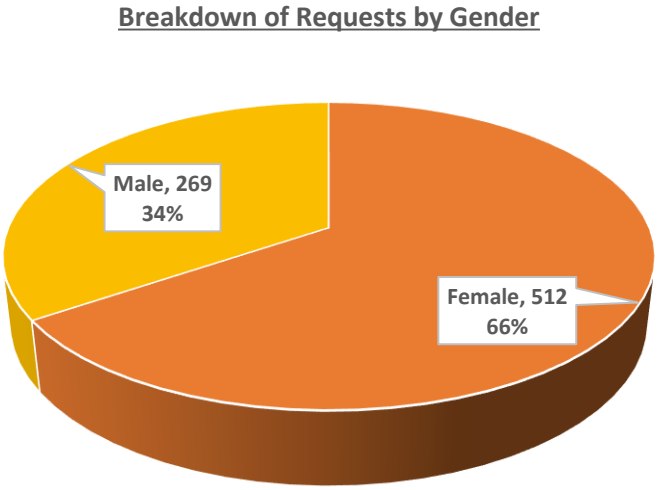
Chart 2: Breakdown of Requests received during 2016/17.



3.2 Demographics

Within the year, 512 requests received related to females (65.5%) and 269 requests received related to males (34.5%). This is consistent with previous years where a higher number of requests received are for females. The breakdown is shown in chart 3.

Chart 3: Breakdown of Requests received by Gender during 2016/17.



The majority of DoLS requests received (49.7%) were for those aged 85 years and above and are largely from the Mental Health Dementia user group. The 107 requests received for people aged 18-64 (13.9%) are mainly from the Learning Disability user group. Chart 4 details this breakdown.

Chart 4: Breakdown of Requests received by Age during 2016/17.

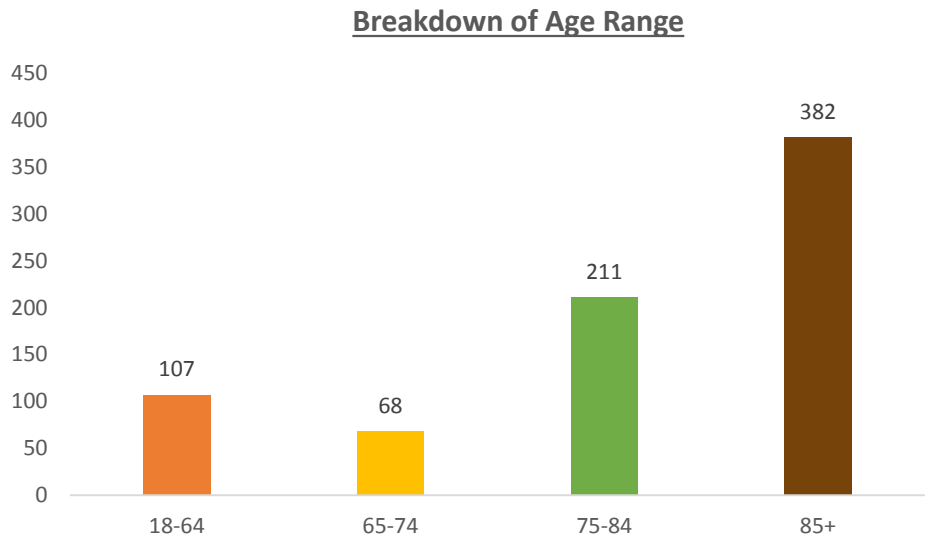
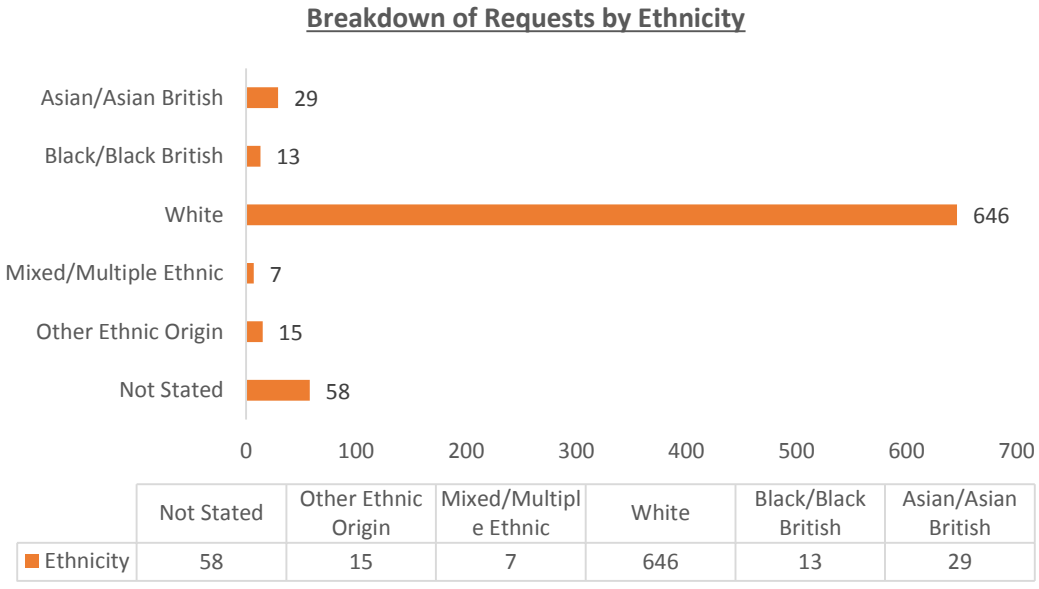


Chart 5 details the breakdown of the DoLS requests received by Ethnicity. As shown 84.1% (646) related to the White British origin, 3.8% (29) Asian/Asian British origin, 2% (15) from Other Ethnic origin, 1.7% (13) Black/Black British origin, 0.9% (7) Mixed/Multiple Ethnic origin and 7.5% (58) did not disclose their ethnicity.

Chart 5: Breakdown of Requests by Ethnicity during 2016/17.

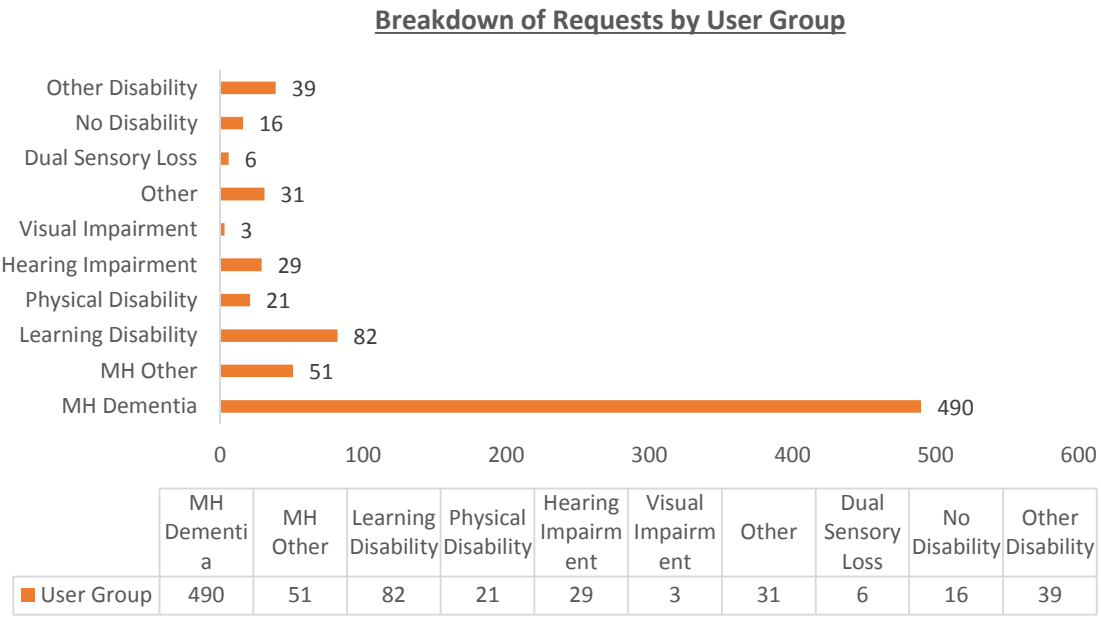


3.3 User Group

Chart 6 below shows the number of DoLS requests received by service user group. The mental health dementia user group are the largest proportion of all DoLS requests received equating

to 63.8% followed by the learning disability (10.7%), mental health (6.6%), other (4%), hearing impairment (3.7%), physical disability 2.7% and dual sensory loss (0.8%).

Chart 6: Breakdown of Requests by User Group during 2016/17.

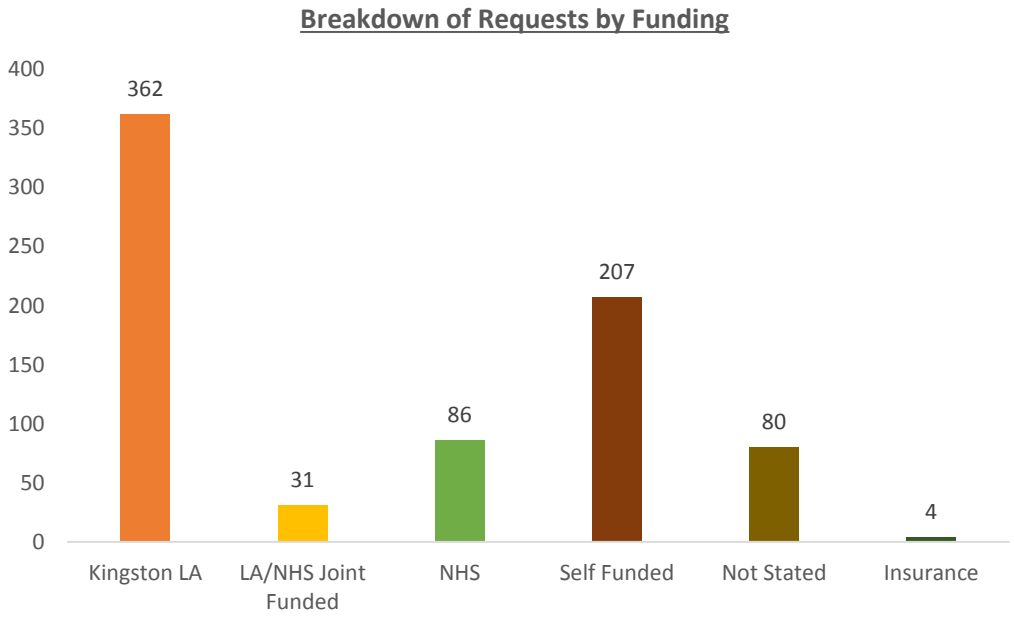


	MH Dementia	MH Other	Learning Disability	Physical Disability	Hearing Impairment	Visual Impairment	Other	Dual Sensory Loss	No Disability	Other Disability
User Group	490	51	82	21	29	3	31	6	16	39

3.4 Funding

Chart 7 below shows the breakdown of how residents are funded in the care/nursing homes. These figures are based on active DoLS requests (not including the requests on the waiting lists). 47.1% of people are being funded by Kingston and 27% are self-funding.

Chart 7: Breakdown of Requests by Funding during 2016/17.

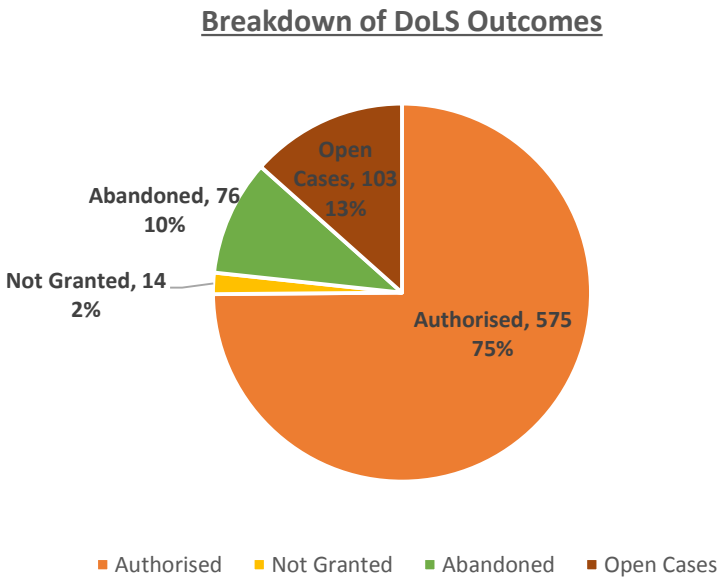


3.5 Outcomes

From the DoLS requests received 665 (86.6%) are closed and 103 (13.4%) are still open, going through the DoLS process. 76 cases were abandoned due to:

- Residents leaving the care home after the DoLS requests received
- Discharged from hospital prior to be assessed
- Funded by another Local Authority
- Died before assessment completed

Chart 8: Breakdown of DoLS Outcomes during 2016/17.



3.6 Comparative Data

The comparative data for DoLS is for 2015/16 data. The 2016/17 data will not be available until later this year. Kingston's comparator boroughs are Merton, Sutton, Wandsworth and Richmond.

Chart 9 shows the number of DoLS referrals received into each borough during 2015/16. Kingston received the second highest number across the boroughs with 729 applications.

Chart 9: Breakdown of DoLS Applications received.

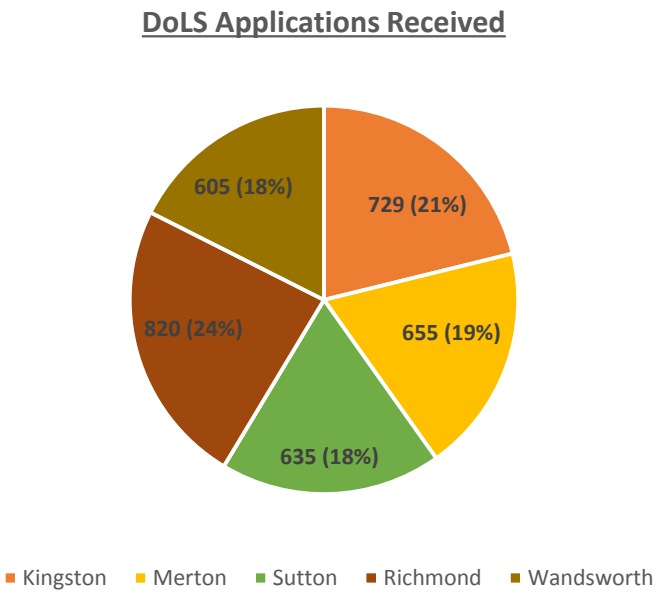
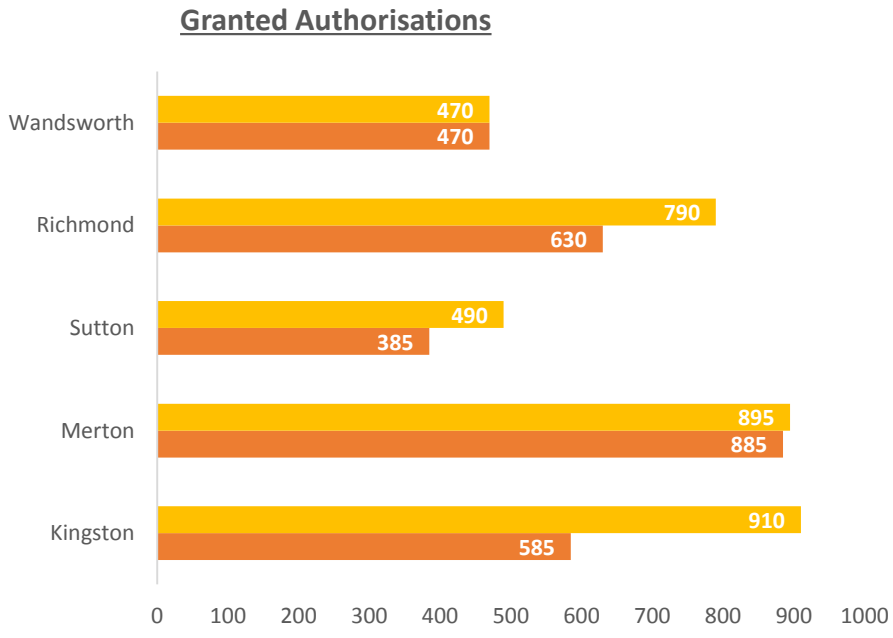


Chart 10 shows the number of authorisations granted as a DoLS. This number is higher than the referrals received in 2015/16 as it takes into account those who had DoLS granted in 2015/16 whereby their applications were received at the end of the 2014/15 year. This also takes into account where an individual may have been granted more than one DoLS within a year, due to being granted DoLS with shorter authorisations of less than 1 year. Kingston granted the highest number of DoLS (910) but these were for 585 people.

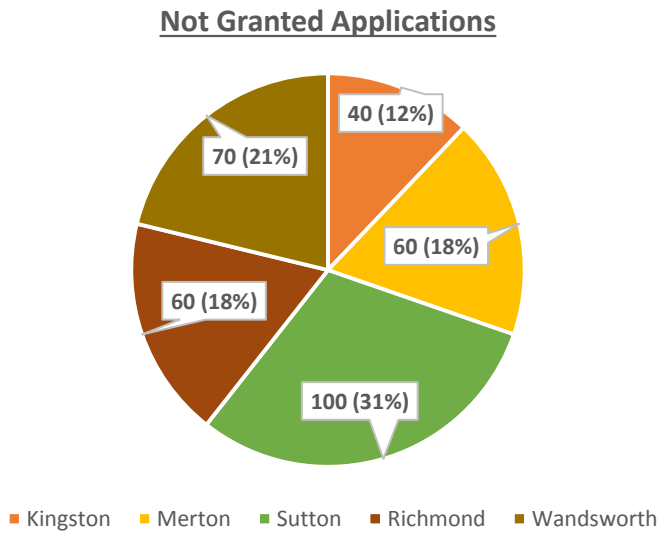
Chart 10: Breakdown of Granted Authorisations.



	Kingston	Merton	Sutton	Richmond	Wandsworth
Number of Granted Authorisations	910	895	490	790	470
Number of Individuals	585	885	385	630	470

Chart 11 shows the number of DoLS referrals that were Not Granted by the comparator boroughs. Kingston had the lowest number of DoLS that were declined in 2015/16 (40).

Chart 11: Breakdown of Not Granted Authorisations.



Appendix 4: Contact Points

1. Reporting a Safeguarding Concern

During Office Hours: Safeguarding alerts and concerns should be raised via the Council's Contact Centre/Access Team on 020-8547-5005
Out of Office Hours: via the Adults Emergency Duty Team on 020-8770-5000

Remember in an emergency, call the Police or Emergency Services on: **999**

2. Reporting and Advice – Deprivation of Liberty Safeguards

Deprivation of Liberty Safeguards (DoLS) are managed by the Safeguarding DoLS and Access Team. They can be registered or reported to the following:

Tel: 020-8547-5834 / 6766
Email: dolsadmin@kingston.gov.uk

3. Safeguarding Training

If you would like to access the Council's safeguarding training programme or would like more information on safeguarding training in general, please contact:

Tel: 020-8547-6082
Email: asclearninganddevelopment@kingston.gov.uk

4. Questions about this Report

If you have any questions about this report, please email:

Email: adult.safeguarding@kingston.gov.uk