Safeguarding Adults Executive Board

ANNUAL REPORT

Communities keeping themselves safe

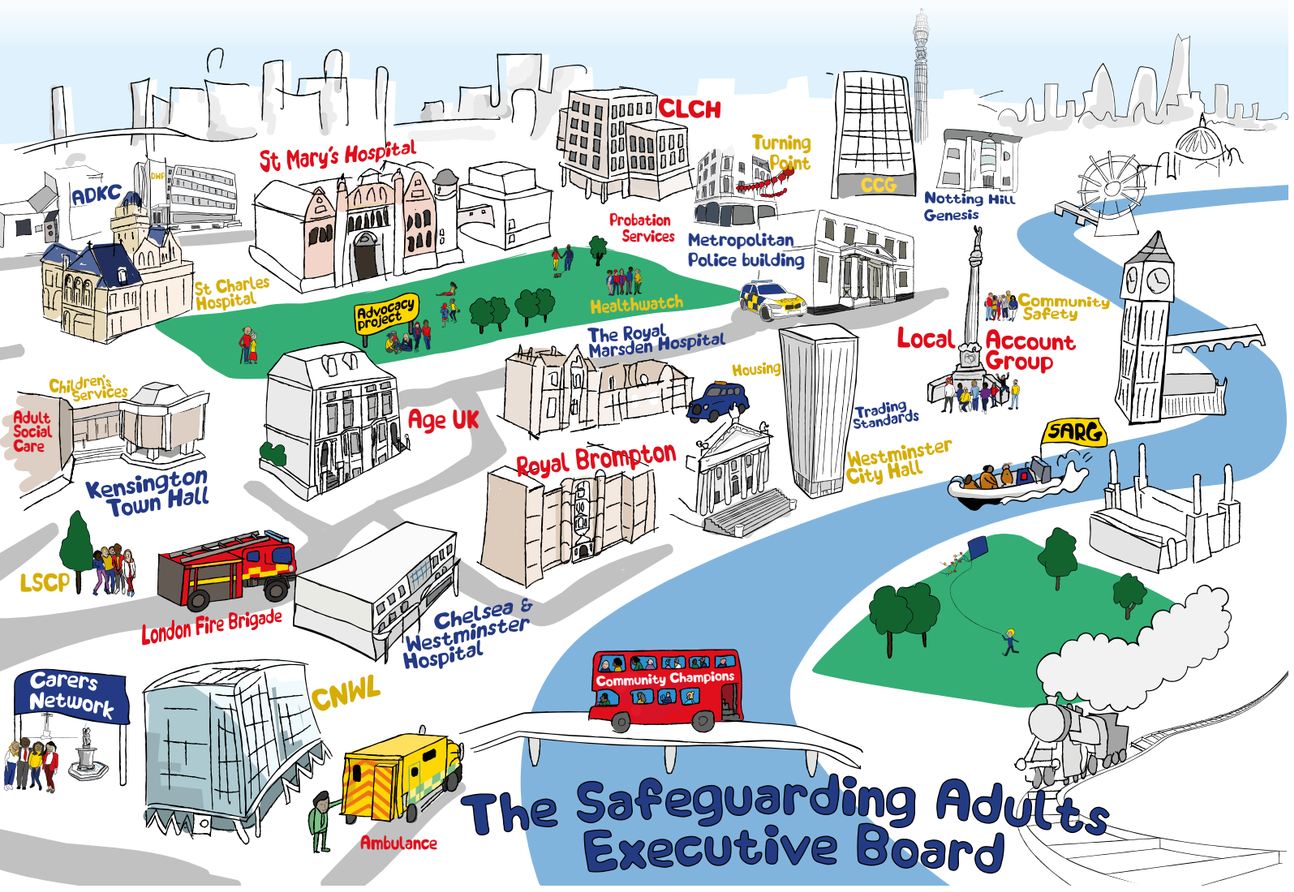
THE ROYAL BOROUGH OF KENSINGTON AND CHELSEA

Safeguarding Adults Executive Board

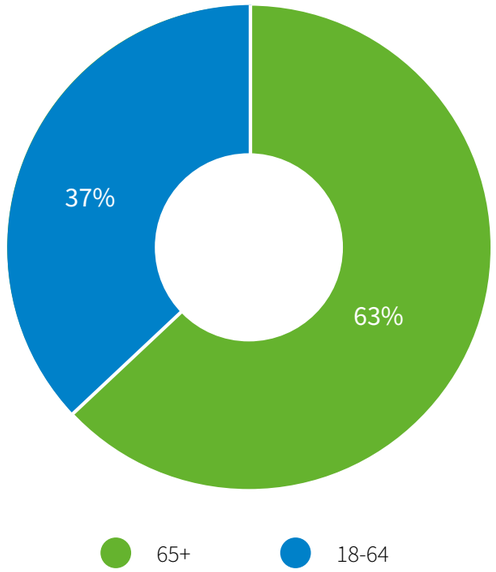
City of Westminster

The context of our two boroughs is important as it provides information about the community our service users live in

Every local area is unique from the north of the boroughs to the south. They have their own cultures and challenges. This data helps us to understand the landscape in which we work with communities and our safeguarding ambassadors to manage risk and collaborate in keeping people safe.



Royal Borough of Kensington and Chelsea – Adult Social Care insight data 2021-22



1,429
People receiving long term care and support

60% Physical Support

12% Mental Health Support

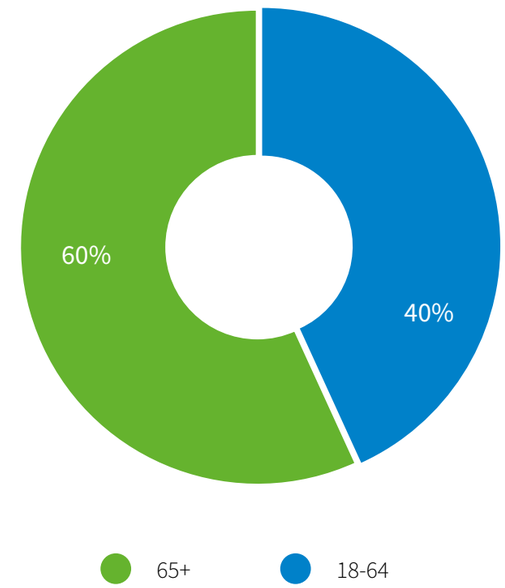
18% Learning Disability Support

7% Support with Memory and Cognition

2% Social Support

1% Sensory Support

Westminster City Council – Adult Social Care insight data 2021-2022



2,486
People receiving long term care and support

52% Physical Support

19% Mental Health Support

17% Learning Disability Support

10% Support with Memory and Cognition

1% Social Support

1% Sensory Support

Contents

Safeguarding Adults Executive Board

True or false?

The SAEB membership consists of the statutory agencies, namely the Local Authority, Police and the NHS...

False!

The SAEB membership which brings together a range of skills from agencies who are experienced in working with vulnerable adults. This includes core membership from the Local Authority, Police and Health but also community and voluntary sector services. The SAEB has a vibrant representation from service users to ensure that the voice of adults and carers who use safeguarding services are represented.

Foreword

I have great pleasure in presenting the annual report for the Bi-Borough Safeguarding Adults Executive Board (SAEB), covering the period from March 2021 to April 2022.

The SAEB brings together statutory and voluntary organisations from across both boroughs, elected members and local residents who work together to support local communities to keep themselves safe, and to safeguard adults who are experiencing or at risk of abuse and neglect. This annual report outlines the objectives that the board set for the year 21/22 and highlights some of the key achievements.

In the foreword to last year's report, I wrote about both the safeguarding challenges and opportunities created by the Covid-19 pandemic. This report for 2021 – 22 reflects the ongoing commitment and hard work of our Board members to evaluate the impact of Covid-19 on safeguarding activity and identify new concerns and challenges which they responded to.

I would like to pay tribute to the innovative and collaborative ways in which the Bi-borough services worked through the stresses and demands of the pandemic whilst still keeping safeguarding at the forefront. This set a legacy of ensuring that our services find new ways of working together to adapt and respond to new challenges.

A real challenge for any Safeguarding Adults Board is to make safeguarding services accessible to all and this was particularly challenging during the period of the pandemic. This is not just about overcoming language, ethnicity and disability barriers but understanding differences in cultural perceptions of abuse and neglect and the role of statutory agencies in safeguarding people. The Bi-Borough benefits from being an area which is culturally and ethnically diverse, but the board has to ensure that we listen to all resident communities. The Board has been delighted to have supported the Staying Safe Project. The project worked with many of our community organisations whose voices are seldom heard with the aim of breaking down barriers that can make it difficult for communities to reach out for help. The messages from these community groups are clear – we must listen to their experience of safeguarding and ensure this informs local services.

I would also like to highlight the fantastic work of our Safeguarding Ambassadors and the Local Account Group who, despite the pandemic, played a key role in linking the Board to local residents to highlighting what the safeguarding issues are for them and empowering people to take action to raise concerns when needed.

We have continued to prioritise our own partnership learning and the need to make practice changes when either nationally or locally we hear of those who faced abuse or harm. The reviews of their very tragic circumstances must inform and shape how we improve our work, and we must remain open to the challenge they bring. It is perhaps the best legacy that we can provide for these residents and their families. The report outlines our actions from Kate and Annie's reviews as documented in last year's report. We have also completed a Safeguarding Adult Review,SAR, for Joan, which will be published in 2022. We are grateful to Joan's family for their contributions and honest insights into this review and that they have been willing to support the learning that we will provide.

This annual report contains many examples of excellent partnership working and I would like to thank Board members for their continued support and engagement, which crucially makes a real difference to those who rely on our shared safeguarding system. My thanks too to both councils for their continued role in supporting the board's work.

Looking back and reflecting on a year's work has of course helped shaped our thinking and practice for this current year 22/23. There are many changes taking place across all of our partner organisations, but our priority remains to keep safeguarding as a central and key focus for us all.

AILEEN BUCKTON

Chair Bi-Borough Safeguarding
Adults Executive Board

Did you know?

Schedule 2.2 of The Care Act states 'Members of Safeguarding Adult Boards are expected to support the board in its work but no formula has been established for the total budget a SAB might need, nor the contributions to be expected from each member.

Financial Contributions and thanks goes to

- the North West London Collaboration of Integrated Care Board (NWL ICB) contribution of £20,500 per borough, per year
- the Mayor's Office for Policing and Crime who provide an annual contribution of £5,000 to each borough for the local safeguarding adult board
- also, for the sixth year running, The London Fire Brigade has contributed £500 per borough

The money is a welcome contribution to the costs of commissioning Statutory Safeguarding Adult Reviews as well as on-going costs of raising awareness of Adult Safeguarding in our communities through events and promotional materials.

Introduction

What is Safeguarding?

It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adults wellbeing is promoted. Safeguarding practice recognises that people have unique interpersonal relationships and may be ambivalent, unclear or unrealistic about their personal circumstances.

What is the Safeguarding Executive Board responsible for?

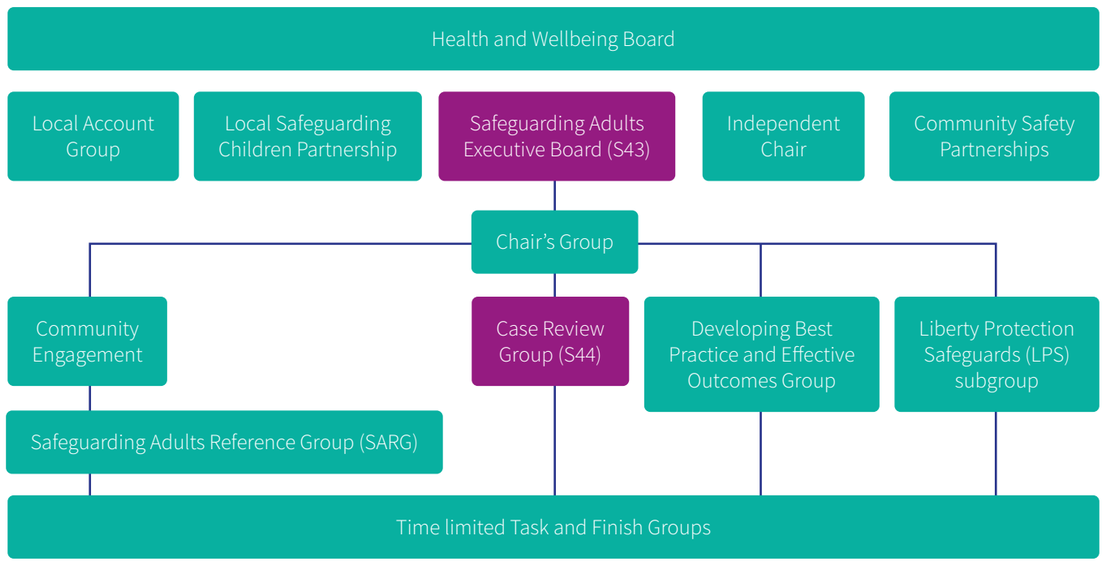
This Safeguarding Executive Board is responsible for overseeing and leading on the protection and promotion of an adult's right to live an independent life, in safety, free from abuse and neglect across Kensington and Chelsea and Westminster.

What it means to abuse someone

Abuse means treating someone with violence, disrespect, cruelty, harm or force.

The Bi-Borough Safeguarding Adults Executive Board is a partnership of organisations working together to prevent abuse and neglect, and when someone experiences abuse or neglect, responds in a way that supports their choices and promotes their well-being. The Board Structure and its workstreams for 2021-2022 is in the diagram below and demonstrates the effective links we have with other boards, partnerships and the Local Account Group.

Safeguarding Adults Executive Board and workstreams 2022/23



True or false?

The SAEB and all of its subgroups held a total of 33 meetings over 2021 – 22.

True!

The board meets four times a year and is supported by a range of subgroups which carry out the work ensuring that the priorities set out in our Strategic Plan are delivered. Each subgroup has a work plan which details the areas of focus for the financial year and is regularly updated with specific actions and timescales. These subgroups ensure that the work of the Board really makes a difference to local safeguarding practice, and to the outcomes of adults and their carers.

Our Board Vision is based on the rights of people to live a life free from harm where communities

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

Our Values and behaviours

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

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

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

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

- have needs for care and support; and
- are experiencing, or at risk of, abuse or neglect; and
- as a result of their care and support needs are unable to protect themselves from either the risk of or experience of abuse or neglect regardless of if the council are funding care or not.

Who is the Safeguarding Executive Board Annual Report 2021-2022 for?

Annual Report is for the people who live and work in the Royal Borough of Kensington and Chelsea and Westminster. The report describes what we have done to help prevent safeguarding in our communities, why we have done it and what the results were. It also describes how we spend our budget and what difference we have made to adults at risk.

Executive Summary

The SAEB focus this year has been about learning from how the pandemic has effected our safeguarding work and what we have done about this. The Annual Report falls into 4 main chapters in which the partnership achievements for 2021-2022 are described.

Safeguarding Ambassadors

- passionate about preventing abuse and neglect
- leaders in promoting and sharing safeguarding knowledge
- convey safeguarding risks and bring real-life stories and concerns to the attention of the Board
- co-produce all community events, activities and products

Making Safeguarding Personal

- using data better to help inform partnership responses to safeguarding referrals
- understanding which abuse types are the most prevalent and doing something about it
- knowing our residents and who is at most risk
- placing partnership responses at the heart of the problem

Communities keeping themselves safe

- culturally competent safeguarding
- raising awareness of safeguarding
- close working with the voluntary sector
- listening and collaborating with service users

Leading, Listening and Learning

- a partnership which is open to new ideas and a willingness to learn from mistakes
- a partnership which wants to get better at preventing abuse and neglect
- a partnership which is transparent and accountable to each other and to its residents
- a partnership that listens and hears what it is being told by families

What the SAEB worked on in 2021-2022

Safeguarding Ambassadors

Safeguarding Ambassadors are the Boards Super Heroes. They are a unique group of individual's from prominent service user groups passionate about preventing abuse and neglect. They lead, promote and share their safeguarding knowledge by listening to and supporting residents. This diverse group are often the first point-of-contact when residents want to seek safeguarding advice and they play a lead role in bringing safeguarding risks to the attention of the Board.

Communities keeping themselves safe

- culturally competent safeguarding
- raising awareness of safeguarding
- close working with the voluntary sector
- listening and collaborating with service users

Diversity and Inclusion: Staying Safe – In partnership with the Advocacy Project and the Black, Minority, Ethnic Health Forum

Safeguarding Awareness Programme successfully rolled out across the communities of the Bi-Borough, to include translation services and co-designed events for 'hard to reach' communities who now feel more confident and better supported in raising safeguarding concerns. This has both Increased engagement and greater awareness of barriers and accessibility issues that hard to reach communities have in raising safeguarding concerns.

National Safeguarding Awareness Week (NSAW) 'Creating Safer Cultures'

Our Safeguarding Ambassadors launched a Cybercrime video to mark Safeguarding Awareness Week, which had 76 public views during launch week. They also led on a session to co-produce our Community Engagement Prevention Agenda to be rolled out during 2022/2023 across all **Community Engagement member organisations.**

Safeguarding Activities were scheduled throughout the week which included a suite of online resources to help develop community awareness, keep residents safe and informed on the work of the board in the communities of the Bi-Borough.

Making Safeguarding Personal

- using data better to help inform partnership responses to safeguarding referrals
- understanding which abuse types are the most prevalent and doing something about it
- knowing our residents and who is at most risk
- placing partnership responses at the heart of the solution

Strategic Hoarding Operational Group

- operational management of hoarding
- multiagency data review completed to better understand the current position and influence the decisions of the group
- prevention and early intervention processes embedded across housing sector
- raising awareness and prevention. Practitioner event in planning for November 2022

Increased service users involvement in SAEB activity: The Community Engagement Group and Safeguarding Ambassadors are working with Community Safety teams to champion the work already being completed on cuckooing and with the **Hate Crime Partnership;** work continues to promote partnership working across the Bi-Borough with local resident groups, voluntary organisations, and the police.

Transitional Safeguarding: We have continued to work together with childrens services to influence better understanding of safeguarding for 16-25 year olds.

London Safeguarding Voices Group:. Safeguarding Ambassadors with lived experience of Safeguarding and have joined the new regional group. They have led discussions at regional conferences and supported the group by sharing and demonstrating their advance knowledge of co-production and Making Safeguarding Personal.

Leading, Listening and Learning

- a partnership which is open to new ideas and a willingness to learn from mistakes
- a partnership which wants to get better at preventing abuse and neglect
- a partnership which is transparent and accountable to each other and to its residents
- a partnership that listens and hears what it is being told by families

In response to a report on the conclusion of the Norfolk Safeguarding Adult Review of Carston Hospital the SAEB set up a task and finish group to review the national recommendations and learning. This included implementation and review of Annual Health checks: embedding local improvements in pathways for service users with a learning disability.

Learning from Safeguarding Adult Reviews (SARs) The partnership completed 2 SARs and subsequent action plans for local service improvements. 1 thematic SAR has been commissioned on fatal fire.

Organisational memory: This has remained a key priority for the SAEB throughout 21/22. We have continued to disseminate learning from national and local SARs relevant to our partnership and community groups. Local action plans reviewed and implemented in response to all 7-minute briefings.

LSCP and SAEB Joint meeting to review support to Afghan Families: Joint Action Plan across Children's and Adults in place to bolster support to all refugees and families. The plan includes partnership agencies providing additional services alongside assistance for refugees into existing health and social care services across the Bi-Borough.

Liberty Protection Safeguards: The LPS subgroup are overseeing the awareness, promotion and application of the new LPS standards across the Bi-Borough. Providing assurance to the Safeguarding Adults Board that partners are ensuring and promoting LPS awareness, and appropriate application in practice through workforce planning and training.

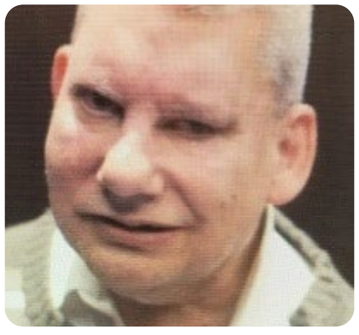
Safeguarding Ambassadors

Safeguarding Ambassadors are the Boards super heroes! We are grateful for their expertise in understanding what makes their communities safe and we support them as they grow from strength to strength in playing a lead role across all our areas of work. They are the key link between our service users and the Board. They inform the Board what is worrying them and tell the Board what they want to do about it.

The first section of the Annual Report offers a profile of the work of our Safeguarding Ambassadors. What they have been doing throughout the year with communities and the fantastic recognition they had this year by representing the SAEB as part of the London Voices work sponsored by Adult Directors of Adult Social Care.









Maria Stoeva – Chair of the Safeguarding Adults Reference Group

Hello everyone, my name is Maria Stoeva, and I am the Chair of the Safeguarding Adults Reference Group. Our work is to raise awareness of safeguarding and empower our communities to be confident in responding to abuse and neglect.

Areas we identified and solutions implemented:

1 Local shops overcharging people by providing food on 'tick'

Bethan Featherby from Trading Standards hosted an informative session about pricing practices and how we can report these matters. The group have co-produced a 'Pricing Practices Guidance 'which we have shared with our communities.

2 Loan Shark training

A very insightful session was delivered by the Illegal Money Lending Team to our group so that we can keep our communities informed and can support each other to stay safe from loan sharks. This risk has become very real due to the economic crisis and we will continue to promote awareness and work to create local campaigns and initiatives and host webinars to warn residents about the dangers of loan sharks.

3 Hate Crime

We have been working with the Community Safety Partnership who have delivered hate crime training to our Group. We have raised awareness to all members of our Community Engagement Group which includes volunteers from 18 member organisations. We are very passionate about Hate Crime, as many of our group members have lived experience of this type of abuse. We co-produced the 7-minute briefing so that we can further raise awareness of this important topic.

Please contact us to join our mailing list and to receive invitations to future events and important updates on the work that we do at **makingsafeguardingpersonal@rbkc.gov.uk**

Best wishes

MARIA STOEVA

7 Minute Briefing: Hate Crime

1 Hate Crime incidents

Hate Crime incidents hurt and can be very frightening for the person subjected to them. They directly strike at who a person is, their community and their way of life and can be committed against a person or a property. People have often suffered abuse and hostility all their lives, just because of who they are. Incidents and crimes that are targeted at a person because of hostility or prejudice towards their disability, race/ethnicity, religion/ belief, sexual orientation or transgender identity are classified as hate incidents or crimes. This briefing is here to remind you of our responsibility to the victims of hate incidents/crimes so that we can make people safe and help them feel safe. Hate incidents and crimes are being committed every day across all force areas and yet research tells us that over 60% are never reported to the Police.

2 What is a Hate Crime?

Any criminal offence, which is perceived by the victim or any other person, as being aggravated or motivated by prejudice or hostility.

Hate Crime is defined as; Any hate incident, which constitutes a criminal offence, perceived by the victim or any other person, as being aggravated or motivated by prejudice or hostility. In both cases this can be before, at the time or after the event.

3 Our duty

It is essential that we all understand that whilst the nature of the hate incident may not grade high on the criminal framework of offences, victims of hate incidents or crimes have often experienced this hostility and behaviours for long periods and contacting the police is a significant step for them due to fears of recrimination and them not being taken seriously.

Hate Incidents and Crimes if not dealt with appropriately have the potential to rapidly escalate for both for the victim and the community and could cause severe damage to public confidence.

4 Public Trust and confidence

Growing public trust and confidence in reporting hate crime is important. By raising awareness we hope that this will lead to better community engagement with the police and community safety partners.

5 Did you Know?

There were over 25,800 reported Hate Crimes in London last year.

6 Ways to report

Positive action to make the behaviour stop and provide victim are and support are vital. There are various ways to report hate crimes and incidents. In an emergency always call 999. For all other reports please call 101.

7 REPORT IT

Take all reports of hate incidents and crimes seriously. The victim impact will be significant even though the incident may appear minor. It doesn't only have to be the victim that reports Hate Crimes/ Incidents. If YOU witness it YOU can report it too. DON'T – assume it is someone else's problem. We ALL have a responsibility to fight Hate Crime.

Fay Sandler, Safeguarding Ambassador, Local Account Group Member

Fay Sandler talks about her volunteer roles and her passion for helping others.

I've always had a passion for helping others and I love the idea of being considered a dependable person. I enjoy when others come to me to talk about the hardship they are experiencing and being able to provide them with feedback or helpful advice.

To do this I learned that you need to have the characteristics of a people person. You must be patient, outgoing and friendly. I allow myself to be comfortable when speaking with our communities. The Local Account Group and Safeguarding Adults Reference group all have a passion for helping others. We all really inspire each other to give others the help, support and guidance when facing difficulties. We represent to the best of our ability, not only our personal perspective, but incorporating the views regarding issues and provision of services that impact upon our diverse communities and we continue to convey our important message that 'Safeguarding is everybody's business'

Glenda Joseph, Safeguarding Ambassador

This year Glenda shared her story about her journey from Service User to Safeguarding Ambassador and to becoming a voice to influence safeguarding for London. Her video is honest, heartfelt and very inspirational – please click below to watch the video.

The London Safeguarding Voices Group

LONDON SAFEGUARDING VOICES

'Our Voices Together Are Stronger'

The London Safeguarding Adult Board want to ensure people with lived experience of Safeguarding are at the heart of governance and practice across London.

"The London Safeguarding Voices group (LSV) is a pleasure to co-ordinate, due to the LSV members dedication, commitment, and honesty in their ability to share their lived experiences of safeguarding, in a safe environment."

Hen Wright, London Safeguarding Voices Lead

We have two members from the Bi-Borough. Glenda and Michael who are quite simply amazing, and we are very lucky to have them! Their contribution to the group is huge, not only in their ideas, but also in their general kindness and support to all. Their dedication to making safeguarding better clearly shows in their willingness to attend all meetings and actively take part in our LSV projects.

Glenda has been invaluable in participating in the London Borough of Barking and Dagenham Peer Review in May, as an expert by experience. She also presented the work of the LSV at the Chief Social Worker 'Revisiting Safeguarding Guidance' launch event, to 100+ delegates not only in London, but nationally.

Michael is influential on us keeping things simple and easy to understand as 'safeguarding is everyone's business', not just for professionals. Michael suggested the group has Basic Adult Safeguarding training, which was delivered by one of our more experienced members. Both Glenda and Michael starred in our animated film.

We are excited about co-planning and co-producing the LSAB Conference in November with LondonADASS. We are planning a safeguarding session for the conference on Fire Safety, with the London Fire Brigade.

Our aim is to have all London Boroughs represented in our group and we would welcome new members with lived experience of safeguarding. Afterall, the success of the LSV group is because of the incredible members. For further information or if you have any questions regarding the LSV please contact Hen Wright (**helena@healthwatchkingston.org.uk**).

Communities keeping themselves safe

This year the SAEB continued to focus on better understanding different and changing patterns of abuse and harm in our communities. The Covid-19 pandemic continued to disrupt our lives, and global events – such as the Afghan evacuee crisis – made us re-think our role in early intervention and prevention of harm.

- culturally competent safeguarding
- raising awareness of safeguarding
- close working with the voluntary sector
- listening and collaborating with service users by experience

The SAEB wanted to build on the work in 2020-2021 in which we collaborated with other council departments and our wider partnership to help in raising awareness in particular of low level mental health and creating a safeguarding culture which is inclusive and diverse.

The Community Engagement Group is a sub-group of the board and is co-chaired by Miles Lanham Assistant Director of Housing Management and Ritu Guha, User Involvement Project Manager at the Advocacy Project.

MILES LANHAM
Assistant Director,
Housing Management

OCTAVIA

RITU GUHA
User Involvement
Project Manager

The Advocacy Project

The SAEB is delighted to have supported this year's community projects which have addressed both the barriers and opportunities in raising safeguarding awareness, by creating an inclusive and diverse safeguarding culture.

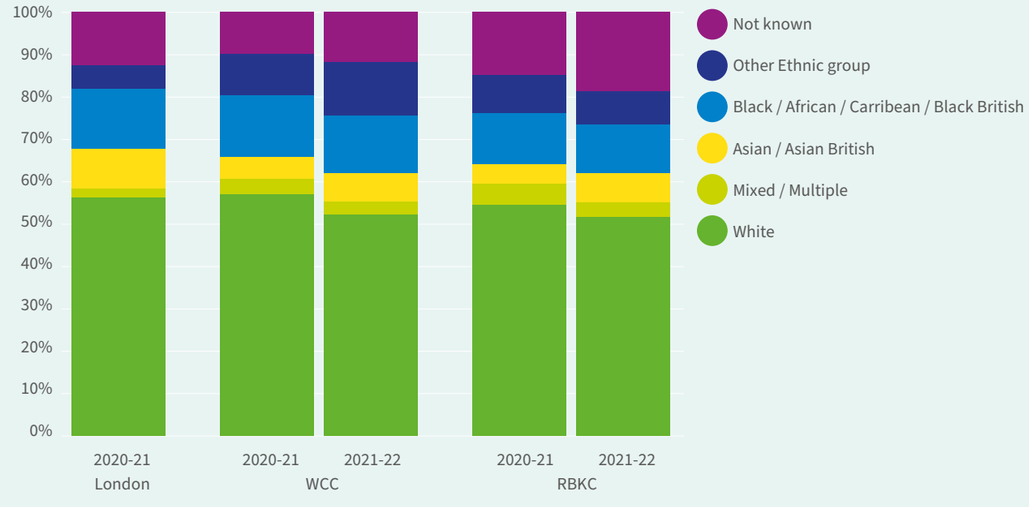
The Staying Safe project is an innovative piece of work in which seldom heard communities talk about what keeping safe means to them. The sections also describes work with Afghan evacuees in which a strong focus on what works to ensure early intervention and prevention of safeguarding is a key component. The section ends with community events and engagement sessions which our Safeguarding Ambassadors requested to ensure they are up to date with key areas of interest.

Staying safe project

We commissioned the Advocacy Project to design and deliver a Safeguarding Awareness 'Train the Trainer' Programme to the Black Minority Ethnic Forum Health Forum throughout 2021/22. This programme was the first of its kind both regionally and countrywide, as it will be translated and delivered by bi-lingual leaders of 14 'hard to reach' language and religious faith groups across Kensington and Chelsea and Westminster and will include delivery of training in Arabic, Sudanese, Moroccan, Kurdish, Bangladeshi, Eritrean, and Somali. Its main objective is twofold: to raise awareness of abuse and neglect and referrals into the council; to understand the barriers to making a referral into the council.

The following table shows the Safeguarding referrals in the year by ethnic origin of adults at risk.

Ethnic origin of individual adults at risk involved in S42 enquiries (S42 enquiries commencing in the year)



> "This innovative, exiting project that The Advocacy Project was commissioned by the Safeguarding Adults Executive Board to deliver has meant working closely with seldom heard from diverse groups in the communities of the Bi-Borough to co-produce Safeguarding Training for them, with them!"
>
> **RITUSHREE GUHA**
> User Involvement Project Manager

The make-up of the adults at risk in terms of ethnic origin in Kensington and Chelsea and Westminster is similar to that for last year and for London as a whole. Findings suggest that the Black and Ethnic communities in the Bi-Borough prefer not to make safeguarding referrals.

Culturally competent safeguarding training

The "Staying Safe" project was commissioned by the Safeguarding Adults Executive Board in October 2021 to engage with and deliver safeguarding training to up to 14 community groups in Westminster and Kensington and Chelsea serving some of the most deprived and seldom heard communities. This project has aimed at identifying challenges faced by diverse communities in accessing Safeguarding services and to empower these communities by delivering tailored Safeguarding training. The project was split into two phases engagement and training.

Diverse Community organisations are telling us about the barriers they experience raising a safeguarding concern to the local authority.

"Social services don't understand the culture and faith of the person of concern in their process of decision-making. They must make decisions within this context."

> "Communities work together and don't like it when concerns are raised with the authorities. The person who raises the concern gets questioned by their community for doing so."
>
> **QUOTE FROM PARTICIPANT**

Engagement phase

Organisations working with diverse communities were approached to participate in the project with support from the BME Health Forum. In the engagement phase, we met the organisations through focus groups and discussion sessions to gather qualitative feedback on Safeguarding practices.

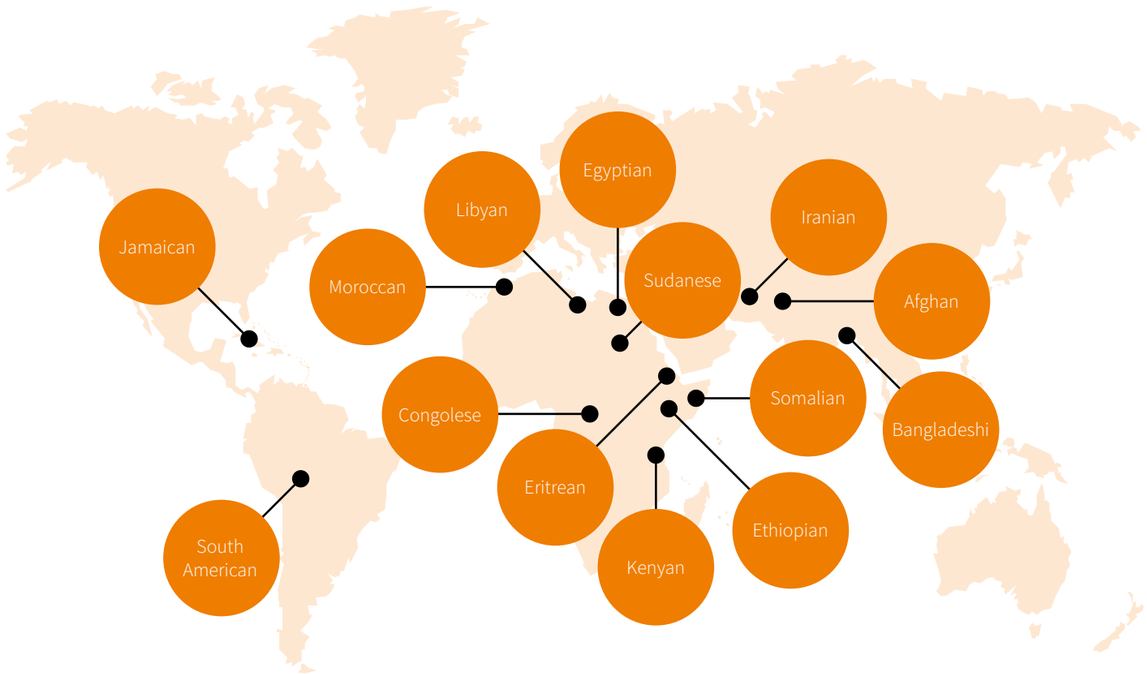
Key findings

- the word ‘safeguarding’ is not easy to translate in many languages
- lack of knowledge of Safeguarding Adults in comparison to Children
- different cultural perspective on ‘safety’ and ‘abuse’

It’s taboo to talk about personal issues in many cultures resulting in hidden abuse.

The feedback informed us of the gaps in knowledge on Safeguarding amongst the communities. This helped us shape the Safeguarding training content. An interactive and culturally competent training was co-produced and delivered to the identified groups.

Number of countries represented



BME Health Forum advised us on the primary groups in the two boroughs:

- Westminster – Arabic-speakers (mainly Sudanese and Moroccan), Kurds and Bangladeshi communities
- Kensington and Chelsea – Moroccan, Eritrean and Somali communities

Case Study

Fear of authority and reluctance to raise concerns

Mariam has mental health issues and lives with her teenage son. Occasionally Mariam goes missing.On one occasion Mariam went missing for more than 5 days. Her son was extremely concerned and called a third sector organisation that works with those from his community, knowing that they were an organisation his mother trusted.

On calling the organisation – Mariam’s son was advised to call the police immediately to seek support and assistance in locating Mariam. Mariam’s son was worried about police getting involved in his life and about the backlash from the community should they find out he had contacted the police. The manager in the third sector organisation offered support to the son and explained the need to prioritise his mother’s safety.

Mariam’s son called the police, and the police took action immediately. Mariam was found and returned home safely.

After the matter was resolved, some members of the community raised concerns as to why the police were informed instead of them. However, the organisation was able to sensitively address the issue with the community by highlighting the significance of getting help at the right time.

Barriers:

- **fear of authority**
- **taboo to discuss personal issues with professionals**
- **lack of awareness on the support available**
- **lack of trust**

Training Phase

Types of abuse

The different types of abuse most frequently encountered by the organisations we engaged with were:

- financial abuse related in particular to benefits
- racial and religious incidents related to Hate Crime

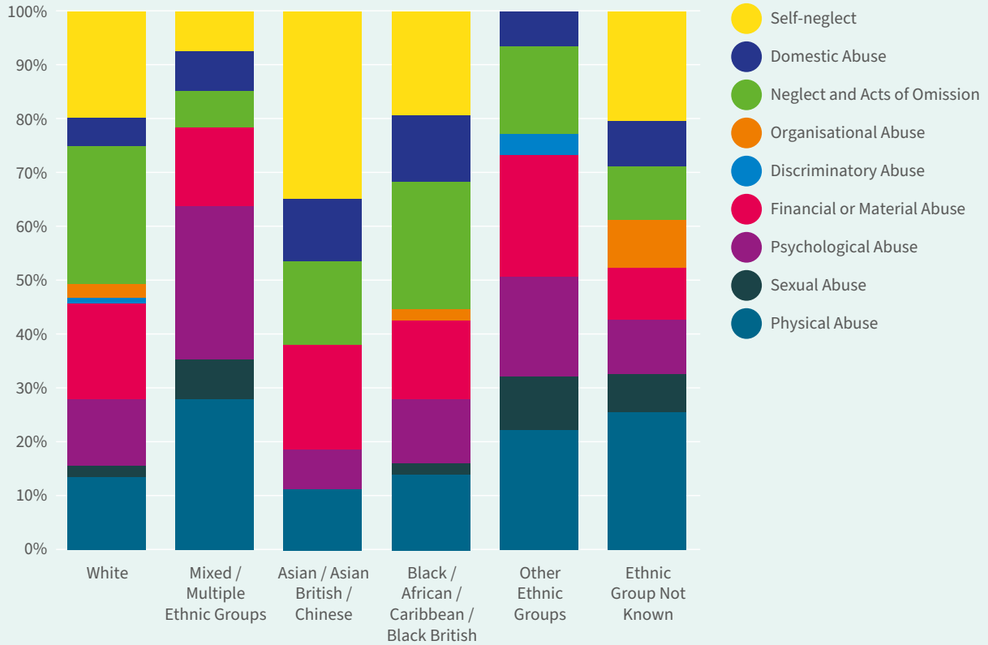
Types of additional issues raised

Mental Health: Many people experience mental health needs (post-traumatic stress disorder, schizophrenia, etc.). Some have had no prior diagnosis before arriving in the UK. Accessing services is very challenging in a new country.

LGBTQ: Talking about sexual orientation is considered a taboo in many cultures we engaged with. One organisation reported getting a high number of LGBTQ referrals as those individuals don’t want to seek support directly within their own communities. While these are not primarily safeguarding concerns these are individuals who live in fear and are vulnerable to discrimination and abuse.

Homelessness: Homeless people (without leave to remain) are exploited in various ways on the streets.

Types of Risk by Ethnic Origin – Kensington and Chelsea 2021-2022



Case Study

Cultural barriers to asking for support

Farha lives with her husband and speaks limited English. Farha's husband regularly abuses her physically and psychologically. Farha feels isolated as she has nobody that she can trust to talk to.

After gathering her courage after an incident at home, Farha calls the council's Housing team.She doesn't get through straight away and is put on a waiting list. Farha continues to live with fear.

After several weeks of waiting she receives a call from the Housing team but as she was with her husband she curtly refused support on the phone. After ending the call Farha panicked as she had been waiting for this opportunity for months. The third sector organisation she was in contact with stepped in to support her to re-establish contact with the Housing team and she has now been safely re-housed.

Barriers:

- **waiting period**
- **language barrier**
- **lack of cultural understanding,**
- **fear of authority**
- **unsure of how the system works**
- **isolation**

Barriers identified by organisations

- fear of authority and how the systems work
- poor experience of using social services in the past
- limited understanding of the legislation and statutory obligations
- lack of awareness of services on how to address cultural issues
- organisations unanimously reported that there wasn't enough information on Safeguarding available in different languages
- access to interpretation services not consistent. Sometimes professionals assume that a family member or a friend can do the interpretations during a meeting. However, that might not always be appropriate
- some residents find it hard to disclose abuse due to fear that others in the community will find out about their personal circumstances
- concerns around breaking trust and overriding consent when passing on the information to Safeguarding teams especially if disclosure has been made in confidence

The SAEB has listened to suggestions from the organisations involved on how to improve services and is committed to:

- regular refresher training for organisations to keep up to date with information and clarify any information
- an accessible website where Safeguarding information is available in a variety of languages if requested and where regular social events and workshops are advertised
- helpline to guide people through the safeguarding process (exploring information on language line)
- training/ workshops for residents to learn about abuse and how to seek help. Training should cover basic information on relevant legislations and can be delivered in various languages

LSCP Local Safeguarding Children Partnership
Kensington and Chelsea | Westminster

Safeguarding Adults Executive Board

Working Together across Adults and Children's Services to support Afghan Families

In 2022 the LSCP and SAEB held an extraordinary meeting to review support to Afghan Families who had been housed in the Bi-Borough after the Kabul airlift in August and September 2021. A joint Action Plan across Children's and Adults included all partnership agencies providing additional services alongside assistance for refugees into existing health and social care services across the Bi-Borough.

Work started to:

- support new arrivals into accommodation
- pursue education
- integrate into local communities
- provide and review interpretation services
- provide 'Safety Week' workshops
- review mental health and wellbeing approaches, post-natal health checks and support in place for long-term health conditions

Community and Maternity Champions

Our Community and Maternity Champions are resident volunteers on hand to help and support those most at risk.

Community Champions come from the diverse communities they serve, bringing local people and services together to promote health and wellbeing and deliver:

The Maternity champions project in Westminster were asked to work with the Afghan refugees who were staying at a bridging hotel within the borough, there were a lot of pregnant women and families with young babies that needed support. Although most of the families had been registered with GPs and midwifes they did not understand how the healthcare system works in the U.K. We decided to start with what are the most important things they should know and most importantly come up with some activities to foster bonding between parents and babies during this difficult time in their lives.

We arranged various sessions to include a midwife to come and give a talk on what to expect form antenatal appointments and what giving birth at the hospital would involve. We organised antenatal classes to be delivered within the hotel by a midwife that spoke their language.

Another session was delivered by a GP and Public Health Medicine Specialist Registrar who specialises in vaccinations. During this session it was explained what the current schedule was for routine childhood vaccinations as well as the covid vaccine during the pre and postnatal period. The GP gave advice about accessing GP services and what to expect at appointments for adults and children.

We promoted the use of voluntary mental health services in the community and also explained different domestic abuse services if anyone should need them. Building the relationships with these families was important we had the same volunteers attending every week and the women saw them as people they could trust. Community living well came and gave a talk on perinatal wellbeing, understanding more about mental health during pregnancy and after birth: coping with anxiety and spotting post-natal depression. We asked them to provide a list of support services that worked nationally as the families were just starting to be rehoused/ relocated.

Sometimes we just listened to these families stories of life back home and the worries for the futures giving by providing them with a safe space to do this.

We made one of the sessions interactive by bringing cooked foods for them and the children to try and was able to show them the correct textures needed for different age groups. This was flagged up by staff working at the hotel as they had seen parents giving inappropriate foods to babies.

For the remainder of the sessions we worked with a partner organisation called creative futures that specialise on using music and arts to support children's learning. They provided us with an early years specialist music practitioner to deliver singing sessions for parents and babies. We had a small team of maternity champions supporting these sessions by modelling the songs and actions and also providing a non-judgemental listening ear for any concerns parents may have. Although some of our champions spoke some of the common languages and we were provided with an interpreter, having one to one private conversations was difficult.

Events

National Safeguarding Adults Week (NSAW) 2021 November 15th – 19th

The theme for the week was Creating Safer Cultures. Promoting safer cultures is about how organisations and individuals can take steps to minimise harm occurring in the first instance, whilst simultaneously ensuring correct policies and procedures are in place so that safeguarding concerns that are raised, are recognised and responded to effectively.

Our Safeguarding Ambassadors led on the design on all activities for this annual highlight in which they launched a **Top Tips on Cybercrime video** to mark Safeguarding Awareness Week.

Did you know?

In 2021-2022 the Office of National Statistics showed that at least 55% of all crime in England and Wales involves a computer

Events that took place during the week

How to keep yourself mentally healthy

Monday 15 November, 4pm to 5pm

It is important to look after your mental health as during this pandemic it can be easy to fall into bad habits, neglecting already established healthy routines. Staying mentally healthy supports your mind and body, making you better equipped to deal with the difficulties posed by the coronavirus pandemic.

Central and North West London NHS Foundation Trust Chief Psychologist, Dr Ryan Kemp talked live to the communities and staff across the Bi-Borough on how to keep yourself mentally healthy and how to help and support others.

Leading, listening and learning

Tuesday 16 November, 3pm to 5pm

Our communities should feel confident about how to respond to, report and refer safeguarding concerns. It is really important that we as a partnership take the time to listen and learn from what is being shared by our Safeguarding Ambassadors and support them to continue to play a lead role to help others to raise concerns and bring risks to the attention of the safeguarding board.

The stories from this closed session informed our Community Engagement Prevention Agenda.

Introduction to digital safeguarding

Wednesday 17 November

The Ann Craft Trust shared best practice in relation to how to create safer cultures online.

Read more about digital safeguarding

Community Champions annual conference

Thursday 18 November

Louise Butler, Head of Service for Safeguarding and Workforce Development hosted a workshop at the Community Champions 9th annual conference on how to create safer cultures.

Find out more about Community Champions and what they do.

Community safety hate crime prevention and awareness training

Friday 19 November, 1pm to 2pm

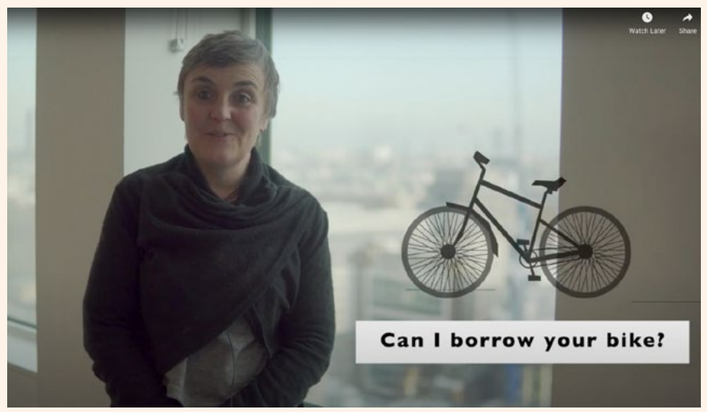
Lorna Platt, RBKC Community Safety Team hosted this training session which covered What Hate Crime is, how you can report it and support that is available across Kensington, Chelsea and Westminster. Guest Speakers included Victim Support and Action Disability Kensington and Chelsea. As requested by our Safeguarding Ambassadors a hate crime 7-minute briefing was created as a preventative tool to help to raise awareness of this important topic

Launch of Blue Light Project (Changing Futures Programme)

December 2021

Aileen Buckton on behalf of the Safeguarding Adults Executive Board sponsored the launch of the Blue Light Project.The project is Alcohol Change UK's national initiative to develop alternative approaches and care pathways for change resistant drinkers in Westminster. The approach challenges the common belief 'there's nothing you can do if someone doesn't want to change' and it's a 'lifestyle choice'. The Blue Light project is using positive strategies to support this group and its approach is that while someone may not change completely, they can be helped to reduce harm and manage the risk they pose to themselves and others. By making the a Board sponsored project Kensington and Chelsea can also benefit from the learning for its change resistant drinkers.

This short video about Ian's story was shared at the event. This story is not a safeguarding adult review but rather a story about a homeless man who had someone who really cared about him. A supportive friend, who worked tirelessly with professionals to ensure that his capacity issues were recognised and reviewed to ensure he was supported medically and not just discharged back onto the streets.



7 Minute Briefing: Ian's story

1 Who was Ian?

'An intelligent and interesting man with a great sense of humour.' Ian grew up in care in Glasgow. At 9 years old, he was introduced to substances. He came to London at the age of 16 to avoid a prison sentence. Ian lived on the streets heavily addicted to heroin and crack and became chronically addicted to alcohol. He committed crime to finance addictions, mainly shoplifting. Ian regularly ended up in prison and over-dosed many times earning the nickname of 'Lazarus'. Ian was like marmite people either loved him or hated him. Those who got on with Ian would see a kind generous man who fought for the underdog, witnessing an intelligent, interesting man with a great sense of humour, that would share his last bit of tobacco and wouldn't leave a person without a drink.

2 Themes

Ian had numerous hospital admissions throughout his 11 years in London. Themes included **Fluctuating, Capacity, Self-neglect, Mental Health and wellbeing, Homelessness.**

3 Learning point 1: Korsakoff's

The need to raise awareness of Korsakoff's, confabulation and masking. Just because someone is answering questions with logical sentences it is not evidence of an informed choice, especially for those people who have experienced homelessness who have become so adept/skilled at hiding their vulnerabilities.

4 Learning point 2: The Care Act

Individuals like Ian need to be carefully evaluated to determine if their medical history, alcohol use and pattern of memory problems may be consistent with Korsakoff syndrome. The Care Act identifies alcohol (and drug) users as people who fall with-in its remit (s.92, para 5). Statutory guidance supporting the Care Act identifies self-neglect as a form of neglect. The guidance states that someone does not need to lack capacity to be regarded as vulnerable.

5 Learning Point 3: The Principles of MCA

- a person has capacity to make a decision unless proved otherwise
- a person must be given all practical help to make a decision
- people have the right to make an unwise or eccentric decision
- anything done on behalf of a person who lacks capacity must be done in their best interest
- a person who is acting on behalf of the person who lacks capacity must consider the least restrictive option

6 Learning Point 4: Professional Curiosity

For many street homeless people with Korsakoff's there is no network, family or friends. Ian had a supportive friend who worked tirelessly with professionals to ensure that his capacity issues were recognised and reviewed to ensure he was supported. A lack of professional curiosity can lead to missed opportunities to identify less obvious indicators of vulnerability, significant harm and assumptions which can lead to wrong interventions for the person.

7 Ian died in September 2021

at the age of 52, while being detained under the mental health act. He died of Cardiac Arrest Electrolyte Disturbance/ Hyperkalemia, with secondary causes End Stage Renal Disease, Suspected Carcinoma Oral Cavity and Korsakoff Syndrome. He died in his sleep in a clean, warm bed, with people around him that he knew in an environment that he called 'safe'. Leaving this world calm and worry-free.

Online suite of resources

Throughout the year we send out safeguarding bulletins which advertise key bits of information to keep our communities informed of the work of the SAEB .

Fire safety training

This free e-learning course produced by the London Fire Brigade is for everyone that provide care and support to others in the community.

Access the training **HERE**

Also view our short film **Safeguarding Ambassadors on Fire Safety** (risks and general safety tips)

Friends against scams online learning

Anyone can learn about the different types of scams and how to spot and support a victim. With increased knowledge and awareness, people can make scams part of everyday conversation with their family, friends and neighbours. You can turn your knowledge into action and spread the word, protect others and take a stand against scams.

Take the online learning course

How to stay safe online

Download the digital safeguarding resource pack from Ann Craft Trust.

Find out more about cyber bullying.

Using social media safely

Social media is a great way to stay in touch with family, friends and keep up to date on the latest news.

However, it's important to know how to manage the security and privacy settings on your accounts.
Find out more about how to use Social Media safely

Thrive

Thrive is a London mental health campaign. The website has great information and resources of outcomes from London engagement sessions:
About – Thrive LDN: Thrive LDN

Suicide prevention

Suicide prevention is one of the strands of Thrive's work:

- Suicide Prevention - Thrive LDN: Thrive LDN
- Core activities Archive - Thrive LDN: Thrive LDN
- Zero Suicide LDN - Thrive LDN: Thrive LDN
- ZSA Resources: Zero Suicide Alliance

Suicide prevention was the theme for World Mental Health Day October 2021. The key message was 'Creating Hope Through Action'. Our Ambassadors were keen that we included in our online resource pack information focussed on suicide prevention and for those affected by suicide.

Digital mental wellbeing

This excellent resource "The good thinking" site provides access to digital mental wellbeing resources free to Londoners **Good Thinking**.

Watch these videos produced by our Safeguarding Ambassadors to help you stay safe at home. Includes information and advice on mail scams, phone scams and doorstep scams.

Safe at Home – Doorstep Scams
Safe at Home – Mail Scams
Safe at Home – Phone Scams

Jeffrey Lake, Deputy Director, Public Health reports on 'how the Covid Pandemic Exacerbated many of the Risk Factors associated with Suicide'

The Covid pandemic exacerbated many of the risk factors associated with suicide including relationship breakdown and bereavement, social isolation and difficulties with work and money.

Through communication with police and care services we have maintained robust surveillance of possible suicides and analysis of these events to identify any lessons for prevention and any potential for emerging trends.

Encouragingly, national data suggests that suicide rates actually declined during the pandemic and whilst local data is not yet available to confidently assess the local position (which is reported in 3 year rolling averages due to relatively low numbers at local level) we have not seen any evidence to suggest an increase. With cost of living concerns we will maintain particular vigilance.

Local partnership working across the NHS, educational settings, statutory and voluntary sector partners is very strong with regular input from national charities such as Samaritans and MIND as well as local networks. We have also been able to work with partners from other parts of the country recognised as examples of best practice. Every Life Matters, a VCS organisation that led on the creation of suicide safer in Cumbria, have hosted workshops to build local capacity and will be providing a further training offer in the Autumn.

Community Engagement Sessions

This year the Community Engagement group wanted to know more about

- fire risk
- modern slavery
- safeguarding and care homes
- mystery shopping

London Fire Brigade Community Risk Management Events

Engaging with YOU • Protecting YOU • Learning from YOU • Representing YOU

The London Fire Brigade held a series of community events with our Safeguarding Ambassadors and voluntary groups. Focused workshops took place to hear what the communites had to say about their fire safety needs and to create a shared vision.

The findings will inform the LFB regional strategy.

Following the workshops and throughout 2021/22 London Fire Brigade provided across the Bi-Borough:

- 1,171 Home Fire Safety Visits
- 24 Hard of hearing alarms

"We want our proposals for change to be informed by communities, especially those who are seldom heard."

DARREN TULLEY
Borough Commander of Kensington and Chelsea

Raising Awareness of Modern Slavery

Modern Slavery affects millions of people worldwide and thousands of people are being exploited in the UK. By recognising the indicators of modern slavery and understanding how to respond, you can support some of the most vulnerable people in our community and help prevent this crime from happening.

Across the Bi-Borough in 2022 there have been 228 people trained to recognise and respond to modern slavery. Training was also delivered to our Community Engagement Group who found the information useful to take back to their organisations so they had a better awareness of how to raise a concern.

Did you know?

Westminster, Kensington and Chelsea work together with the charity Stop the Traffik to gather anonymous data about modern slavery occurring across the Bi-Borough. Modern slavery is largely a hidden crime and understanding the true scale of the issue is challenging.

True or false?

Slavery is a thing of the past

False!

No, it is not. Slavery has ancient roots in history, but modern slavery still exists today. The Modern Slavery Act 2015 outlines the umbrella term of modern slavery, covering human trafficking, slavery, servitude and forced or compulsory labour. When someone experiences modern slavery, they are forced into a situation where they may have to work or provide services through the use of threats, coercion, violence or deception. There are many ways people are exploited through modern slavery, for example it may be working in a car wash, being forced to commit crimes for others or providing domestic services in a private home. People who experience modern slavery can be people brought from countries across the world or British nationals.

In 2021 the Bi-Borough released its first modern slavery strategy: 'Ending Modern Slavery; Our Strategy for a Co-ordinated Community Response 2021-2026'. The strategy outlines how all partners and residents can work together to:

- prevent exploitation
- identify victims
- support victims
- bring exploiters to justice

No one agency can end modern slavery alone and every organisation and individual must play their part.

Case Study

Hasana's story

Hasana began a romantic relationship with a man she met online. She accepted his offer of marriage and he arranged for her to come to the UK and live with him. It quickly became clear that he never intended to marry her, and she was forced into domestic servitude. She was physically, verbally and sexually abused by him and his children. After years of abuse, Hasana called the police after the perpetrator threatened to kill her. She was removed from the property and the perpetrator was arrested. Finding herself homeless, Hasana attended The Passage where she was identified as a victim of domestic servitude and referred to the Modern Slavery Team. She was placed in emergency accommodation and assisted to regularize her immigration status. Through the multi-agency Case Conference (MACC) process in partnership with Westminster City Council, Hasana was referred to the National Referral Mechanism (NRM). As London was a high-risk area for her, the MACC attendees requested emergency accommodation under the Modern Slavery Victim Care Contract (MSVCC) and she was moved to a safehouse the following day. Hasana is now in a safe place with plenty of support. She is assisting the police with their investigation and a non-molestation order has been placed against the perpetrator. She is hoping to start working soon and wants to transfer her qualifications to the UK.

Community Engagement with care and support providers

- residential and nursing care homes
- supported and extra-care housing
- domiciliary home care
- community outreach and mental health support
- day care
- other specialist services, such as employment support

Managers of these services have an important role to play in ensuring that their staff are suitably trained and supported to understand safeguarding policy and procedures and be able to identify and respond effectively where abuse or neglect takes place. A series of community Focus Group meetings to hear views from services on their experiences of safeguarding in the Bi-Borough were attended by 69 managers across a range of service which helped us to get a clear picture of the strengths and challenges faced in these services. It was decided as part of these conversations that a separate series of sessions was needed for service users and their families which will take place in 2022 – 2023.

What our regulated provider services told us:

"We need to have a clearer understanding of what types of safeguarding concerns lead to enquiries and to receive more consistent feedback from the Local Authority when a safeguarding referral is raised."

"We need greater links with the SAEB to ensure that the voice of the service and its service users are represented."

What the SAEB will do :

- have a provider representative at the SAEB
- set up a provider forum which specialises in safeguarding
- review the National Pressure Ulcer protocol and local systems collaboratively with our providers and health colleagues to ensure the service user / patient is at the centre of the communication journey between hospitals and the community

Next steps

- Better engagement with the Local Authority i.e. forums, meetings, feedback
- Strategic input – SAEB representative
- Guidance i.e. clear referral/escalation process, handbooks etc.
- Training programme for managers – use learning needs

healthwatch Central West London

In February 2022 Healthwatch completed a mystery shopping exercise to determine whether, when residents contacted council front door services with general queries, that the responses were both adequate and helpful.

Healthwatch reviewed virtual information and pathways into the local authorities of Kensington, Chelsea and Westminster and identified 15 touchpoints for online mystery shopping across a range of services and departments that included

- adult social care
- safeguarding
- environmental Health
- waste services
- safeguarding Teams

The project commenced in December 2021 with planning and testing training sessions to ensure that the residents completing the shopping were trained and confident to undertake the calls and send forward enquires virtually. Training consisted of a series of co-produced scenarios and an understanding of barriers to be included.

> "Customer Service Staff were professional and supportive and followed up to ensure I had all the information I needed to refer into social services."
>
> **QUOTE FROM A MYSTERY SHOPPER**

Key findings

- Better engagement with the Local Authority i.e. forums, meetings, feedback
- 24 % of Services responded within 48 hours
- OK — 5% of inboxes had a redirection response to an appropriate telephone or mailbox
- 100% — All responses to Safeguarding queries were responded to within 24 hours

The findings were reported to the SAEB in March 2022 and discussion took place that positive responses were demonstrated across all departments and included staff not usually involved in safeguarding.

Making Safeguarding Personal

Having conversations with people about what they want to get out of the safeguarding enquiry continues to be a golden thread throughout the work of the partnership.

This section looks at some of the data the SAEB collects and what we do with it to inform our work. There is a special section on financial abuse which continues to be the highest referral abuse type in both boroughs as well as nationally. But first we discuss outcomes.

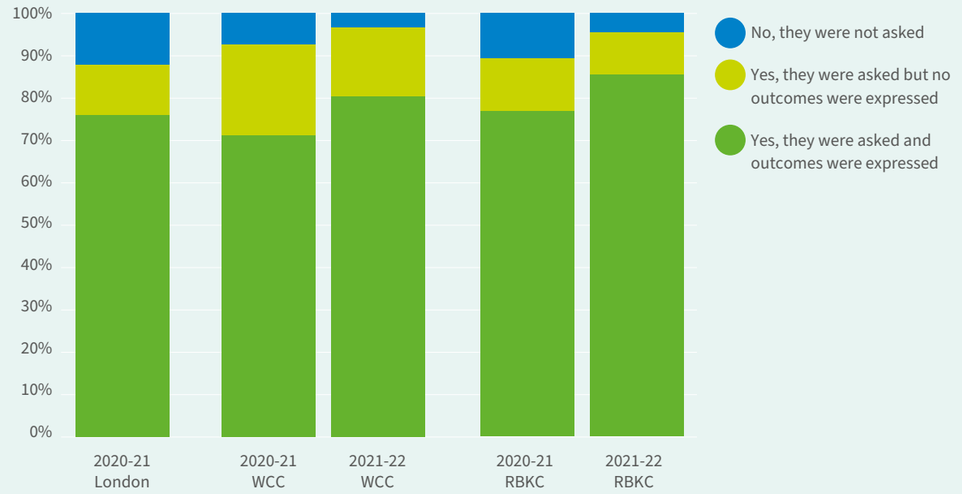
- using data better to inform partnership responses to safeguarding referrals
- understanding which abuse types are the most prevalent and doing something about it
- knowing our residents and who is most at risk
- placing partnership resources at the heart of the problem

Our outcomes

We are delighted that year on year we can demonstrate improvements to our safegaurding outcomes. We can demonstrate that the adult or their representative involved in the safeguarding enquiry have been asked about what their desired outcomes were and, if they were asked, whether these were achieved

In Kensington and Chelsea in 2021-22 the adult at risk or their representative was asked what their desired outcomes were to the safeguarding incident. This year a higher proportion of people were asked 95% compared with 89% in 2020-21. Thanks goes to the work of front line staff in K&C who made a great impact in focusing on what people want to get out of their safeguarding enquiry and making this happen.

Whether the adult at risk or their representative was asked what their desired outcomes were (S42 enquiries concluded in the year)



Where the adult at risk, or their representative, was asked what their desired outcomes were and they expressed an outcome, in the great majority of cases (over 95%) these outcomes were judged to have been fully or partially achieved. We know that when an outcome may be partially achieved this could be referring to a person known to the adult who has caused harm and that the person is wanted to be supported to minimise the risk of harm occurring again because the adult at risk has expressed this wish as an outcome.

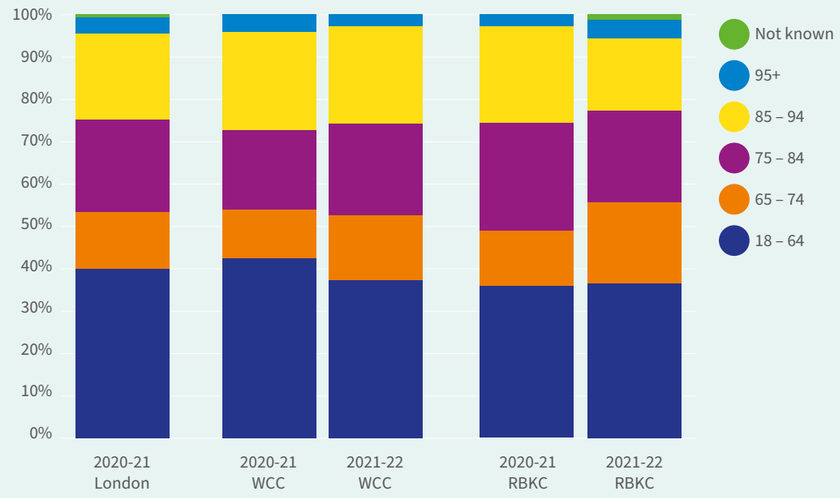
In Westminster in 2021-22 the adult at risk or their representative was asked what their desired outcomes were in a higher proportion of concluded S42 enquiries,

Where the adult at risk, or their representative, was asked what their desired outcomes were and they expressed an outcome, in the great majority of cases (over 95%) these outcomes were judged to have been fully or partially achieved. A big thank you to front line staff in Westminster for making this happen and ensuring that the adult at risk is placed at the centre of the safeguarding enquiry.

Where the adult at risk, or their representative, was asked what their desired outcomes were and they expressed an outcome, in the great majority of cases (over 95%) these outcomes were judged to have been fully or partially achieved.

The age of our adults at risk

Age groups of individual adults at risk involved in S42 enquiries (S42 enquiries concluded in the year)



In both boroughs the age profile of individual adults at risk involved in S42 enquiries is similar to the profile for the previous year and to London as a whole. Across the board about 60% of adults at risk are aged 65+. Knowing this allows us to focus our attention on elder abuse incidents particular in our regulated services and to ensure we have safe systems in place to ensure a strong focus on early intervention and prevention.

The gender of our adults at risk

Gender of individual adults at risk involved in S42 enquiries (S42 enquiries commencing in the year)

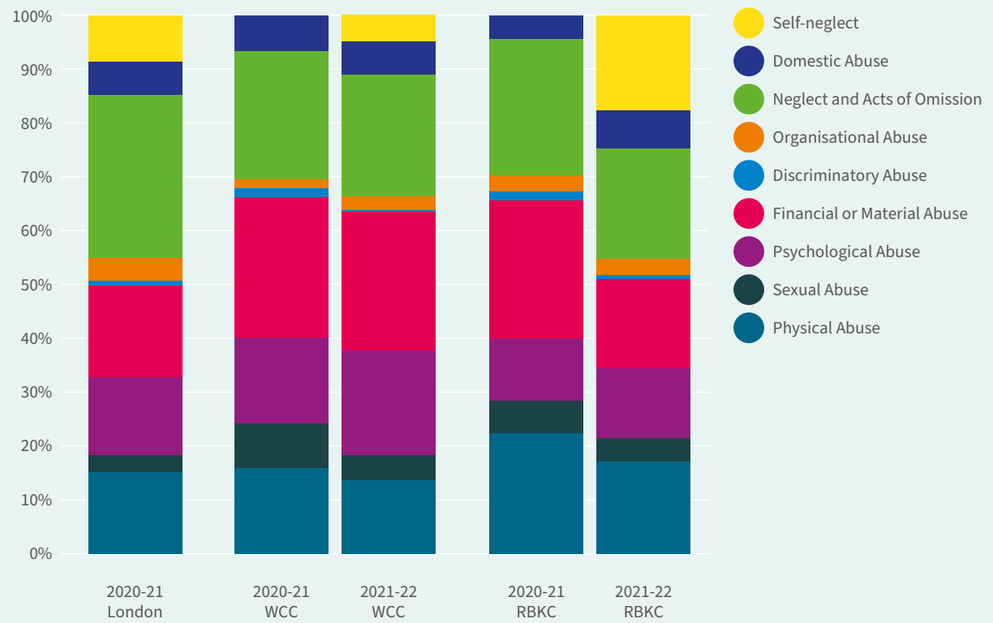
As for age of adults at risk the gender split is similar to that for last year and to London as a whole. In K&C and WCC and London as a whole about 55% of adults at risk are female. If we combine the age of our adults at risk with the gender we know that more female adults at risk over the age of 65 will be effected by a safeguarding incident than our male adults at risk of the same age. This is a national indicator as well as a local one.This allows us to place emphasis upon gender specific abuse such as Domestic Abuse to ensure we are proportionate in where we place our focus for project work.

Types of risk alleged with focus on Financial Abuse and Hoarding and Self neglect

The frequency with which different types of abuse were alleged is broadly in line with London as a whole. This data on abuse type has helped us to prioritise our work locally in 2 specific areas :

1. Continued focus on financial abuse and has been given additional attention throughout the Covid Pandemic with national coverage around fraud associated with vaccination passports and boosters. It was felt by the SAEB that we continue to place emphasis on this abuse type with the growing concerns related to the economic crisis and impact upon vulnerable people and susceptibility to scams such as money lending.
2. To better understand how to work with Hoarding and Self Neglect cases.In both K&C and WCC there tended to be proportionally fewer S42 enquiries involving neglect and acts of omission, compared with London. However compared with WCC, K&C had proportionately more S42 enquiries which involved self-neglect. Many of these enquiries also involved hoarding.

Types of risk alleged (S42 enquiries concluded in the year)



Focus on Financial Abuse

Insights into financial abuse Kensington and Chelsea

200 safeguarding referrals received. **54%** of concerns received were regarded as a crime or potential crime. Of these **71%** were raised with the police (although many came from the police). A large proportion of concerns **16.5%** are for people that were previously not known to Adult Social Care. The biggest proportion of concerns received were for people with physical support needs at **43%.**

Who sent in these concerns?

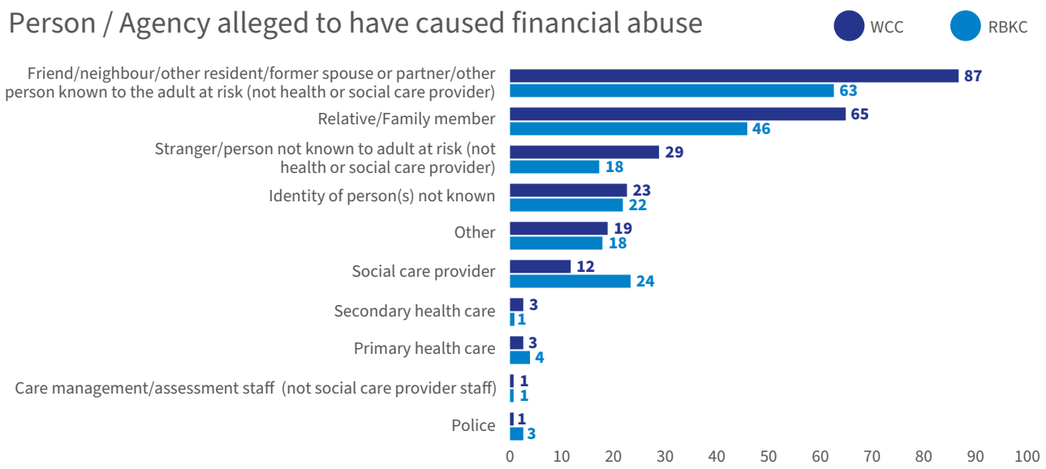
The majority of concerns were sent in by health and social care staff and police making up to **75%** of referrals.

Insights into financial abuse in Westminster

243 safeguarding referrals received. **46%** of concerns received were regarded as a crime or potential crime. And of these **70%** were raised with the police (although many came from the police!). The biggest proportion of concerns received were for people with a physical disability with support needs at **39.5%** with mental health support needs at **29.8%**.**19.3**% of people were not known previously to Adult Social Care.

Who sent in these concerns?

The majority of concerns were sent in by health and social care staff and police making up to **69%** of referrals.



What did we do with this data

Throughout 2021-2022 our Safeguarding Ambassadors continued to witness and share stories about Financial Abuse happening in their communities. Stories of scams related to Covid Vaccinations has brought additional risks to our elderly residents.

We invited the Central Specialist Crime and Cybercrime Team to help us to learn how to raise awareness and inform us of 'how to Stay Safe from COVID19 scams'.

The video has been shared with our community engagement group and members of the SAEB. We continue to share the top 10 tips which our safeguarding ambassadors Michael and Shiv describe so well.I hope you enjoy the video and please share these important messages.

"People are still falling for scams. They are still opening their door and letting people in, they are receiving emails, texts and having their personal information stolen. We want to do more to help people who are vulnerable to stay informed and that is why we have put together a Top Tips on Cybercrime video. We want to protect our loved ones and continue to raise awareness of prevention tactics as criminals continue to target the most vulnerable members of our communities."

QUOTE FROM OUR SAFEGUARDING AMBASSADORS GROUP MEETING IN OCTOBER 2021

Tasio Capello, Head of Community Engagement Age UK Kensington and Chelsea, reports on why Financial Abuse of the Elderly is still a Growing Problem in the UK

Please remember – Everyone has the right to make independent financial decisions.

Incidences of financial abuse perpetrated against elderly people are on the increase according to investigations carried out by Age UK, which performs a wide range of research into helping improve the lives of elderly people in the UK. The most recently carried out review suggests older people **are at greater risk of financial exploitation than previously thought.**

Age UK's findings established that approximately 130, 000 people over the age of 65 in Britain have been the victims of financial abuse. While anyone can find themselves subject to such abuse, it is acknowledged that older people are at particular risk given that many are seen to have substantial savings and are considered to be more vulnerable than younger people.

If your partner, family member, carer or anybody else is mismanaging your financial affairs, then this is financial abuse. Always remember you are not alone. There are places to go for help and support and things you can do.

Learning Briefing: Financial Abuse and the Bi-Borough Client Affairs Team

The Bi-Borough Client Affairs Specialist Team shared that one of the worst cases of financial abuse in 2021/22 was an 89-year-old vulnerable resident who had no known family and who was exploited in his own home by several people. They gained access to his bank account and had withdrawn virtually all his money.

Multiagency working to protect Jim

Adult Social Care acted swiftly when alerted by the Police. A safeguarding was raised and when it was established that the resident did not have capacity to make decisions about how to manage his finances, a referral was made to our Client Affairs Team. The Client Affairs Team step in when there is no suitable person to represent the person such as family member or friend. After making immediate arrangements for all bank accounts to be frozen the team then made an application to the Court of Protection and they were appointed deputy to manage the residents financial affairs. Client Affairs discovered that exploitation had taken place over 5 years from 2016 – 2021 and they were able to reclaim more than £140, 000 which was repaid to the resident, in recompense for the fraudulent transactions.

Financial Abuse can take many forms and will include the obvious – theft and fraud – but also behaviour that is harder to identify such as coercion, the misuse of a power of attorney or even predatory marriage.

Section 42(3) of the Care Act 2014 defines financial abuse as including:

a. having money or other property stolen,
b. being defrauded,
c. being put under pressure in relation to money or other property, and;
d. having money or other property misused

The Mental Capacity Act is designed to protect and empower people who may lack the mental capacity to make their own decisions about their care, treatment or financial affairs. It applies to people aged 16 and over. It is important if you are asking someone to make a financial decision that you are confident they have the mental capacity to do so. Remember capacity is both time and decision specific. A person can have mental capacity to make some decisions but not others.

The impact of financial abuse should never be underestimated as it can be as significant as any other type of abuse. Any financial or material loss have the potential to have a significant impact on the adult at risk and can leave people feeling very vulnerable. It can cause a person who previously did not have any care or support needs, to deteriorate to a level that requires intervention and in need of support and services from Adult Social Care.

If you are worried that you or someone you know is suffering abuse or neglect, please contact the relevant Local Authority or police.

Kensington and Chelsea T: 020 7361 3013 | E: socialservices@rbkc.gov.uk
Westminster: T: 020 7641 2176 | E: adultsocialcare@westminster.gov.uk

Or contact Crimestoppers confidentially and anonymously on 0800 555 111

Focus on Hoarding and Self neglect

Doug Goldring, Director of Housing Management, reports on the activity of the Hoarding and Self Neglect Group

In 2020/2021 the SAEB agreed that the data was telling us to review our hoarding strategy as there was an increase in cases and that responding to individuals with hoarding behaviours must be a multi-agency priority.

The VISION in the Bi-Borough:

For all professionals to be supported to recognise and respond to individuals who hoard and become expert in person centred responses that are sensitive and proportionate to each individual.

What is Hoarding?

Hoarding is the persistent difficulty discarding or parting with possessions, regardless of their actual value. For those who hoard, the quantity of their collected items sets them apart from other people. Commonly hoarded items may be newspapers, magazines, paper and plastic bags, cardboard boxes, photographs, household supplies, food, and clothing. Hoarding can also be due to compulsive buying as some people struggle with never passing up a bargain or free items, or the compulsive need for unique items, which may not appear to others as unique.

Hoarding Symptoms and Behaviours can include:

- inability to throw away possessions
- severe anxiety when attempting to discard items
- great difficulty categorizing or organizing possessions
- indecision about what to keep or where to put things
- distress, such as feeling overwhelmed or embarrassed by possessions
- suspicion of other people touching items
- obsessive thoughts and actions: fear of running out of an item or of needing it in the future; checking the trash for accidentally discarded objects
- functional impairments, including loss of living space, social isolation, family or marital discord, financial difficulties, health hazards

What we did

Step 1:

Data Sharing

We commenced by sharing local multiagency data to gain the best possible actionable insights into what is needed. It was clear there have been common challenges. Data was shared on the basis of risk where no protocol exists, we established that while not all cases were known to every agency there was good coverage across partnership organisations and evidence of some great work taking place.

Step 2:

What the data revealed

Borough	2020/21 no. H&SN Cases	2021/22 no. H&SN Cases
WCC	26	87 (not all cases were known to ASC)
K&C	64	108 (not all cases were known to ASC)

Step 3:

Progress so far in 2021/22

1. Data sharing Aide Memoire developed for staff across the partnership
2. ‘Pilot on Prevention’ launched with a direct focus on supporting people within their homes
3. Governance processes set up to ensure operational monitoring of all work underway
4. Formal data sharing protocol agreement implemented between Housing and Adult Social Care
5. Fire Brigade joint working embedded across all front-line Teams

Step 4:

Reflection and Planning for 2022/23

Reflections

- prevention is managed differently in each individual organisation
- people/organisations are able to raise awareness and this happens in practice
- the person’s wishes are respected and they are supported in having their voice heard but we need to do more to ensure this happens
- services are working more collaboratively with people who hoard and each other

Planning

Holding a professionals event in November 2022 to:

Review local protocols with a focus on prevention at a partnership level.

Sharing best practice and raising awareness that include:

- de-cluttering
- advocacy
- support for residents facing eviction
- environmental Health awareness and support for residents

Three examples of good outcomes from recent multi-agency work.

Case Study 1:
TW, 63 years of age, hoarding issues for over 20 years, category level 10 clutter rating. Services could not successfully engage with TW. Tenancy Support officer worked intensively for over a year and this was in conjunction with legal action being taken before the 3-bed house was decluttered. TW moved onto smaller accommodation and teams are monitoring this.

Case Study 2:
CK, 74 years of age, severe mobility impairment, severe hoarding. CK could not receive the care she needed due to the state of CK's home. Staff worked on the ground with CK for 3 days to declutter and clean. CK is now receiving the care they needed (carers and nurses visiting daily) and lives in more hygienic environment.

Case Study 3:
DA, history of hoarding and non-engagement, collected wood materials in their home. Surveyors report raised concerns on the integrity of the structure of the building due to the weight of the wood being stored in DA's home. Support officer had to work to build relationship and clearance took place over 5 days. Property is now safe and so is the building.

Carers Network

Making Safeguarding Personal for Carers

Caring is more than just a job. It's more than going for the prescriptions; it's more than doing the shopping or helping the person you care for dress. It's a commitment to someone you love. It's supporting their emotional and physical needs and helping them retain their pride and dignity.

Safeguarding Adults Reviews have raised the issues about carers needs. Key learning includes that Carers should be asked about their own needs and offered a carers assessment where this is required and that all services should make efforts to ensure that carers are kept informed of key updates in relation to safeguarding the people they are caring for. As a core member of the Community Engagement Group we are committed to raising awareness of safeguarding. In 2022 we collaboratively created this 7-minute briefing to help raise awareness amongst our membership of over 5,300 unpaid carers.

SONIA BENITEZ
Head of Services

7 Minute Briefing:

Carers and Safeguarding

1 Who is a carer?

A carer is anyone who cares, unpaid, for a friend or family member. Sometimes they can care for more than one person. The people they support may be affected by disability, physical or mental ill health, frailty or substance misuse. Anyone can become a carer at any point in their life. In the UK today 1 in 8 adults are carers this equates to 6.5 million people; it is believed that this number increased over the lockdown period to 13.6 million people. Therefore increasing numbers of us have caring roles to a greater or lesser extent in our personal lives. Recognising that this is an everyday experience for many people is an important reminder that 'carers are not to be stereotyped. Carers are from a diverse range of backgrounds. Carers may be parents, daughters, sons, partners, neighbours and friends. Carers may be adults or children and patients and service users – and at risk themselves.

2 The impact of caring

Many carers have reported to suffering negative impacts from caring:

- social
- financial
- physical and psychological
- wellbeing
- employment and education
- identifying and supporting carers matter: making caring and carers visible and making support services inclusive

3 The Care Act 2014

Recognised the important role that carers play in relation to safeguarding. Carers can witness abuse, experience intentional or unintentional harm from the person they are providing care to or can intentionally or unintentionally harm or neglect the person they support.

4 Carers and Safeguarding:

Making Safeguarding Personal is central to supporting safeguarding for both carers and the person they care for. When reviewing a safeguarding situation it is important that ensure the safety and wellbeing of both the person and their carer. Early interventions can, in particular, make a big difference in preventing situations escalating or abuse and neglect occurring. Examples that require a safeguarding response involving a carer include:

- the carer witnessing or disclosing the existence of abuse or neglect
- when supporting those they care for, experiencing deliberate or unintended harm from them
- neglect and poor practice in care settings such as a care home or hospital or in relation to care services at home
- deliberate or accidental harm or neglect to the person they are caring for

5 Learning from regional Safeguarding Adults Reviews

Safeguarding Adults Reviews that have raised the issues about carers needs. Key learning that has been highlighted includes:

- carers, whether formal or informal, should be asked about their own needs and offered a carers assessment where this is required
- all services should make efforts to ensure that carers are kept informed of key updates in relation to the people they are caring for

The Think Family approach should be adopted when working with individuals around their safeguarding needs. This means that whole of the family dynamic and wider family needs should be considered when engaging with service users.

6 Key Tips: Things that you can do to further support carers include:

1. Ask questions and check whether someone is a carer or has caring responsibilities
2. Familiarise yourself with support that is available to carers and services that they can be signposted to
3. Remember that people with care and support needs, such as learning disabilities, can also be carers. Do not make assumptions about who may or may not be a carer
4. If you are concerned that about a carer's ability to cope or are worried that they may be experiencing abuse or neglect you can make a referral to safeguarding adults or children's

7 Support available in Kensington, Chelsea and Westminster:

Carers network exists to reach and empower every unpaid carer in the Bi-Borough. We do this by helping carers lead healthy fulfilling lives, with a range of practical, personal and financial support suited to their needs.

Our Opening times are Monday – Friday from 9am – 5pm. Please call us on **020 8960 3033** or send us an email on: **info@carers-network.org.uk.** More details can be found on our **website**

Leading, Listening and Learning

The SAEB is a learning organisation and is committed to developing what this looks like across the partnership when things go wrong but also celebrating good practice.

The Safeguarding Adults Case Review Group is the subgroup of the SAEB which considers referrals for a Safeguarding Adults Review (SAR), maintains oversight of any reviews in progress and drives forward recommendations from reviews to ensure we strive for continuous improvement and organisational change. Thanks goes to the Catherine and Trish the co-chairs of this group and their continuing enthusiasm and support to chairing and supporting learning across the partnership.

- a partnership which is open to new ideas and a willingness to learn from mistakes
- a partnership which wants to get better at preventing abuse and neglect
- a partnership which is transparent and accountable to each other and to its residents
- a partnership that listens and hears what it is being told by families

CATHERINE KNIGHTS

Director of Quality Central and North West London NHS Foundation Trust

Co-Chair of the Safeguarding Adults Case Review Group

TRISH STEWART

Associate Director of Safeguarding Central London Community Healthcare NHS Trust

Co-Chair of the Safeguarding Adults Case Review Group

Safeguarding Adults Reviews in the Bi-Borough

Section 44 of the Care Act 2014 sets out that Safeguarding Adults Boards have a duty to undertake SARs where an adult with care and support needs dies or experiences serious harm as a result of abuse or neglect, and there is concern that partner agencies could have worked together more effectively to protect the adult.

The purpose of a SAR is set out in the SAR Protocol and Guidance and is to look at the ways professionals and agencies work together to determine what might have been done differently that could have prevented harm and death. It is not an enquiry into how the person died, nor is it to apportion blame but to learn from such situations and to ensure that learning is applied to future cases to reduce the likelihood of harm occurring again.

True or false?

Primary responsibility for carrying out safeguarding enquiries in any area lies with the NHS.

False!

The Care Act 2014 places a duty on the Local Authority to lead and coordinate safeguarding enquiries for concerns that involve:

- an adult with needs for care and support
- is experiencing, or is at risk of, abuse or neglect, and;
- is unable to protect themselves from that abuse or neglect because of their care and support needs.

Any enquiry should involve partnership working across agencies who are involved in supporting and working with the adult.

This year our Key achievements are highlighted below

- the SACRG developed an action plan to respond to the recommendations within the National Analysis of SARs to benchmark the SAEB's position and identify areas for improvement.
- the above work informed the development of our new SAR Protocol and Guidance, which links to the SAR Quality Markers, launched by the Social Care Institute for Excellence (SCIE) in April 2022 and provides a clearer framework to help govern and inform our approach to carrying out SARs.
- we have used our learning from SAR Joan (which is outlined on the next page) to inform our approach to engaging better with families and to ensuring the voice of the adult and their significant others are central to our reviews. This is involved producing a new Guide for Families and Carers involved in SARs.
- we have established a network of SAR Champions across the partnership who will help support sharing and embedding learning from our reviews. We will utilise our SAR Champions to support the implementation of a SAR learning and development programme. We will be carrying out regular 'Lunch and Learn' multi-agency sessions to help raise awareness of SARs and ensure our focus on sharing learning is central to the work we do.
- we set up a task and finish group to look at the learning from a SAR published by Norfolk SAB in September 2021. The review explored the learning in relation to the deaths of three young adults Joanna, Jon and Ben, who all had learning disabilities and had been patients at a long-stay hospital for adults with mental health needs. The group sought assurance from services across the Bi-Borough that effective arrangements are in place to support adults with mental health needs that are placed in mental health facilities out of the area.

SAR referrals in 2021-22

The SACRG considered one new SAR notification and made decisions in respect of five referrals. A range of issues were presented in these referrals including:

- domestic abuse within same sex relationships
- the challenges for maintaining consistency of services when working with people who move across different boroughs
- management of pressure ulcers between hospital and community settings
- frequent readmissions to hospital
- a high number of deaths from fires within people's own homes and risks in relation to smoking

One was deemed to meet the mandatory criteria for a SAR and another to meet the discretionary criteria. Both of these cases related to fire deaths and will be taken forward as a thematic review during 2022-23.

Care Act 2014

Learning from Fatal Fires

Our annual report for 2020-21 highlighted the work that LFB undertook in partnership with SAEB agencies to respond to the learning identified from the five cases that were referred into the SACRG that year via the fatal fire pathway. The fatal fire pathway is a process in which the LFB notify the SACRG of any fatality from a fire that has taken place in the Bi-Borough and consideration is given as to whether the criteria for a SAR are met and what actions may be required to support multi-agency learning.

Given the additional fatal fire notifications received in 2021-22, and the decision to progress two of these referrals as SARs, the board has commissioned a thematic review which will review the specific involvement of agencies in the two cases, as well as evaluating how the learning from all the fatal fire cases in 2020-21 has been embedded and consider if there are any remaining gaps or barriers which may hinder practitioners in responding to fire risks.

The findings and learning from this thematic review will be reported in next year's annual report.

7 Minute Briefing: Telecare and Fire Safety

1 Background

Telecare is way of providing support and assistance when required by using equipment which is monitored at a distance by an organisation. Devices such as smoke alarms, fall detectors and pull cords alert the responsible organisation that a vulnerable person needs urgent assistance. When installed and operated in accordance to the relevant British Standards telecare can improve a resident's likelihood to survive a fire.

2 The role of telecare during fires:

- early detection of fire in the room of origin
- alerting the resident to escape or raise the alarm (if possible)
- alerting the onsite staff to take appropriate actions
- reduction of delays in summoning the fire brigade due to the automatic fire alarms
- provision of an emergency line of communication, which can facilitate vital fire survival Guidance during a fire

3 Why it matters:

A significant proportion of people who die in accidental dwelling fires in London had telecare in place, but it was not linked to smoke detection, or operated in accordance with the relevant British Standards,

Recurring issues include:

- fire detection not linked to a monitored telecare system
- over-reliance on pendants, where fire detection would be more appropriate

4 More people are expected to receive care at home

In the years to come the demand for adult domiciliary care is projected to steadily increase to high levels, largely due to the England's ageing population.

The Dept of Health and Social Care (DHSC) predicts that 57% more adults aged 65 and over in England will require care in 2038 compared to 2018. According to the National Audit Office there were 814,000 adults in England receiving domiciliary care in March 2020.

The NHS Long Term Plan states that people will be increasingly cared for in their own homes with the option for their physiology to be effortlessly monitored by a wearable device. This means that the 1.7million people who receive telecare in the UK is likely to rise.

5 Fire Risk assessment:

The use of telecare must be considered in your fire risk assessment to ensure that all reasonably practicable steps are taken to reduce the risk of a fire and its likelihood of occurring.

British Standards: The following British Standards must be complied with to ensure that residents have a reduced probability of dying in a fire:

- BS 9518:2021 Processing of alarm signals by an alarm receiving centre
- BS 5839 Part 6 2019 Fire Detection and Fire Alarm Systems for Buildings
- BS 8604-1:2019 Social alarm systems Design, installation and maintenance of social alarm systems in specialized grouped living environments

6 What to do:

The following recommendations were issued by coroner Fiona Wilcox following the death of Elizabeth Griffin:

1. All users of telecare systems should have some form of fire detection linked to FAMOs.
2. Contractual requirement, for new and existing clients to have linked fire detection. In the same way such providers insist on the provision of keys to access client's home.
3. Telecare system operators should apply the call handling protocol in British Standards.
4. Telecare Providers should base staff training for appropriate response on British Standards.
5. Training on what smoke alarms sound like in the background of a call to a client.
6. It should be recorded which clients do not have linked detection. The response in life critical situations should be based on this knowledge.

7 Questions to consider:

1. Would the resident benefit from receiving telecare? For example do they have reduced mobility or mental health issues that could impair their ability to react to a fire appropriately or effectively?
2. If they have existing smoke alarms, are they linked to the telecare system?
3. Are telecare systems installed, monitored and maintained in accordance with the British Standards?

Learning Lessons and Achieving Change from Safeguarding Adults Reviews

Work has continued to take forward the learning from SARs Annie and Kate which were reported on in our last annual report 2020-21. It is important to understand that once a SAR has been completed the work is only just beginning on co-ordinating the improvement plan and evaluating the results.

"Annie"

Excellent progress has also been made over the past year in responding to the learning from SAR Annie a lady with a learning disability who died from late detection of cancer.

- work by the North-West London Integrated Care Board (NWL ICB) to improve the pathways and processes for annual health checks for adults with learning disabilities. A review of reasonable adjustments across community and acute sectors has taken place particularly in relation to high areas of risk for adults with learning disabilities, including bowel cancer, coronary heart disease and epilepsy.
- the purple pathways system created by Imperial College Healthcare NHS Trust to help patients with learning disabilities or autism to experience the best journey through their hospitals, has been expanded to GPs, outpatients and pre-operative assessment services. Awareness training has also been rolled out to staff across the Trust.
- improved communication pathways have been developed across health and community learning disability services, including joint meetings to discuss referrals. Further work is planned to look at options to enable specific areas of information held across health and social care systems to be shared where this would be of benefit to safeguarding and risk management.

"Kate"

The SAR on Kate highlighted the important role practitioners and managers in housing services play in identifying and raising safeguarding concerns. Housing colleagues are leading on work to review the various forums to discuss high risk cases and to bring together key stakeholders across statutory, voluntary and Registered Providers to ensure more effective information sharing and joint risk assessment where safeguarding risks are identified.

The learning from SAR Kate has also led to the development of a quick reference checklist to support practitioners around best practice considerations when they encounter challenges in making contact and / or gaining access when visiting adults at risk who do not choose to engage with services.

We would like to thank our partners from Imperial College Healthcare Trust NHS in contributing to this years Annual Report with this interesting article on the learning that is influencing the organisation to look for system solutions for people with a learning disability and or autism.

NHS Long Term Plan

As part of the long term plan 2019, the NHS provided specific commitment to working together as a system to improve the health outcomes of people with a learning disability, autism or both to lead longer, happier and healthier lives. Some of the learning that is influencing Imperial College Healthcare NHS Trust to system solutions for people with a learning disability and or autism

The need to increase awareness of the needs of people with a learning disability and autism and ensure reasonable adjustments are made within all health services to enable equitable access.

Better patient experience was observed where learning disability Liaison Nurses were available to ensure well designed, person centred and coordinated care, reasonable adjustments and support for families throughout a patient's hospital journey.

Annual health checks and robust health action plans contributed to good quality care. As the most common cause of death is respiratory conditions, take up of flu and COVID-19 vaccines is vital.

Late detection of cancer due to low take-up of screening or no health action plan for this.

There were concerns around the lack of detection of a change in a person's condition. This was especially noticeable during the first wave of the pandemic. This learning highlighted the need for testing and awareness raising amongst families and staff working in supported living and care home settings. Clinical Leads and liaison to including check-in visits.

Diagnostic overshadowing when symptoms arising from physical or mental health problems are misattributed to an individual's learning disability, leading to delayed diagnosis and treatment. This is compounded by lack of organisational alignment (including different systems/processes) within health and cross health and social care.

The end-of-life pathways should keep the needs and wishes of the person and family at the heart of decisions.

In some cases, the mental capacity act was not followed. Training has been provided but this needs to be ongoing.

Jargon buster

Reasonable adjustments

This arises in situations which place a disabled person at a substantial disadvantage compared with people who are not disabled. The provider or employer needs to adjust the situation such as providing easy access to a building or easy read guidance.

Reasonable adjustments for a Colonoscopy

- admit patient one day or two days before procedure
- carer to accompany/ remain with patient
- complete bowel prep on the ward, administered or supervised by hospital staff
- first on list for procedure to minimise 'conscious' wait for food / drink

At the outset of the pandemic, there were concerns about do not attempt cardiopulmonary resuscitation ((DNACPR) decisions being made on the basis of the presence of learning disability and / or autism alone. This outlines the importance of well-designed, person centred and co-ordinated care with clear lines of accountability.

Reasonable adjustments to improve access to services for people with learning disabilites and autism

Person centred

Take time

- allow more time – double consultation periods
- avoid the patient having to wait
- avoid noisy, busy periods, offer first or last appointments, first on theatre lists
- avoid follow-up appointments unless clinically essential

Good environment

- environment is very important
- some people are particulary sensitive to light, movement, sound, smell and touch
- keep the environment as calm as possible, quiet and uncluttered, consider side rooms

Understand behaviours

- avoid diagnastic overshadowing
- don't assume the behaviour is a result of the learning disability
- see the person not the disability
- consider sensory impairment

The person and carers

- work in partnership with carers as they know the person best
- read Hospital / Communication Passports to get to know the person better
- ask what support is needed

Communication style

Tell people what you are doing

- speak directly to the patient
- explain and demonstrate what you are about to do
- use pictures / symbols / photographs / actions
- check consent throughout
- offer pre-procedure visit to departments

Keep language simple

- avoid complex language, jargon, idioms and metaphors as these can be taken literally
- make sure your facial expressions and tone of voice match what you say
- speak clearly and not too fast

Help people understand

- allow time for what you have said to be processed (at least 6 seconds)
- check understanding – ask what you have said
- repeat and rephrase if necessary
- use pictures, symbols, actions

Questions

- ask direct, brief questions
- only one or two information words per sentence
- avoid difficult concepts such as time'
- check answers, ask again in a different way

North West London Integrated Care System

NHS North West London

North West London Integrated Care Board which shares with us local insights into the work currently underway around Annual Health Checks and Health and Well begin reviews for a people with a learning disability and autism.

Peter Beard, Delivery Manager, Learning disabilities, autism and carers, North West London Integrated Care Board shares important local insights on Annual Health Checks, Health and Wellbeing Reviews and LeDeR, the NHS service improvement programme for people with a learning disability and autistic people.

Annual Health Checks 2021-22

Annual health checks are important because people with learning disabilities experience barriers in access to health services, greater health inequalities and poorer outcomes.

Over the last four years we have worked to improve the rate of annual health checks delivered to people with learning disabilities.

We have achieved this through:

- working with primary care leads in our local area to monitor performance on a practice and primary care network level
- connecting our local learning disability nursing teams to primary care networks
- training of GP practices on a rolling programme

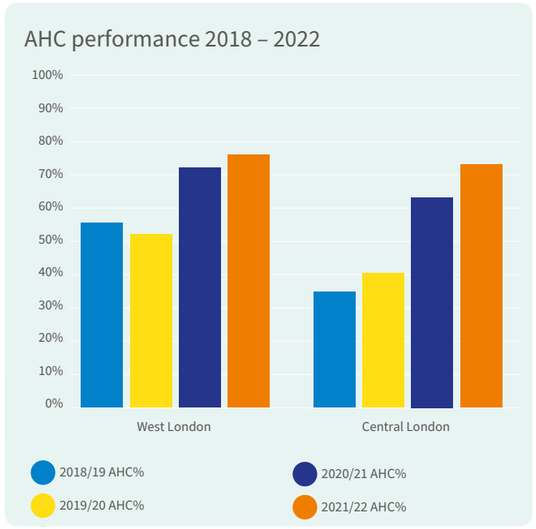
Central London

401 health checks completed from 546 on GP register this equates to 73% completion rate which is just below the target for 2021/22 but above the target set for 2020-21 which was at 67% but took into account the challenges with carrying out heath checks during the Covid Pandemic.

West London

536 health checks completed from 709 on GP register this equates to 76% completion rate which exceeds the target for 2021/22. The graph on the right identifies the improvement in health check delivery over the last four years. We have also worked in partnership with the North West London Diabetes team and The Advocacy Project to design and produce accessible information on the Know Diabetes website. This will enable people with learning disabilities to access information to prevent and manage type 2 Diabetes.

The graph to the right identifies the improvement in health check delivery over the last four years:



Next steps:

- we are strengthening links with primary care to continue improvements in the performance rate, as well as ongoing training program agreed with CLCH as part of an offer of support to primary care.
- our new training programme has been developed in partnership with CLCH and the broader primary care system and feedback from GP practices has been positive. This is due to launch in September 2022.
- we have worked with local learning disabilities teams on quantifying and clarifying their offer of support to practices within a broader health facilitation role.

Safe and Wellbeing reviews

Background

The National Safe and Wellbeing Review Programme was identified as part of the NHSE response to a recent SAR that was undertaken to learn from the safety and wellbeing of all people with a learning disability and autistic people who were in a mental health hospital or inpatient setting.

In terms of Safe and Wellbeing reviews, we conducted reviews for those who were in in-patient hospital receiving assessment and treatment.

Our findings confirmed that they were receiving good care with clear plans for discharge. In addition to safe and wellbeing reviews we have carried out eight weekly visits and six-monthly care and treatment reviews for those eligible within Hospital inpatient settings as standard.

Next steps:

- continue to sustain service quality through Quality Assurance visits with an enhanced approach through the appointment of a Complex Placements Senior Delivery Manager.
- continue with eight weekly face to face visits to all people in mental health inpatient services.
- regular reporting to the North West London ICB surgery.

LeDeR – learning from lives and deaths

Background

The NHS Long Term Plan made a commitment to continue LeDeR and to improve the health and well being of people with a learning disability .

We use the findings of LeDeR reveiws to make changes to services locally to help prevent people dying from things which could be treated and prevented. North West London CCG produde an annual report which describes action from learning.

Each LeDeR review gives us information about the life and death of the person. From all the information we look at what we can do locally to positively reduce health inequalities.

Learning and implimentation

We have learnt from themes that have been identified in SAR's and have seen a significant reduction in these themes over the last year:

- application of Deprivation of Liberty Safeguards
- issues relating to carers assessments
- long term condition management
- lack of access to specialist services
- access to GP records
- medication issues
- lack of face to face contact
- lack of annnual health checks

Next steps:

- plan to improve the process between the LeDeR process and safeguarding to ensure they are robustly aligned.
- local focus and strategy group to support reviews and implementation of operational and strategic action plans.

Joan's Legacy

Key Findings and Recommendations from the Safeguarding Adults Review

Sharing learning from SARs is a key priority of the Safeguarding Adults Executive Board (SAEB) and ensures that lessons in relation to safeguarding adults support best practice and encourages a culture of continuous improvement.

All staff and mangers are encouraged to discuss this briefing and the key learning and reflection points to ensure that the learning outcomes are used to consolidate best practice and support improvements in practice where required.

Safeguarding Adults Reviews or SARS are commissioned under Section 44 of the Care Act 2014 in circumstances in which an adult has died or sustained serious harm as a result of abuse or neglect, and there are lessons to be learnt around how agencies worked together to safeguard the adult.

The aim of a SAR is to carry out a review to determine what agencies involved could have done differently that could have prevented the harm or death from taking place. The aim is not to apportion blame, but to promote effective learning and improvement actions.

The SAEB commissioned an Independent Reviewer to conduct a Lessons Learnt Review. The review examined events from 30 December 2018 to Joan's death in October 2019.

The review analysed agencies involvement via chronologies and the reviewer also led a facilitated event with practitioners and managers. Joan's family were also involved in the review and met with the Independent Reviewer as well as members of the SAR Panel.

Joan with her great grand-daughters

Joan passed away at the age of 88 after experiencing a significant and rapid decline in her health over the last year of her life. Joan was admitted to hospital five times, in the last 10 months of her life, and there were concerns about discharge arrangements and the care and support services set up to meet her needs, as well as frequent re-admissions to hospital. Joan lived with dementia and became very physically frail in the last year of life, leading to her no longer being able to mobilise independently and developing pressure ulcers.

As part of the review, Joan's family were able to offer powerful insights regarding their experiences. They want Joan's legacy to be that the learning from this case, means that other adults in similar circumstances should not face the same shortfalls in care and support.

The SAEB would like to thank Joan's family for their valuable contributions and open honest reflections of their own experiences and of Joan's care.

Key findings and learning outcomes

Communication and coordination between agencies and family members

The review identified an overriding theme of inconsistent communication between agencies involved as well as with Joan and her family. his led to poorly coordinated hospital discharges, delays in the provision of care services, contradictory information being given to family members and their concerns not being addressed in timely or effective ways. There was no clear lead agency and the large number of different agencies involved caused confusion around different roles and responsibilities. There was a lack of formal multi-agency meetings both in relation to planning hospital discharges as well as reviewing the care Joan received at home, as well as a lack of effective partnership working with Joan's family who knew her needs well and what was important to her.

In addition, the review found that there were missed opportunities to consider the concerns raised via safeguarding procedures. Only one safeguarding enquiry was instigated in August 2019 in relation to Joan being admitted to hospital with pressure ulcers but there were delays in this enquiry being taken forward and a lack of management oversight.

Mental capacity curiosity by professionals

There was little recorded evidence of Joan's wishes and feelings within records across the organisations. Documentation frequently referred to 'best interests' decisions being made, but without decision-specific mental capacity assessments being completed.

Reasonable adjustments and person-centred care

During Joan's hospital admissions she was often deemed by professionals to be unresponsive and uncommunicative, and they advised her family members that at times she was not eating. However, practitioners did not take into account the reasonable adjustments Joan needed to be able to engage with them. She was visually impaired and hard of hearing but often left without access to her glasses or hearing aids which meant that she could not understand what people were saying and communicate with them.

Involving families in SARs and complaints

Joan's family were strong advocates acting on her behalf but struggled to make her voice heard. Their frustrations were often perceived by professionals that they were being difficult and aggressive. The family found that their concerns about the poor quality of care were not satisfactorily addressed until they escalated matters through the complaints and Local Government Ombudsman processes.

The family have provided feedback that they found some aspects of the SAR process challenging, in relation being informed about the SAR taking place 2 years following Joan's death via letter, when their preference would have been for an initial conversation to discuss the purpose of the review.

Recommendations

Learn	Develop a partnership process to ensure that learning from SARs is disseminated effectively throughout organisations and that multi-agency learning is prioritised and tested in day-to-day practice. Ensure the adult and families are central to the process.
Raise Awareness	Build on recent developments around reviewing the national protocol of pressure ulcers. Ensure SAEB partners lead on raising awareness and working on clearer pathways across care home and statutory health sector.
Quality Assurance	Introduce a programme of multi-disciplinary audits of safeguarding practice and decision making to compliment the SAEB Assurance and Performance Framework.
Review	Review the operational model of My Care My Way in the Royal Borough of Kensington and Chelsea.
Coordinate	Develop mechanisms to ensure a more coordinated approach across acute hospital trusts and Adult Social Care to ensure effective case management.

What we are doing to respond to the learning:

- Adult Social Care has led on an audit of hospital discharge pathways and joint working across health and social care. The findings will be used to strengthen the Discharge to Assess (D2A) arrangements, including establishing multi-agency hospital hubs.
- a Training Needs Analysis with regulated provider services highlighted the need for greater awareness of the pressure ulcer protocol. In response to this bespoke training sessions will be delivered later in 2022.
- the SAEB will undertake a multi-agency audit to look at how well the Mental Capacity Act is being used in practice.
- the new SAR Protocol and Guidance has been launched by the SAEB in June 2022 and the board will deliver a series of 'Lunch and Learn' sessions to partners to help raise awareness of the process.
- a new SAR Guide for Families and Carers has been produced.
- the review highlighted important learning around how we work with families both within day-to-day practice as well as in SARs. The board is working with Joan's family for dialogue around how they may wish to support sharing the learning from this review.

Key Points for Learning and Reflection

- do you have an established process for deciding who needs to be involved in multi-agency meetings and plans, and how do you ensure all relevant agencies are involved in discharge / care and support planning? How do you ensure that agreed actions are monitored and followed up?
- how have you overcome challenges to good multi-agency working? For example, how do you take responsibility for effective information sharing and communication?
- do you feel you have the skills to explore and understand families who are expressing frustration and dissatisfaction? Are you able to hold 'difficult conversations' with confidence?
- are you aware of the Department of Health and Social Care's (DHSC) Safeguarding Adults Protocol for Pressure Ulcers, and how to use its Safeguarding Decision Guide Assessment?
- how do you ensure you adopt a person-centred approach consider all reasonable adjustments are met when working with adults with care and support needs?
- are you confident in applying the Mental Capacity Act in practice?

Safeguarding Executive Board Strategy 2022-2025

Our Strategic Plan 2022-2025 sets out how the Board will work towards achieving its ambitions for safeguarding adults in the Bi-Borough and has four key priorities to ensure that, wherever possible, safeguarding responsibilities are delivered in a way that creates safeguarding prosperity within our communities and continues to have 'Making Safeguarding Personal' (MSP) at the heart of everything we do.

Safeguarding Adults Executive Board

Making Safeguarding Personal

Service user engagement

Ensuring that adults are being supported and encouraged to make their own decisions on how to keep themselves safe.

Sharing experiences and best practice through collaborative and bespoke safeguarding training and community events.

Collaborating with our Safeguarding Ambassador to ensure their voices are heard in the communities and London wide.

Making safeguarding everybody's business

- improve awareness of safeguarding across all communities
- culturally competent safeguarding and support
- close working with the voluntary sector
- listening and collaborating with service users by experience

Communities keeping themselves safe

Community Engagement Group

Working together with our communities to prevent harm and abuse and improve awareness of safeguarding to ensure they are informed, confident and supported in raising safeguarding concerns.

Continuing to create an inclusive and diverse safeguarding culture that learns from the information we have collected about what is most important to specific community groups in raising awareness and providing tailored Learning Programmes and support.

Communication and Involvement and Prevention and Early Intervention

- building Community resilience and and developing strategies that reduce the risk of abuse, as well as seeking assurance from partners
- knowing our residents and who is at most risk
- placing partnership responses at the heart of the problem

Leading, Listening, Learning

Safeguarding Adults Case Review Group

Providing high quality Learning and Development opportunities to the partnership and working together to provide leadership ambition for change.

The SAEB Learning Programme and network of SAR Champions is extended across the wider partnership, housing and voluntary sectors to support, share and embed learning.

Sharing learning to prevent harm and abuse

- a partnership which is open to new ideas and a willingness to learn from mistakes
- a partnership which wants to get better at preventing abuse and neglect
- a partnership which is transparent and accountable to each other and to its residents
- a partnership that listens and hears what it is being told by families

Quality and Performance

Developing Best Practice and Effective Outcomes Group

Making sure safeguarding arrangements for adults at risk work effectively and support organisations to continually improve practice.

Ensuring our safeguarding systems are improving and we are learning and getting better through use of digital technology to get our messages across.

Learning through Development of best Practice and using data better to help inform partnership responses to safeguarding referrals

- shared safeguarding goals and wellbeing responsibilities partnership wide that seek assurance across all safeguarding agendas
- understanding what the most prevalent abuse types are and doing something about it
- making sure safeguarding arrangements for adults with care and support needs work effectively and we have people by experience working alongside us informing our learning

Big thank you to the members of the Safeguarding Executive Board

- The Bi-Borough Executive Director of Adult Social Care and Health
- The Chief Nurse and Director of Quality, Caldicott Guardian, NHS North West London Integrated Care Board (NWL ICB)
- Basic Command Unit Commander of Central West, Chief Superintendent, Metropolitan Police
- London Fire Brigade
- Imperial College Healthcare NHS Trust
- Chelsea and Westminster Hospital Foundation NHS Trust
- The Royal Marsden NHS Foundation Trust
- Central London Community Healthcare Trust
- Central North West London NHS Foundation Trust
- Community Rehabilitation Company (CRC)
- National London Probation Service
- Children's Services (Local Authority)
- Community Safety (Local Authority)
- Lead Portfolio Holder (Local Councillors)
- Housing (Local Authority)
- Genesis Notting Hill Housing
- Trading Standards (Local Authority)
- Public Health
- Royal Brompton and Harefield HNS Foundation Trust
- Healthwatch
- Adult Social Care (Local Authority)
- Safeguarding Ambassadors
  The Local Account Group
  The Safeguarding Adults Reference Group

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

Don't ignore it. Report it.

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