Safeguarding Adults Executive Board

OPEN AGE life's just begun

7 Minute Briefing: Cuckooing

1 What is cuckooing?

Cuckooing is a form of exploitation whereby criminals take over the home of a vulnerable person and use it for criminal purposes, such as dealing drugs. The intention of this process is to find a discreet, inconspicuous location away from police view. Initially, a criminal may befriend a vulnerable person, or pacify them with drugs. They will then maintain control over them and their property through intimidation, threats, and abuse. Drug dealers will often cuckoo numerous properties at once in order to evade police. The term comes from the behaviour of cuckoos who take over the nests of other birds.

2 Who is at risk?

Criminals will deliberately seek out vulnerable individuals who they can more easily exploit. Typically, people who are cuckooed may be:

- Older
- Living with mental or physical health conditions
- Living with learning disability
- Involved in prostitution
- Single parents
- Experiencing poverty
- Isolated
- Living with drug or alcohol addiction

3 Abuse and control of victims

Criminals will use various means to gain access to a person's home and exploit them. In some cases the victim may be living alone and this will be used as a means to befriend them. Often the victim will be a drug user, so the criminals may be able to pacify them with drugs. Once criminals have gained control of the victim, they may start to bring larger groups into the property. They will maintain control by intimidation and violence towards the vulnerable individual.

4 Signs of cuckooing at a property

You may notice changes around a property that indicate criminal activity is taking place. These could include:

- High number of vehicles stopping at the property for a short time.
- Increased anti-social behaviour around the property
- Open drug dealing near the property
- Not seeing the resident of the property as often
- People coming and going at various times day and night.

5 The vulnerable person

Due to the presence of criminals in their home, alongside continuing threats and intimidation, it is extremely difficult for people who have been cuckooed to report the crime. It is essential to be curious and think critically about what you see. Some typical signs are:

- Not engaging with services
- May have unexplained injuries
- Has paid off debts in full with cash
- Misusing substances
- Appears withdrawn and fearful of disclosing information
- New, unidentified associates who are often present at the home
- Has changed appearance, either wearing expensive clothing or appearing unkempt

6 Making a referral

Contact Adult Social Care for advice where someone may need an assessment of their care and support needs.

Kensington and Chelsea

020 7361 3013

socialservices@rbkc.gov.uk

To tell Kensington and Chelsea about any concerns you have (known as 'raising a Safeguarding Alert') you can ring them on the above numbers or complete and send **this alert form** to them.

Westminster

020 7641 2176

adultsocialcare@westminster.gov.uk

To tell Westminster about any concerns you have (known as 'raising a Safeguarding Alert') you can ring them on the above numbers or complete and send this **alert form** to them.

In an emergency call the Police on **999**.

You can also contact the Police on **101** for non-emergency situations.

It is also important to involve the housing provider if this is a registered housing provider or the landlord if it is a privately rented property.

7 Consolidate your learning

Please share this briefing that can be used for individual learning and group discussions to understand cuckooing and how to safeguard victims.

Julie Ryan

Turning Point Bi-Borough
Safeguarding Manager reports

Throughout 2022 – 2023 Turning Point has seen an increase in people presenting with mental health and substance misuse, people that are impacted by the cost-of-living crisis needing food banks and self-care packages and people on the verge of eviction, this has included clients with parental responsibility. We have also seen an increase in

Missing persons

Domestic Abuse

Suicidal Ideation

Here at turning point we follow the six principles of safeguarding. These are empowerment, prevention, proportionality, protection, partnership, and accountability. While also ensuring all colleagues involved with service delivery work to promote wellbeing and are aware of actions to take if they suspect abuse or neglect of a client. Turning Point is committed to developing a culture in which employees feel able to raise appropriate concerns to the relevant teams, relating to safeguarding of adults at risk without fear of the consequences of making a disclosure.

We ensure all staff are trained, completing safeguarding level one, two and three training as well as safeguarding and mental capacity act inductions. This is a mandatory requirement, with training being refreshed every one to two years. All managers are also trained as DSOs (designated safeguarding officers) ensuring all concerns are responded to and processes are followed. Our policies and procedures are updated and reviewed regularly; they are also displayed in our hubs along with being accessible on the shared drive.

Turning point DAWS holds a monthly webinar on Eventbrite to inform professionals of the support available for substance misuse clients and the complexity that comes alongside it and we work in partnership with them to support people.

Next year with the support of the Safeguarding Board we are looking forward to delivering joint training with partners, supporting the Staying Safe Project and continuing our commitment to both residents and organisations of the Bi-borough.

Launch of the London Trading Standards guide to consumers on Door Step Crime

Bethan Featherby, Senior Trading Standards Officer, Public Protection and Licensing, **Matt Allwright**, presenter from BBC tv Watchdog and Rogue Trader programmes officiated the launch along with a representative from Victim Support and MOPAC.

Bethan Featherby, Senior Trading Standards Officer, Public Protection and Licensing reports has helped the SAEB with raising awareness of criminals claiming to be bogus builders, roofers, etc and the misery this has inflicted often causing huge financial devastation on vulnerable residents.

The alleged repairs have left some properties in a worse state than before or even structurally unsound, and the suspects involved are invariably difficult to trace having provided false contact details. In some cases, the criminals are a front for distraction burglary. All too often the suspects claim their office address is in Westminster, many in prestigious locations thereby reassuring some consumers that they must be legitimate, but these are frequently 'virtual offices'. The criminals often 'cyber squat' these address - having no contractual relationship for mailing or telephony services with the virtual office providers. This leaves consumers with no viable means of trying to trace the criminals to get their money back and impacts on effective investigation by enforcement agencies.

The guide provides invaluable information on doorstep crime, with tips on how to source reliable tradespeople and what to do if you receive that unexpected knock at your door available at: **www.londontradingstandards.org.uk/wp-content/uploads/2022/07/V4_LTS-Doorstep-Booklet_Digital.pdf**

You can also watch the SAEB Safeguarding Ambassador video on common doorstep scams which provides advice on ways to protect yourself and others **here**.

Lost for words

Language support and Interpretation Services in Primary Care

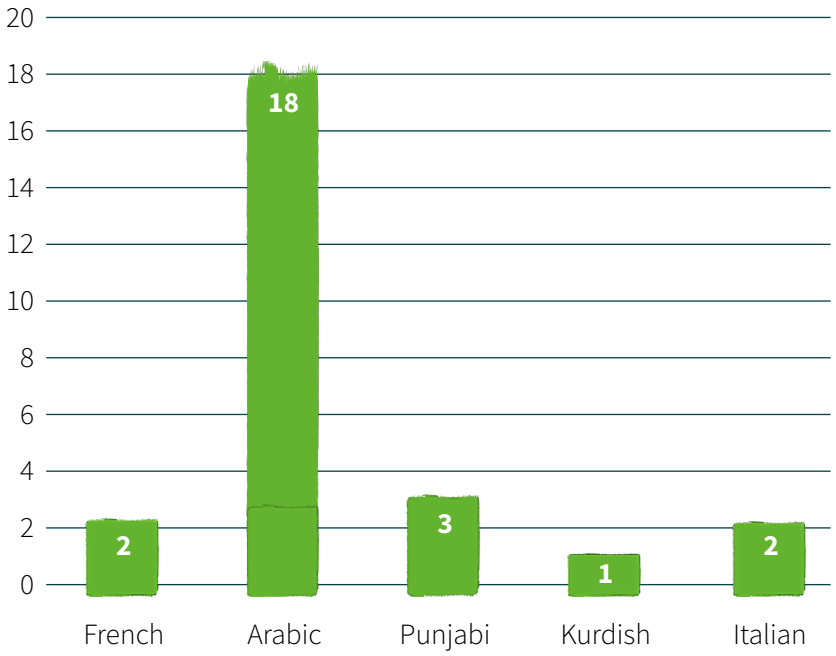
Danni O'Connell Reports

Lost for Words, a report produced by Healthwatch England and six local Healthwatch, outlined how a lack of appropriate language support in NHS services caused barriers and delays in receiving care for patients who didn't speak English.

In response to the findings in this report we launched a survey on interpretation services in primary care during 2022 – 2023 to better understand how Bi-Borough residents who don't speak English as a first language navigate and use healthcare in the Bi-Borough.

22 residents participated in our survey and within 3 focus group discussions we explored topics such as residents' language-related difficulties in healthcare, experiences with interpretation services and suggestions to improve interpretation services. In some cases, Healthwatch staff and interpreters from other organisations provided language support for non-English-speaking residents in completing the surveys.

Primary spoken languages among surveyed residents



18 of the 22 surveyed residents reported previously using an interpreter for their GP appointments. Several described typically relying on partners and children to accompany them for visits, and only seeking interpretation services if their family and friends weren't available. Among those who participated in the focus groups, residents relied on a mix of family, friends, neighbours, acquaintances, and interpretation services for language support during their appointments.

> It was easy and good; the GP was willing to help."

> It was very easy to get a translator."

> It was a smooth process simply because I understand English. However, I struggle with understanding the medical language the Doctor refers to."

> I cannot make an easy appointment through the receptionist."

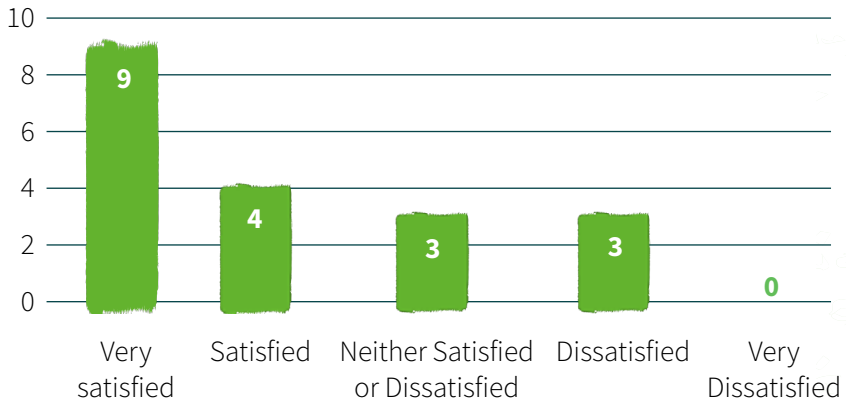
> It used to be easier to receive a translator when I went to the GP in the past."

> Sometimes it is difficult to request an interpreter, and it takes a lot of time."

> When I first came to the country it was difficult accessing the service especially when I want to make a complaint."

Residents satisfaction with the service

Among the 22 service ratings from residents using the service (3 residents did not respond to the service rating question), 9 reported being 'very satisfied' and 4 'satisfied'.



Findings 'Limitations and Learning'

Representation of residents

Our analysis lacked diversity in participant ethnicities and spoken languages with an overrepresentation of Arabic-speakers and middle-aged women.

Language support and interpretation

We only organised focus groups and printed surveys in English, as we didn't have enough interpretation support for all languages or the ability to translate responses written in other languages into English. When speaking with residents, we relied on either Healthwatch staff's language skills, partnered organisations' staff or people's own interpreters. This meant that our surveys and focus groups discussions excluded people who had very limited or no English proficiency and had no interpretation support, or for whom we couldn't find language support to participate in the project. This also meant that residents who had higher English proficiency could contribute more than those with lower English proficiency.

The accuracy of some of the residents' stories and narratives that we collected may be limited for numerous reasons.

- misinterpreted by speaking to residents interpreters, many of whom were not professional interpreters
- many residents could not read or write in English, we asked the questions in person and recorded their responses on paper. This may have affected the accuracy or detail of what was recorded
- Findings from residents who didn't rely on an interpreter during our conversation may be inaccurate because these residents may have misinterpreted some questions.

Accuracy of residents' narratives

Several residents described how they used to need interpreters in primary care settings but have since gained enough English proficiency to attend their appointments without an interpreter. Since they were sharing their past experiences of using interpretation services, findings from these residents may not be as reliable due to time lag and memory, and additionally may not be reflective of the current language support provided.

Recommendations

Priority one: Increase access to and awareness of interpretation services

Residents suggested offering more diversity in languages, dialects and accents to increase access to residents of different language, ethnic, and cultural backgrounds. Some residents additionally recommended allowing patients to choose an interpreter of the same ethnic origin, to account for accent, dialect, and other linguistic or cultural factors. One resident suggested:

"Assign patients interpreters that not only speak the same language but are also from the same country or ethnic background, because of challenges with understanding different accents and words."

Some residents described how community members were sometimes unaware of interpretation services available and suggested providing more information and increasing awareness of language support services for non-English speakers. One resident highlighted the role that healthcare providers could play:

"Doctors could be more proactive in offering an interpreter."

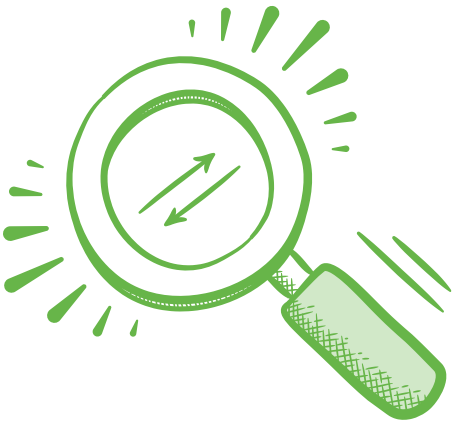
Priority two: Improve quality of interpretation services through recruitment, training, and regular evaluations.

Residents expressed a need for better training and recruitment of interpreters. Many described interpreters' lack of medical knowledge and medical vocabulary as a cause of miscommunication and misinformation during their medical appointments. At the same time, one resident suggested advising interpreters to avoid using technical jargon or acronyms where possible.

Another key issue surrounded interpreters' attitudes, with some residents expressing a need for training around professionalism, confidentiality, and compassion to build trust in interpretation services. One resident told us:

"The interpreters could be more polite and less patronising with the users."

In the focus group discussion, one resident suggested a regular review of interpretation services and interpreters, asking patients for feedback on their experiences using the service.



Priority three: Provide additional support and accommodation for non-native English-speaking residents.

Residents suggested that, where possible, in person GP appointments should be made for non-native English speakers to avoid communication problems during virtual appointments. If appointments are virtual, their preferred method would be a video call to reduce miscommunication and misinterpretation.

One resident shared that it would be helpful to keep a note of language support needs on patients' files, and to keep the same interpreter for each patient where possible:

"It's always a different person who has no clue on the patient health conditions. You always have to request it. It is never a permanent action for GP appointments which is rather annoying."

Residents also requested that more time be allocated for their medical appointments, as using an interpreter often meant that it took longer for issues to be communicated and addressed. For emergency services, such as when calling 111, residents wanted better language support and interpreters on hand.

In the focus group discussions, some residents suggested that organisations and charities provide workshops and training to empower non-native English-speaking patients to be more independent, confident, and self-sufficient in seeking and using medical care.

Events and Campaigns 2022-2023

Stop Loan Sharks

In response to the economic crisis in September 2022 our Safeguarding Ambassadors launched a series of webinars to raise awareness of 'How to Stay Safe from Loan Sharks'. Risks for residents are very real given the cost of living is high for the foreseeable future and they may resort to borrowing from loan sharks.

The SAEB Hate Crime Advocator Training Programme

Hate Crime Week in October 2022. Launch of Training sessions delivered by Community Safety Partnerships & The Metropolitan Police to our Community Engagement Group member organisations. habits to reduces their chances of becoming a victim of cybercrime, making them less vulnerable.

The Domestic Abuse Act – has it gone far enough?

CNWL opened its doors to partners wishing to join our 5th Annual Domestic Abuse (DA) conference, held in November 2022. The theme was "The Domestic Abuse Act – has it gone far enough?" Over 600 people attended, including people with lived experience and professionals from partner agencies within the Bi-Borough.

National Safeguarding Awareness Week 2022 November 21st- 27th 2022

The theme for the week was 'Sensible Precautions and Local Solutions' . Promoting a series of useful tips and campaigns about how people and organisations can take steps to minimise effects of the cost-of-living crisis. The Community Engagement Group put together a webpage to provide residents with support and advice available which can be accessed on the SAEB website **here**.

> The Community Engagement Group are extremely concerned about the people they support especially as most were already struggling
>
> Quote from our National Safeguarding Adults Week Event 2022

Partner agencies to include Public Health, The Department for Works and Pensions, Community Alarm Services, Age UK and The London Fire Brigade collaboratively held a webinar to support residents.

Topics included

- Fire Safety
- The Cost-of-Living Solutions
- Mental Wellbeing
- Community Alarm Services
- Local Payment Support Services

The SAEB Holistic Approach to Hoarding Event took place in March 2023 and welcomed various community organisations who play a vital role in supporting people who are at risk from self-neglect and hoarding to share best practice and raise awareness of local support services.

The Relaunch of the CNWL Suicide Prevention Strategy extended a warm welcome to Bi-borough partners in November 2022 and shared key messages about "Let's get talking…" with a keynote speech from Professor Louis Appleby. This focused on improved communication with service users, their families and across agencies saves lives.
To mark World Suicide Prevention Day the SAEB promoted The Samaritans Tool Kit available **here**.

NHS Central and North West London NHS Foundation Trust

LFB London Fire Brigade

The Royal Borough of Kensington and Chelsea

City of Westminster

Department for Work & Pensions

Safeguarding Adults Week 2022 21 – 27 November

Dealing with cost of living

Fire Safety

Kensington & Chelsea age UK

Making Safeguarding Personal

In this section:

- Outcomes Safeguarding Adults data for Kensington and Chelsea
- Outcomes Safeguarding Adults Data for Westminster

Talking, exploring and listening is a key part of how we build strong relationships with our partnership and our Adults at risk. Making Safeguarding Personal is a key concept and continues to be the cornerstone of our safeguarding work. We celebrate when we get things right and learn from our mistakes when we need to improve.

We are proud of the work we have done in ensuring that adults at risk are supported in achieving the outcomes they want from the safeguarding enquiry. We have seen a steady increase in good outcomes for adults at risk. Our improvements have been the result of a remodel of our safeguarding structures and better engagement with people involved in the safeguarding enquiry ,their family, friends or advocate.

There are two aspects in particular of the new model which we have worked hard at getting right:

1. Engaging better through relationship building. The safeguarding team have strong links with various organisations. We talk to staff and service users to find out how they experienced the safeguarding process. We listen and collect this feedback so we can learn about how to make improvements.
2. Working closely with front line staff in making improvements to performance by using data more effectively.

In this chapter we discuss the comparator data from the last 4 years across the Bi-Borough and London to highlight trends in our successes and to view gaps where improvements are required.

Outcomes Safeguarding Adults data for Kensington and Chelsea

Good quality safeguarding referrals

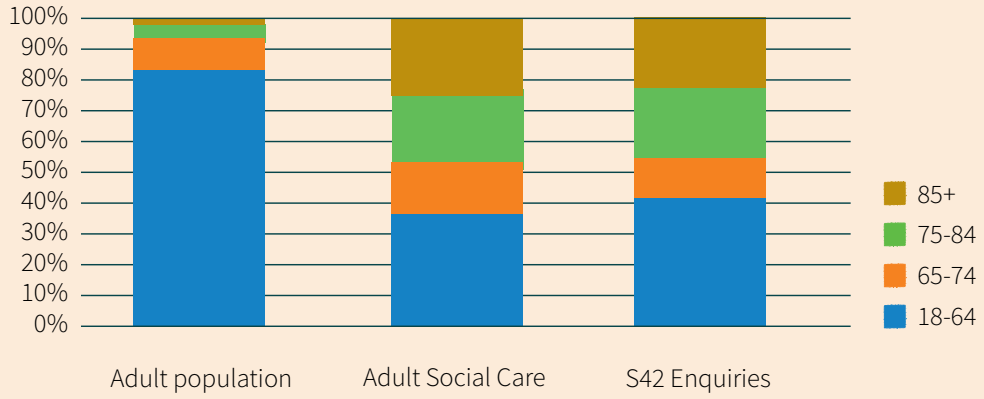
In 2022-23 we received a total of 561 safeguarding concerns. Of these, just under two-thirds (365 or 65%) were assessed as requiring a safeguarding enquiry. And of these, 27 were assessed as meeting the safeguarding duty under S42 of the 2014 Care Act and so were classified as S42 enquiries. This means that our referral process is understood and very few inappropriate referrals are made into the system. The 35% of safeguarding concerns which do not go forward to become an enquiry are worked on by front line staff putting in preventative measures.

Who are the adults at risk

Age profile

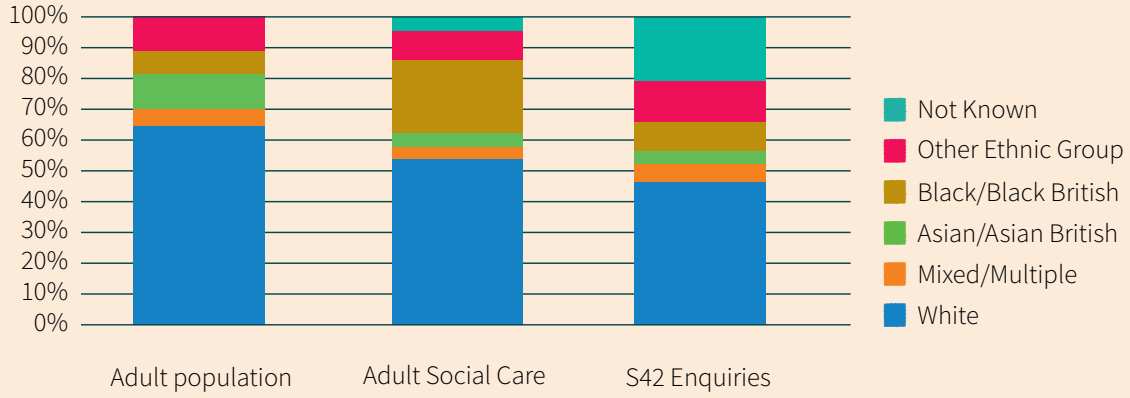
The S42 enquires undertaken involved 313 individual adults at risk. This is equivalent to 1.1 enquiries per person. The age profile of these adults largely reflected the age profile of those receiving long-term care and support. About six out of ten were in the 65+ years age group and four out of ten in the 18-64 age group. This contrasts markedly with the age profile of the general resident adult population where people aged 18-64 make up over 80% of the population. Just over half (52%) of the individual adults at risk were female, slightly below the corresponding proportion for adults receiving long-term care and support (58%).

The age profiles of (a) the general adult population; (b) adults receiving long-term care and support; and (c) individuals involved in S42 enquiries: a comparison.



Ethnic profile

The ethnic groups of (a) the general adult population; (b) adults receiving long-term care and support; and (c) individuals involved in S42 enquiries: a comparison.

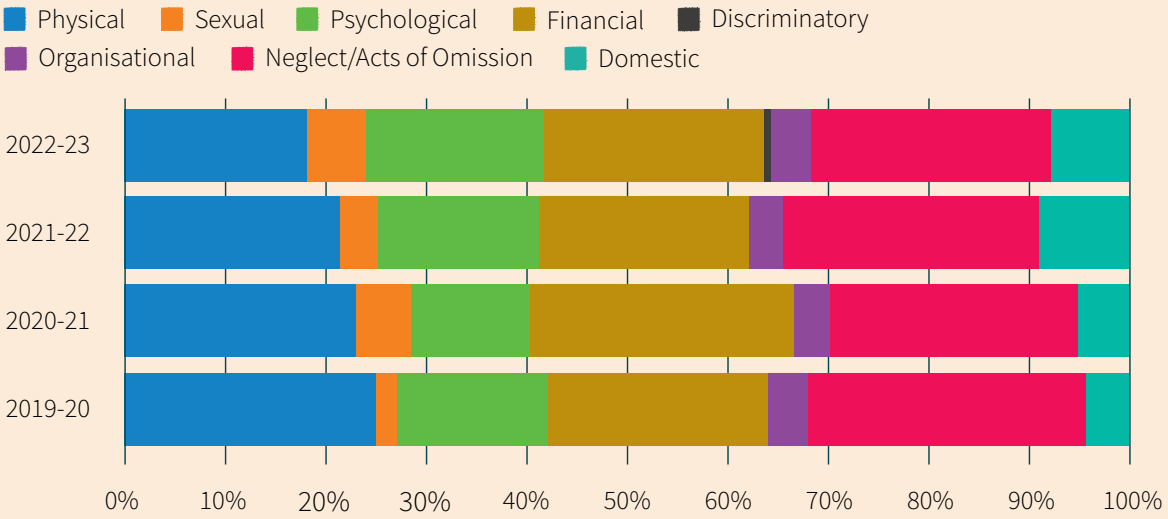


The ethnic diversity of the individual adults at risk was closer to that of those receiving long-term care and support than to the general adult population. But it is difficult to make a direct comparison as in a large proportion of cases the ethnicity of the adult was not known. In many cases this is because the individual has not previously been known to adult social care. Work is being done to understand equality, diversity and inclusion issues within the safeguarding systems. The Staying Safe project is an example of this described in the Community Engagement Chapter.

Types of risk or harm alleged- A comparator over the last 4 years

More allegations of domestic abuse and psychological abuse.

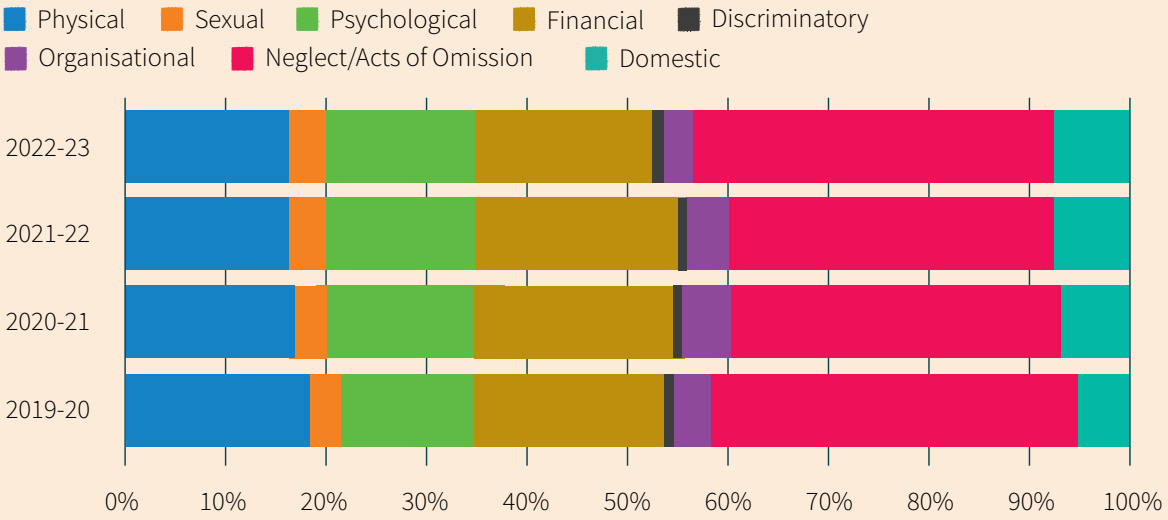
The frequency with which different types of abuse were alleged – RBKC



Safeguarding concerns may involve allegations of more than one type of harm or abuse. The Table above shows the frequency with which different types of abuse were alleged for those S42 enquiries which were completed in the last four years. Over this period proportionately fewer enquiries have involved physical abuse and neglect or acts of omission, while proportionately more have involved psychological abuse and domestic abuse. This is an interesting move away from health and social care staff reporting abuse related to a commissioned service. We are now experiencing increased and different abuse types in a person's home not necessarily associated with any care and support being received.

London comparator sees some increase in domestic abuse

The frequency with which different types of abuse were alleged – London



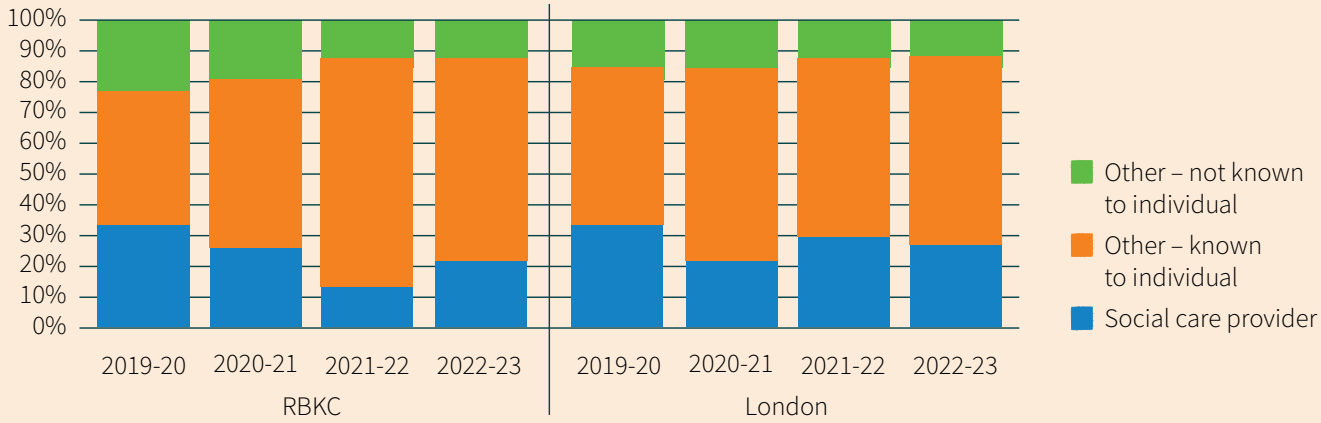
This contrasting trend in neglect/acts of omission and domestic abuse has also been reflected across London to some extent although across London as a whole neglect/acts of omission account for a higher proportion of the allegations raised. This could possibly reflect the higher number of care homes in other boroughs across London compared to RBKC.

The SAEB response to this data trend is to set up a project group to scope out domestic abuse for people in receipt of care and support needs with a focus on elder domestic abuse.

The source of risk

Reduction of abuse coming in from Care Homes and Home Care

Whether the source of risk was a social care provider or someone else, and, if someone else, whether they were known to the adult at risk.

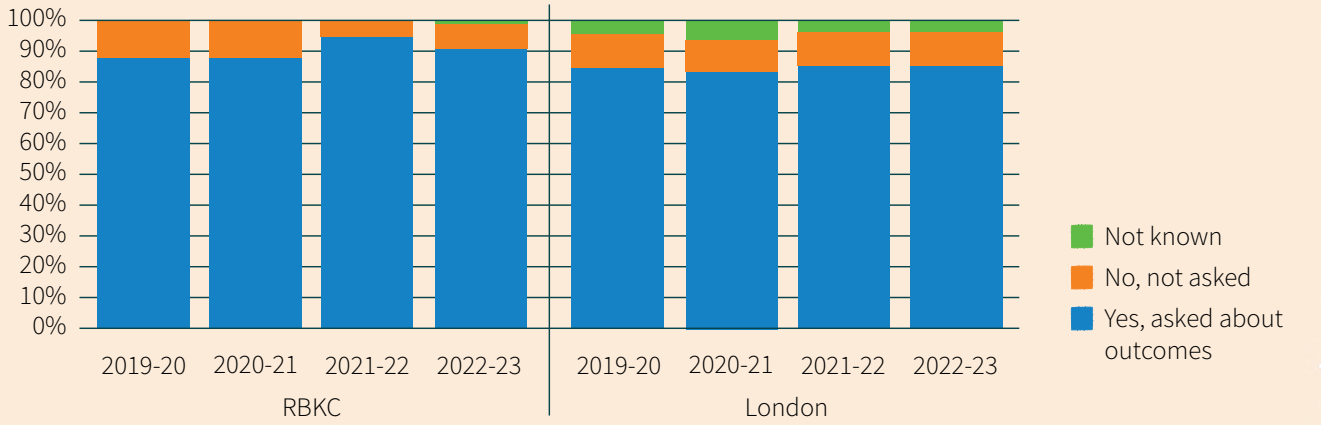


Neglect and acts of omission are most often associated with providers of adult social care such as a home care agency or care home. Consistent with the trend noted above there has been a decline in RBKC and across London in the proportion of enquiries where a social care provider was the source of risk, and a corresponding increase in the proportion where the source of risk was not a social care provider but was known to the adult at risk, for example a family member. This trend possibly reflects the focus Bi-Borough Adult Social Care has had over the last couple of years in ensuring we have a strong quality assurance model in place. The impact can be seen in the reduction of safeguarding concerns related to regulated services.

The Adult at risk and their outcomes

RBKC outcomes above London average

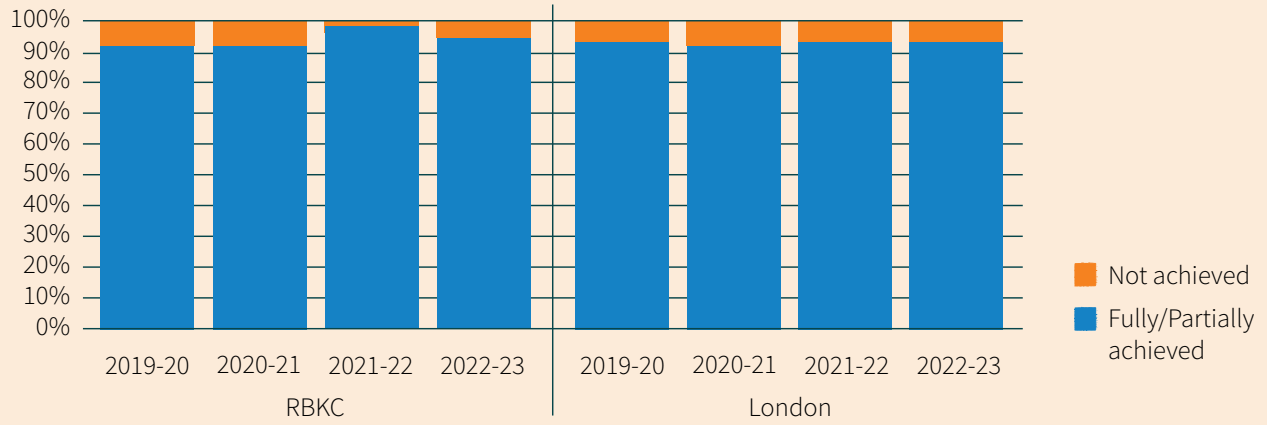
Whether the adult risk, or their representative, was asked what their desired outcomes were.



Making Safeguarding personal is about building relationships. This means having conversations with people (or their representative) about how they want to be supported in a safeguarding situation in a way that promotes involvement, choice and control as well as improving quality of life, wellbeing and safety.

Over the last four years in about 90% of completed S42 enquiries the adult at risk or their representative has been asked what they would like to achieve through the enquiry. This has been consistently above the London average. This means that we have evidence that front line staff are talking to adults at risk about their safeguarding situation and supporting them to achieve the outcomes they desire.

Whether the desired outcomes were achieved



It will not always be possible to achieve the outcome the adult would wish for and sometimes it can only be partially achieved but over the last four years in over 90% of completed S42 enquiries the outcomes desired were judged to have been fully or partially achieved, consistent with the outcomes across London as a whole.

Outcomes Safeguarding Adults Data for Westminster

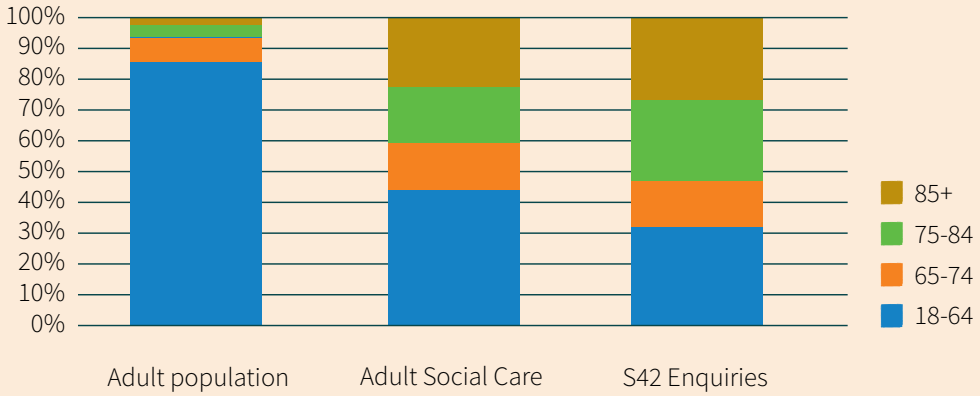
Good quality safeguarding referrals

In 2022-23 WCC received a total of 545 safeguarding concerns. Of these, over a half (295 or 54%) were assessed as requiring a safeguarding enquiry. The great majority (87%) of these were assessed as meeting the safeguarding duty under S42 of the 2014 Care Act and so were classified as S42 enquiries.

Who are the Adults at Risk

Age profile

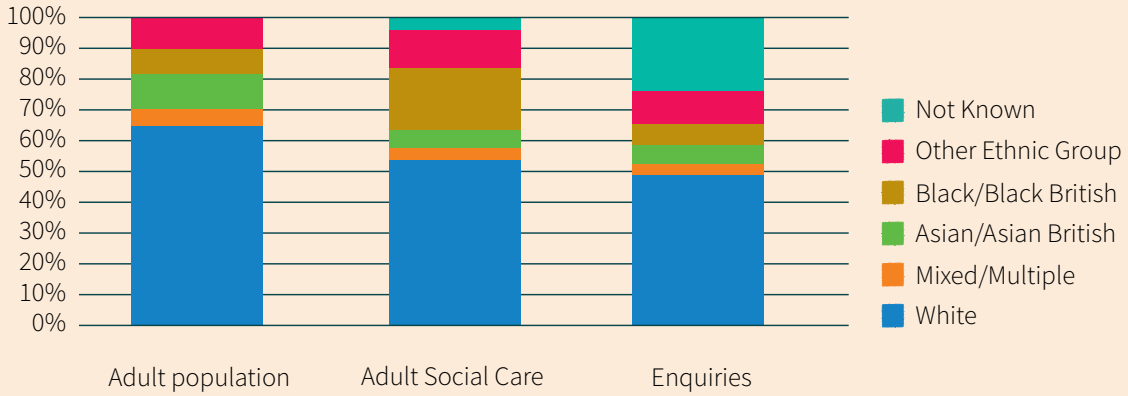
The age profiles of (a) the general adult population; (b) adults receiving long-term care and support; and (c) individuals involved in S42 enquiries; a comparison.



The S42 enquires undertaken involved 238 individual adults at risk. This is equivalent to 1.1 enquiries per person. The age profile of these adults largely reflected the age profile of those receiving long-term care and support, although it included proportionately more people aged 65 and over. About seven out of ten were in the 65+ years age group and three out of ten in the 18-64 age group. This contrasts markedly with the age profile of the general resident adult population where people aged 18-64 make up over 80% of the population. Over half of the individual adults at risk were female, above the proportion for those receiving long-term care and support (58% compared with 52%). The work of the SAEB is generally focused on safeguarding projects related towards vulnerable older adults.

Ethnic profile

The ethnic groups of (a) the general adult population; (b) adults receiving long-term care and support; and (c) individuals involved in S42 enquiries: a comparison.

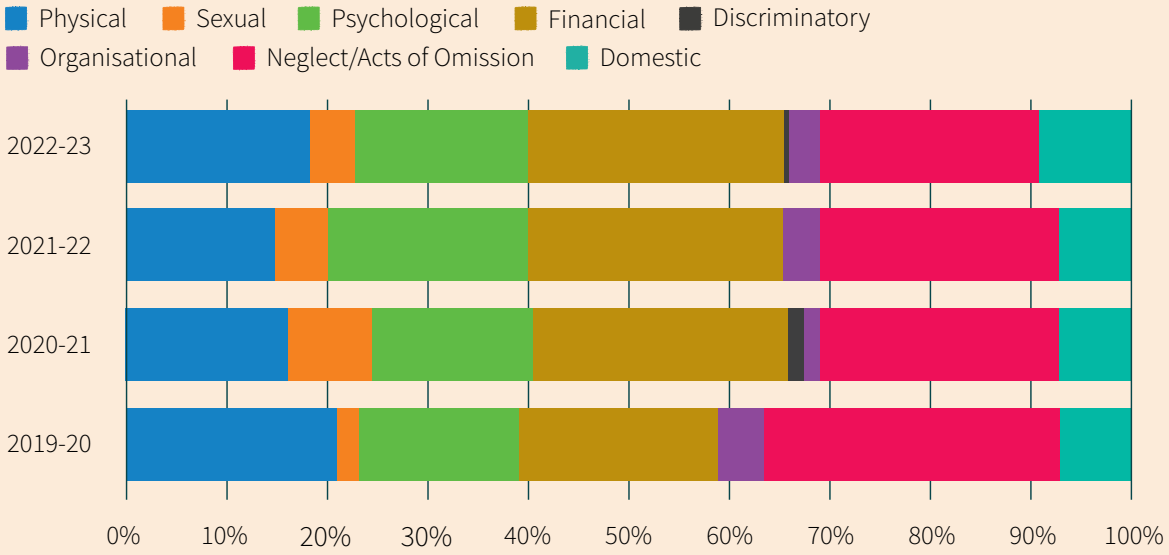


The ethnic diversity of the individual adults at risk was closer to that of those receiving long-term care and support than to the general adult population. But it is difficult to make a direct comparison as in a large proportion of cases the ethnicity of the adult was not known. In many cases this is because the individual has not previously been known to adult social care. Work is being done to address equality, diversity and inclusion issues within the safeguarding systems which includes the Staying Safe project which is which is described in the Community Engagement Chapter of this report.

Types of risk or harm alleged – A comparator over the last 4 years

More allegations of domestic abuse and financial abuse.

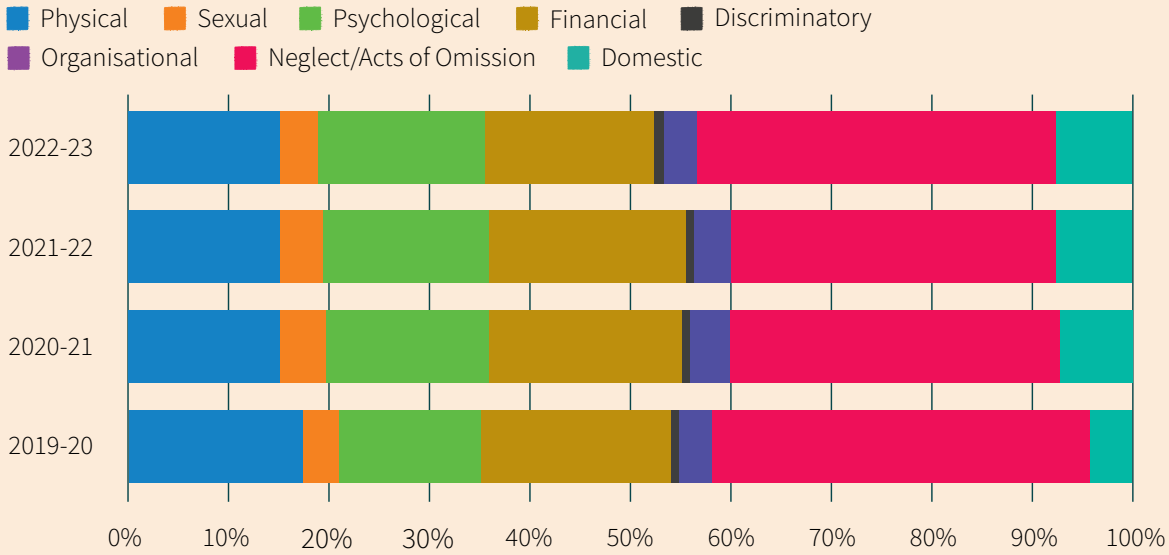
The frequency with which different types of abuse were alleged – WCC



Safeguarding concerns may involve allegations of more than one type of harm or abuse. The table above shows the frequency with which different types of abuse were alleged for those S42 enquiries which were completed in the last four years. Over this period proportionately fewer enquiries have involved physical abuse and neglect or acts of omission, while proportionately more have involved financial abuse and domestic abuse. This is an interesting move away from health and social care staff reporting abuse related to a commissioned service towards abuse normally associated within a person's own home. The rise in financial abuse safeguarding concerns against the elderly has been a key project for the board and its partners for the last 2 years and remains high on the agenda of the Safeguarding Ambassadors in their raising awareness campaigns. People over the age of 65 are particularly at risk given that many are seen to have substantial savings.

London comparator sees some increase in domestic abuse

The frequency with which different types of abuse were alleged – London.

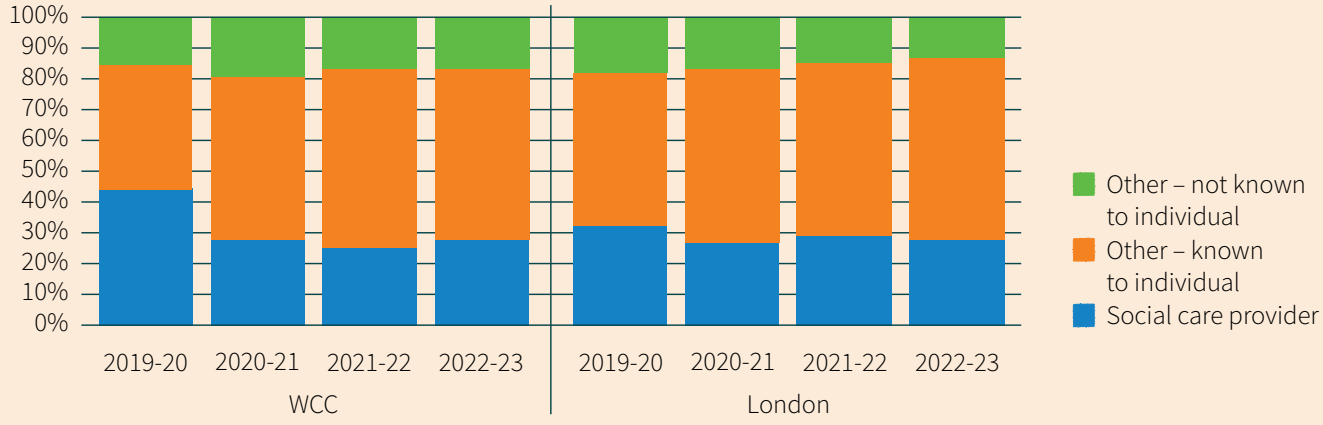


This contrasting trend in neglect/acts of omission and domestic abuse has also been reflected across London to some extent, although across London as a whole neglect/acts of omission account for a higher proportion of the allegations raised . We know that Westminster has relatively few care homes in its borough compared to other councils which may account for this difference.

The source of risk

Reduction of abuse coming in from Care Homes and Home Care.

Whether the source of risk was a social care provider or someone else, and, if someone else, whether they were known to the adult at risk.

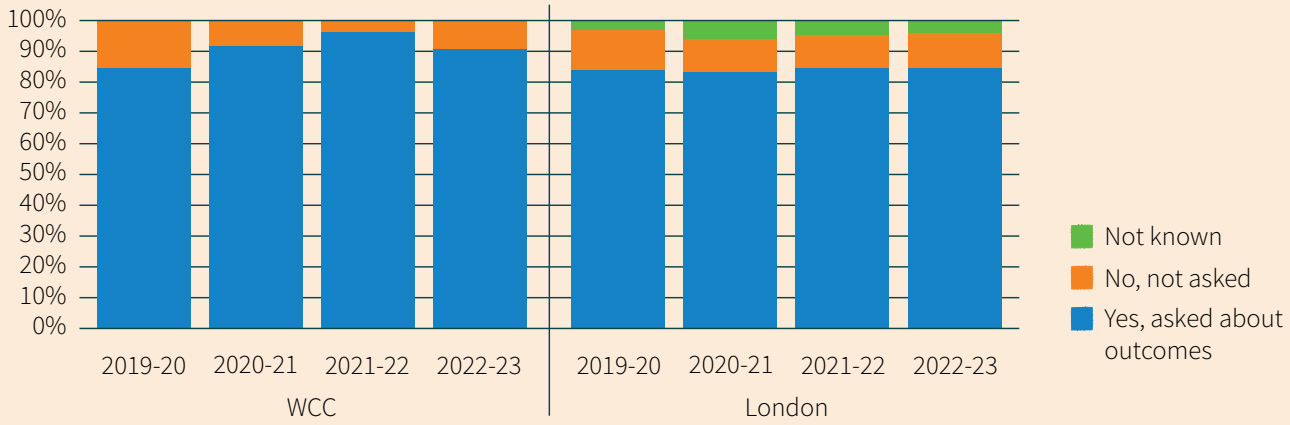


Neglect and acts of omission are most often associated with providers of adult social care such as a home care agency or care home. Consistent with the trend noted above there has been a decline in WCC and across London in the proportion of S42 enquiries completed where a social care provider was the source of risk, and a corresponding increase in the proportion where the source of risk was not a social care provider but was known to the adult at risk, for example a family member.

The Adult at risk and their outcomes

Good outcomes results above London Average

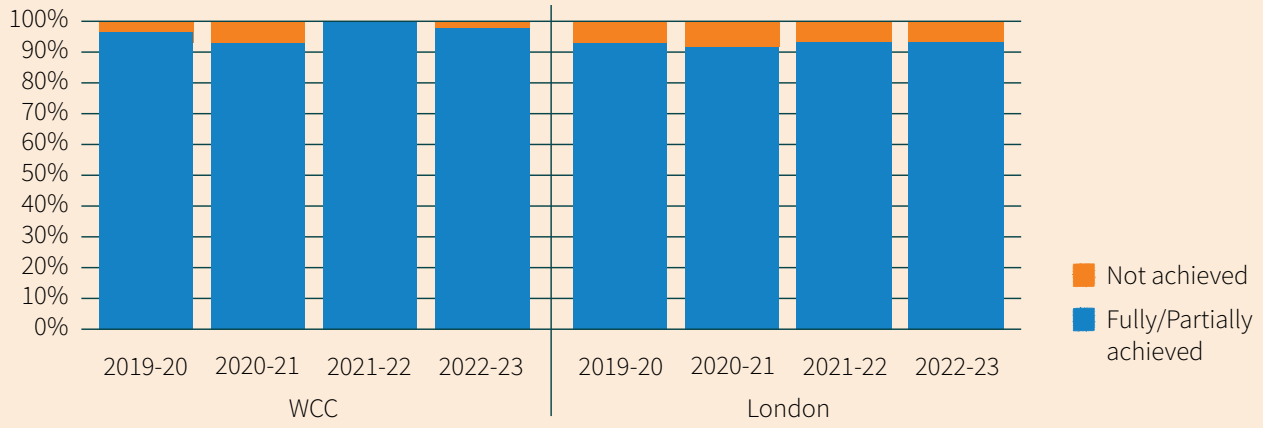
Whether the adult risk, or their representative, was asked what their desired outcomes were.



A central theme of Making Safeguarding personal is about building relationships. The adult at risk should be at the centre of activity. In the case of safeguarding this means having conversations with people (or their representative) about how to respond in safeguarding situations in a way that promotes involvement, choice and control as well as improving quality of life, wellbeing and safety.

Over the last three years in at least 90% of completed S42 enquiries the adult at risk or their representative has been asked what they would like to achieve through the enquiry. This has been consistently above the London average.

Whether the desired outcomes were achieved



It will not always be possible to achieve the outcome the adult would wish for and sometimes it can only be partially achieved but over the last four years in over 90% of completed S42 enquiries the outcomes desired were judged to have been fully or partially achieved, consistent with the outcomes across London as a whole.

SAEB Quality Assurance

In this section:

- Best practice partnership guidance
- Annual Health checks for people with a disability
- Training Assurance
- Accurate application of the Mental Capacity Act

Quality Assurance in adult safeguarding is about assessing the quality of the work we undertake as a partnership to Safeguard vulnerable adults and understanding the impact of this work in terms of its effectiveness in helping to keep vulnerable adults safe.

Effective quality assurance will contribute to a culture of continuous learning and improvement. In this section we have quality assured a number of partnership systems to support making safeguarding personal and to ensure that we keep vulnerable adults at the centre of decision making which include:

- Best practice partnership guidance on how to make a good quality referral
- Assurance from NHS North West London on Annual Health checks for people with a disability
- Safeguarding Training assurance from NWL Integrated Care Board
- Guys And St Thomas NHS Foundation Trust accurate application of the Mental Capacity Act

Best practice partnership guidance on how to make a good quality referral

A Safeguarding Audit commissioned by the Safeguarding Team exposed areas for improving the quality of the safeguarding referrals across the partnership. The data reports run on the audit findings confirmed the audit outcome and highlighted 2 areas for improvement and understanding.

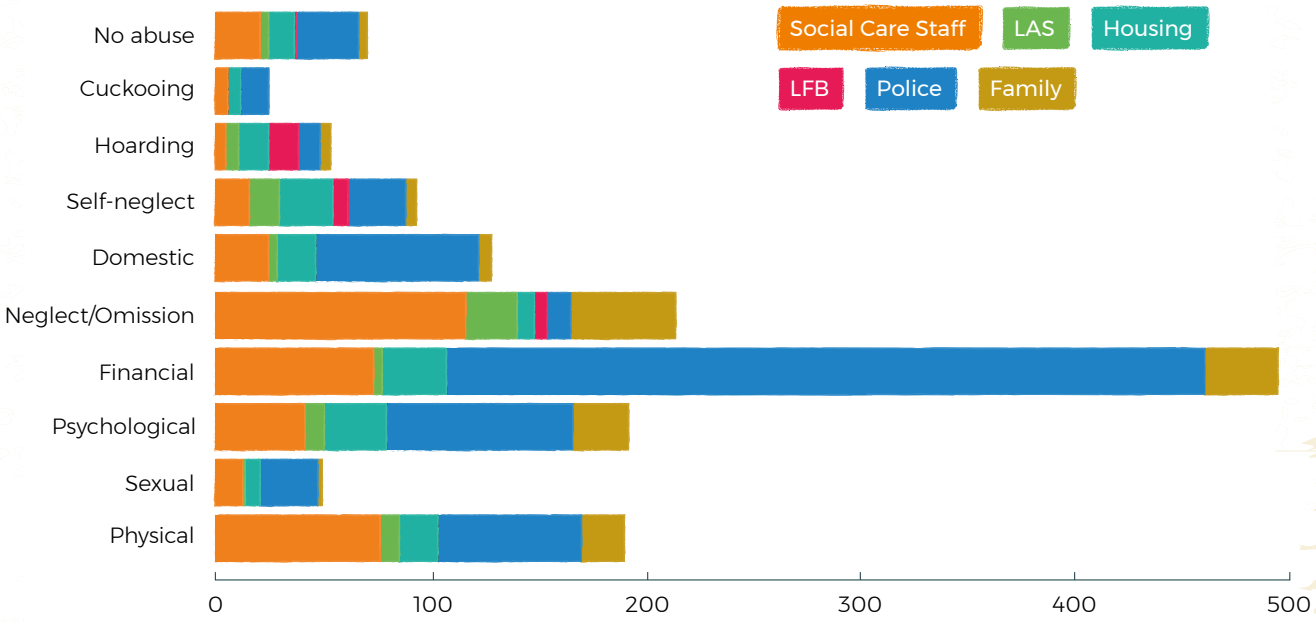
Rarely had the adult at risk been involved, or consulted prior to the safeguarding referral being sent to ASC. In the majority of cases sent to ASC teams **less than 27%** of people had been asked or informed that a safeguarding referral had been made. In mental health cases this **increased to 52%**.

Types of harm alleged from referral source indicated that the abuse type mirrored the organisational remit. Health and Social care staff raised the highest number of neglect and acts of omission abuse types as did families, these were related to care being commissioned either by social services or health. Housing raised the highest number of self -neglect cases. London Fire Brigade raised the highest number of Hoarding cases.

The table below shows abuse type alleged and the organisations who made the safeguarding referral. The data tells us that organisations tend to make safeguarding referrals related to their core business possibly missing other abuse types.

Type of harm / abuse alleged by referral source

1 April 2021 to 20 July 2022



	Social Care Staff	LAS	Housing	LFB	Police	Family
No abuse	21	4	12	1	29	4
Cuckooing	6	0	6	0	13	0
Hoarding	5	6	14	14	10	5
Self-neglect	16	14	25	7	27	5
Domestic	25	4	18	0	76	6
Neglect/Omission	117	24	8	6	11	49
Financial	24	4	30	0	354	34
Psychological	42	9	25	0	87	26
Sexual	13	1	7	0	27	2
Physical	77	9	18	0	67	20

The partnership wanted to ensure that, given the data evidence, support was made available to referring organisations in considering incidents of abuse outside of their core business.

A support tool was created in collaboration with the partnership to provide guidance to assist with risk assessment and decision making in respect of safeguarding concerns. The guidance aims to support organisations to weigh up risk to support consistent safeguarding referrals. It provides a framework for multi-agency partners to assist in identifying whether abuse and or neglect is taking place, and if a safeguarding concern needs to be referred to the local authority or whether alternative actions should be considered. Key abuse types are identified against a matrix of reportable or none reportable incident situations with clear guidance.

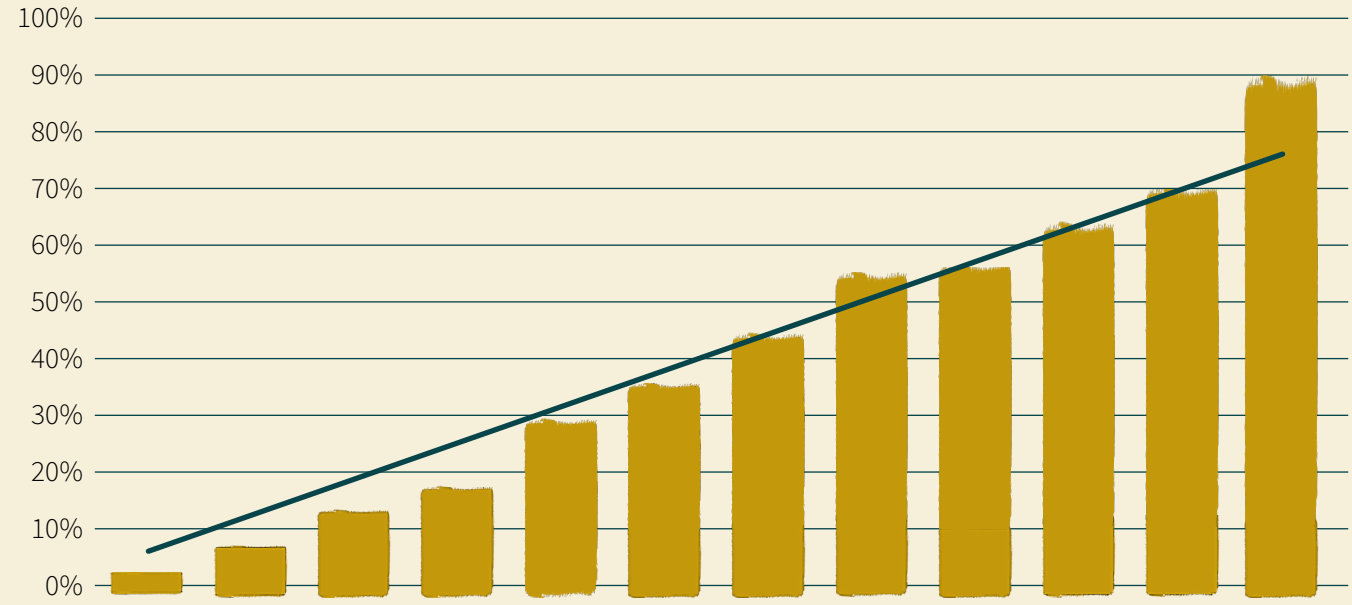
The framework can be found here on the SAEB website
Referring a Safeguarding concern. Practice Guidance (saeb.org.uk)

Assurance from NHS North West London on Annual Health checks for people with a disability

This is the third year we have reported to the SAEB on our Annual Health Checks of people with a disability.

We have seen an improvement in the delivery of annual health and believe that this is because we have worked more closely with our community healthcare provider and GP practices and networks to improve the training and make better the support offer. We have also worked with primary care leads to monitor progress against the national target of 75%.

Central London Annual Health Check Performance 2022/23 – Age Group 14 and over



	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
Actual	3%	7%	12%	19%	30%	35%	43%	54%	56%	61%	67%	85%
Target	6%	13%	19%	25%	31%	38%	44%	50%	56%	63%	69%	75%

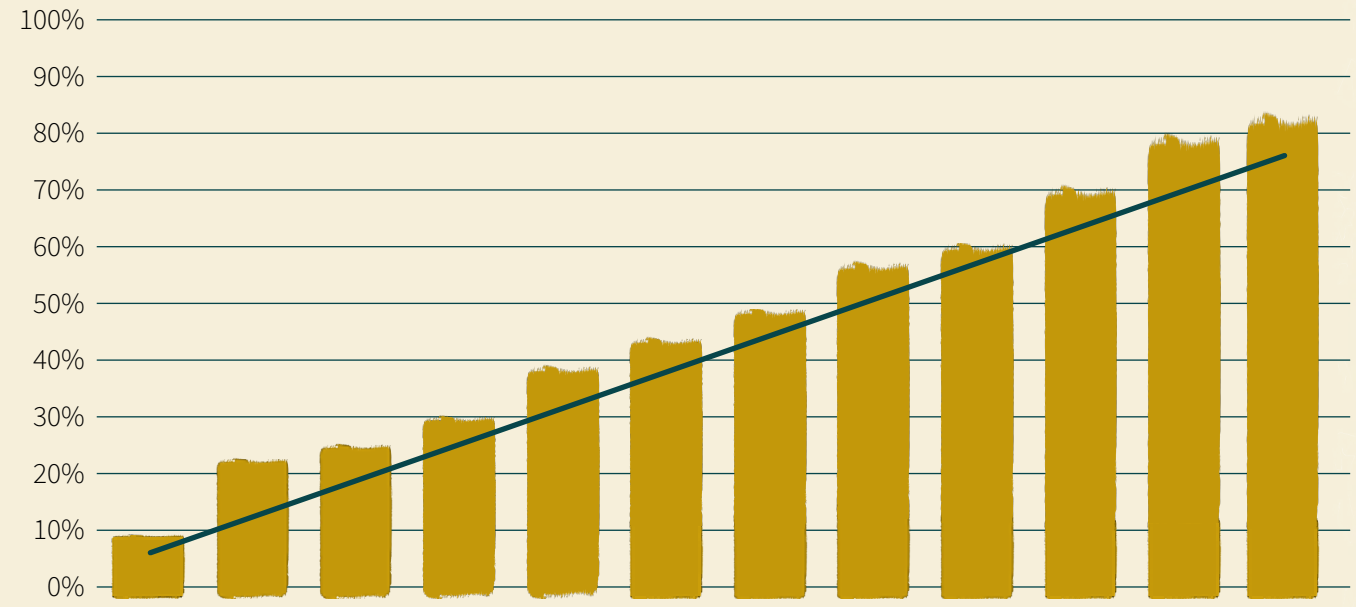
Central London

401 health checks completed from **546** on GP register this equates to **73%** completion rate which is just below the target for 2021/22.

498 health checks completed from **586** on GP register this equates to

85% completion rate which exceeds the target of **75%** for 2022/23.

West London Annual Health Check Performance 2022/23 – Age Group 14 and over



	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
Actual	10%	21%	25%	31%	39%	44%	48%	55%	60%	71%	79%	86%
Target	6%	13%	19%	25%	31%	38%	44%	50%	56%	63%	69%	75%

West London

536 health checks completed from **709** on GP register this equates to **76%** completion rate which exceeds the target for 2021/22.

621 health checks completed from **728** on GP register this equates to **86%** completion rate which exceeds the target of **75%** for 2022/23.

Next Steps

- Exceed the National target for delivery of Annual Health Checks in 2023/24
- Ensure that all health checks to be completed face to face
- Improve the Quality of Annual Health Checks and experience of patients with learning disabilities
- Work with local learning disabilities team to promote quality standards required within the Annual Health Check and health action plan
- Improve compliance with the accessible information standard

Training Assurance provided by NHS North West London Integrated Care Board

Musthafar Oladosu: Designated Professional, Safeguarding Adults. Covering Kensington and Chelsea and Westminster.

This past year has been another exceptional 12 months for our Team. The enactment of Health and Care Act 2022 has meant that much of our focus has been on ensuring a seamless transfer of the NHS NWL Clinical Commissioning Groups (CCG) to the new NHS NWL Integrated Care Boards (ICB), completed in July 2022.

ICB Safeguarding training strategy

Work to produce the new ICB Safeguarding training strategy is at an advanced stage and the document will go live in quarter 1 2023-2024. We have appointed a new Safeguarding Training and MCA Quality Assurance Manager to ensure that the organisation has a clear safeguarding training agenda covering both children and adults safeguarding, further reflecting our commitment to Think Family and Transitional Safeguarding.

Safeguarding training courses

We launched our new training programme in January 2022 and sessions delivered to date include:

- Health of Asylum seekers
- Substance misuse, Self-neglect and the Mental Capacity Act (MCA) 2005
- Human Trafficking
- Executive Functioning and the MCA 2005
- Modern Slavery
- Best Interest Assessor (BIA) Refresher Training and an Introduction to the Mental Health Act 1983.

The sessions have been opened up to colleagues across the wider ICS footprint, which has helped evidence NHS NW London ICB's commitment to promote shared learning and exemplary partnership working for the benefit of the vulnerable adults under our care.

> Great presentation. Informative, especially as I work as a Lead Practitioner/ ANP in an urgent care setting.

> It was an excellence training very powerful. A real eye opener and a reminder of the complexities of safeguarding.

> The event was incredibly well delivered by a knowledgeable and experienced practitioner. The information was relevant to my working remit and it was easy to understand and embed within my practice.

The comments above reflect the ICB's commitment to ensuring that learning from Safeguarding Adult Reviews (SAR's) are shared and embedded in practice within the ICB, wider ICS this continues to support training for GPs who contribute to local SAR's and Domestic Homicide Reviews (DHR's).

Safeguarding Health outcomes Framework (SHOF)

During 2022 – 2023 we have completed a review of the framework to ensure that the tool is smarter, minimises duplication and is fit for purpose. The new improved template will be launched in April 2023 – 2024.

The framework informs the ICB the extent to which our NHS partners are making a difference to the safety of people who are at risk of, or who have suffered, abuse or neglect in their area and has been in use since 2019. It gives the agencies the opportunity to provide a quarterly assurance report that covers an overview of safeguarding activities as evidence of how the organisations are discharging their statutory safeguarding function. The document which is joint for children and adult safeguarding sets out clearly safeguarding roles, duties and responsibilities of the organisations. It also gives the organisations opportunity to report on good practice as well as areas of challenges and how these are being addressed.

Guys And St Thomas NHS Foundation Trust Quality Assurance – Accurate application of the Mental Capacity Act

Frank Butau – Lead for Safeguarding Adults and Learning Disabilities

With the Liberty Protection Safeguards, LPS being deferred indefinitely, the opportunity to embed the MCA requirements further was recognised. Accurate application of the Mental Capacity Act (MCA) has been a focus area for the Trust.

A programme of support started with an audit of practice using one of the local SAEB audit tools. Findings include better guidance on the MCA use which has been made accessible for staff through safeguarding training, information provided via the intranet web page and via ad hoc specific training. Additional training for ward-based staff continues to be provided by the safeguarding team, with the team also supporting with assessment of capacity and best interest decision making for complex cases as and when they arise. Other areas where support has been required has included lasting powers of attorney and advanced decisions. Within the Trust we have set up an MCA implementation group looking at a programme of change to further embed the MCA requirements.

Management of allegations against staff

The last year has seen an increase in allegations against staff compared to the previous year. Improvement of staff awareness of the allegations process may attribute to the increase in reporting. 31% of reported cases investigated were unsubstantiated, 14% substantiated, 3% were inconclusive and 15% were referred via the complaints process. The remainder of the referrals did not progress due to lack of patient engagement, staff having left the Trust without any forwarding contact and the cases not progressing as allegations. The Trust has an allegations management policy and the safeguarding adults team have also developed an allegations pathway to support staff in understanding the processes involved.

Safeguarding Adult Priorities for forthcoming year include:

Developing a bespoke a patient experience tool to get the views of patients with a learning disability and their carers.

Further embedding of the MCA principles to ensure accurate application of the Act.

Policy development for sexual safety of NHS staff.

Leading, Listening and Learning

In this section:

- SAEB Learning and Development programme
- Learning from Conversations
- SAR referrals in 2022 – 23
- Transitional Safeguarding
- Safeguarding Executive Board Strategy 2022-2025

The SAEB is committed to promoting a culture of continuous learning across the safeguarding partnership, both in relation to learning from mistakes as well as celebrating good practice.

This year we demonstrate our learning from listening to families involved in safeguarding situations and ensure their messages are central to developments in our systems, ways of working and understanding from their perspective and how they felt about the situation .

Section 44 of the Care Act 2014 states that we must carry out a Safeguarding Adults Review (SAR) if certain circumstances are met. This is so that we can learn lessons where an adult with care and support needs has died or been seriously harmed, and abuse or neglect is suspected. These reviews are not about apportioning blame or holding organisations to account – rather the focus is on tackling barriers to good practice and preventing similar harm from occurring again in the future. Talking to the family or close friends is central to this process .

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

The Safeguarding Adults Case Review Group (SACRG) is a well-established subgroup of the SAEB whose members bring extensive safeguarding experience and skills. The group is chaired by Catherine and Trish who bring a wealth of knowledge and expertise.

The purpose of the group is to undertake the statutory function of the SAEB to:

- Consider and make recommendations in respect of SAR referrals.
- Commission and coordinate SAR activity.
- Develop and implement action plans to respond to learning and recommendations from reviews to facilitate improvements and organisational change.
- Share learning from local and national SARs and other reviews and ensure this supports workforce development and that changes are embedded into frontline practice.

Key achievements this year

- A new **SAR Protocol and Guidance** was published in June 2022, and has provided a more consistent framework for managing our SAR process.
- **Launch of our Board Website** which hosts a wealth of information to include a professional's zone, which contains a range of practice guidance, learning briefings on a range of safeguarding topics, toolkits and other safeguarding resources to inform and support good practice in Adult Safeguarding.

SAEB Learning and Development programme

The SAEB acknowledged that additional work was needed to develop a partnership response to learning where we could share and embed learning from SARs.

We are particularly proud of our new learning and development programme which has been rolled out over the last year to ensure key learning from Safeguarding Adult Reviews is getting out to the partnership and down to front line staff. We have expanded the membership of our SAR Champions network and our representatives continue to play a key role in promoting learning briefings and other SAEB resources and taking forward learning within their respective agencies. The launch of the SAEB website has ensured that partnership work with Public Health and Community Safety Partners is available to all in particular for those working in provider and voluntary and community sector organisations .

Webinars have been attended by over 200 members of the partnership. Recordings of these sessions have been published on the SAEB website as an additional learning resource in the following topic areas.

1. Safeguarding Adults Reviews and the role of the Safeguarding Adults Executive Board.
2. Rough sleeping and Homelessness : The work of The Blue Light Project in dealing with and a greater understanding of Brain Injury and Alcohol Use.
3. Learning from Safeguarding Adults Reviews: Joan's Legacy and what we have learnt from Joans Family.

Learning from conversations with Families involved in Safeguarding Adult Reviews

Joan's Legacy

Following the publication of SAR Joan written in last year's annual report we continued to work with Joan's family this year to ensure that important messages about the learning from this case are shared.

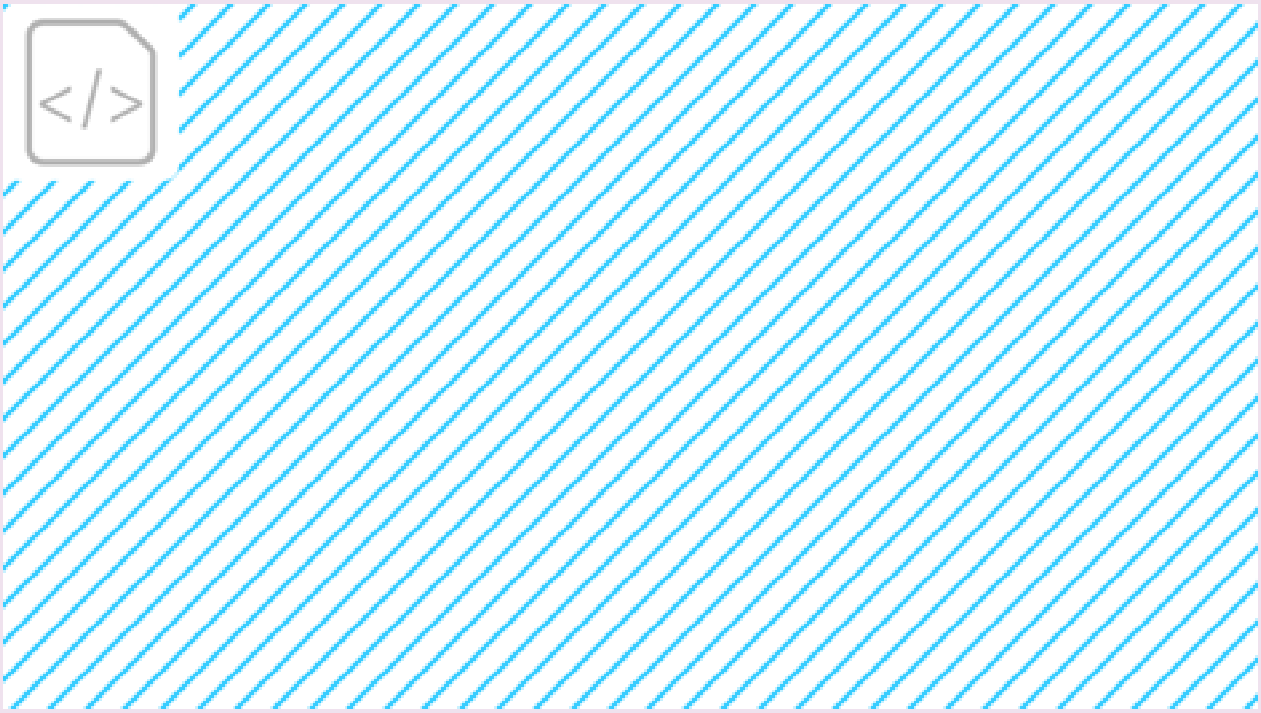
Joan's granddaughter Lesley co-produced with the SAEB 'Joan's Legacy' video, in which Lesley shares her memories of Joan and the family perspectives on Joan's experiences in the last year of her life. The video can be found **here**.

Lesley and her father, Dave also supported a webinar session attended by over 50 members of frontline staff and mangers from SAEB partner agencies. The feedback received from attendees reflected how powerful messages shared by the family resonated with practitioners, feedback is anonymous.

> "I really take on board what was discussed about Joan - listening to the person, as opposed to looking at the 'task'. This is so important and has been so powerfully delivered. I will be able to share the video and highlight the key learning points from Joan's Legacy when I am delivering training to our workforce on Safeguarding Adult Reviews."

> "The workshop has highlighted the Importance of collaborative multi agency working, talking/liaising with colleagues and ensuring good communication with both the individual and their family."

> "We need to 'Think Family' and realise the family are the system that we need to support as they support the individual."



After hearing powerful insights regarding Joan's and her families experiences, we asked what they would share forward to improve practice. This is what our partnership have done.

- Property Policy review to prevent patients belongings from going missing

  Imperial College Healthcare Trust

- Mental Capacity Assessment and Best Interest Policy Review to ensure that families are included in the conversation

  Imperial College Healthcare Trust

- Pressure Care Awareness

  Westminster ASC

- Glasses/hearing aids alert system

  Royal Marsden

- Hospital Discharge & Discharge Forms review with greater focus on communication between hospital and the community Health

  Imperial College Healthcare Trust

- Improvements to engagement with families

  ASC Safeguarding

- Specific Reasonable Adjustments

  Royal Marsden

- Modifying electronic patient records so that several capacity assessments can be carried out whilst assessing the patient

  London Ambulance Service

SAR referrals in 2022 – 23

During 2022 – 23, the SACRG considered two new SAR referrals. These cases were taken forward as a thematic review the learning from which is described below. As well as the decisions reached on these 2 cases, decisions were made in respect of three other referrals.

The range of issues presented in these cases will inform an event which will be explored in next years annual report included:

The challenges of responding to and supporting young adults with complex mental health needs.

The impact of Adverse Childhood Experiences (ACEs) and trauma on vulnerability and risk in adulthood which will be explored.

Mental capacity, including considerations around executive as well as decisional capacity.

Learning lessons and achieving change from Fatal Fires:

Thematic Safeguarding As Review - Fatal Fires

Given the increase in fatal fire notifications received in 2021-22 a decision was made that the board would commission a Thematic Review to explore the circumstances of two men who died in fires in their own homes, as well as looking through a broader lens to consider how well fire safety improvement actions already completed by partner agencies had become embedded into practice.

The two men are referred to as Mr C and Mr D in the anonymised report.
You can read the full published Fatal Fires SAR report **here**.

The review acknowledged that whilst much work has taken place to make improvements to fire safety, gaps in practice remain, and more work is needed to enable practitioners to take appropriate actions to manage fire risks more robustly. Improvements are needed on many levels including in relation to training, having effective risk assessment tools and management plans that are shared across all relevant agencies, improving referral pathways to arrange Home Fire Safety Visits by London Fire Brigade (LFB), strengthening the processes for assessing and reviewing a person's fire safety needs following a discharge from hospital or where they have experienced a change in functioning and ensuring effective management oversight and supervision in complex cases.

The review also highlighted important learning that the Mental Capacity Act should be applied much more routinely in cases where individuals are placing themselves at high risk of serious injury or death because of their smoking habits. This requires practitioners to have confidence and skills in holding difficult conversations but also to consider the person's executive capacity and ability to carry out the decision they have outlined.

The review also identified some areas of national significance in relation to potential gaps in legal framework in relation to the challenges in striking a balance between protecting a person's wish to smoke but considering this alongside risks this may pose to others – for example those living in the same building. The SAEB is working closely with London SAB Chairs Network and ADASS for discussion on the national context and what actions are required regionally and nationally.

You can read the published Fatal Fires SAR report and learning briefing and an action plan is in place to take forward the recommendations that have been made.

Thematic Safeguarding Adults Review Learning Briefing

Learning from Fatal Fire Deaths

BACKGROUND

Over the course of 2020 the Safeguarding Adults Executive Board (SAEB) were informed of several fatal fire deaths across Kensington and Chelsea and Westminster, which led to several improvement actions being completed.

In response to two further fire death notifications in 2021, the SAEB commissioned Independent Reviewers Professors Michael Preston-Shoot and Suzy Braye to undertake a thematic review. As well as exploring the individual circumstances of the two cases the review adopted a broader approach to consider how well fire safety improvement actions already completed had become embedded into practice.

SHARING LEARNING

Learning is a key priority of the SAEB and ensures that lessons in relation to safeguarding adults support direct practice and encourages a culture of continuous improvement.

All staff and mangers are encouraged to read this briefing and reflect together with your team(s) on how the issues presented resonate within your own practice. Please also look out for the forthcoming SAEB Lunch and Learn webinar sessions planned for later in the year which will share the key learning from this review.

You can also read the full SAR report on the SAEB website.

THE REVIEW

focused on the cases of two men, referred to as Mr C and Mr D in the anonymised report. Mr C was an 85-year-old man who lived in an extra care housing scheme who died following a fire in his flat which was likely to have been caused by dropping a match whilst smoking. Mr D died at the age of 61 following a fire in his privately rented flat, in which the most probable cause of the fire was unsafe use or disposal of smoking materials whilst in bed. Both men had experienced a decline in their physical functioning in the recent months prior to their deaths.

The review examined the following areas of practice:

- What do the cases tell us about the barriers and enablers in managing the care and support needs of people with reduced mobility who continue to smoke despite ongoing risks?
- What can we learn about the challenge of identifying how reduced functional ability affects smoking risks?
- How well is mental capacity, including executive functioning, considered in working with an individual who continues to smoke regardless of the fire risks involved?
- What can we learn about the role of Registered Social Landlords in supporting people with complex needs around managing fire risks? Are there sufficient standards in place to ensure the fire safety of residents within supported accommodation who choose to smoke in their own homes?

Key findings and learning points

Learning from Fatal Fire Deaths

MEN'S CARE AND SUPPORT

Amid all the efforts made to meet the men's care and support needs, attention to fire safety was lacking.

Although the risks were noted, appropriate actions to manage the fire risks were not taken. The reasons for these omissions were a collective responsibility across agencies, and included:

- A lack of information sharing between agencies.
- An absence of adequate training in fire risk management.
- Challenges in the process for assessing and reviewing a person's needs following discharge from hospital.
- An absence of prompts within assessment documentation to support practitioners to consider and manage challenges of managing fire risks.

MENTAL CAPACITY

Assessing mental capacity should be a much more routine step in practice where individuals are placing themselves at high risk of serious injury or even death, including in relation to fire risks.

In line with the Mental Capacity Act 2005, a person's mental capacity should be established if there are concerns over their understanding of risks in relation to their smoking habits and/or ability to give informed consent to planned interventions and decisions about fire safety measures.

EXECUTIVE CAPACITY

It is also important to consider a person's executive capacity in relation to fire and smoking risks – i.e. their ability to carry out the decision they have outlined.

For example, an adult may tell you that they are able to extinguish a cigarette safely when smoking in bed, but their ability to respond safety in the actual moment of putting out a cigarette may be impaired. In the context of undertaking mental capacity assessments good practice is for practitioners to ask adults to demonstrate how they can undertake actions, such as putting out a cigarette when smoking in bed.

EVERYONE'S BUSINESS

Fire safety is everyone's business!

The review reflected that more work is needed to enable practitioners to put fire safety at the heart of their practice, regardless of their role or agency they work for. Improvements to training are an important part of this, but other changes are required such as:

- Ensuring that fire risk assessment and management plans are updated routinely following a change in circumstances.
- Improving referral pathways and partnership working around arranging Home Fire Safety Visits from London Fire Brigade.
- Supporting practitioners to develop skills and confidence in having important but at times difficult discussions with individuals about smoking habits and associated risks.
- Improve recording on fire safety advice provided and to ensure this is shared across all relevant agencies involved.
- Ensuring there are clear pathways for escalation of concerns about managing complex cases involving fire risks to support effective supervision and management oversight.

CHALLENGES

The review and other national SARs have reflected the challenges in striking the balance to respect a person's wish and lifestyle choice to smoke alongside considering the risk to others.

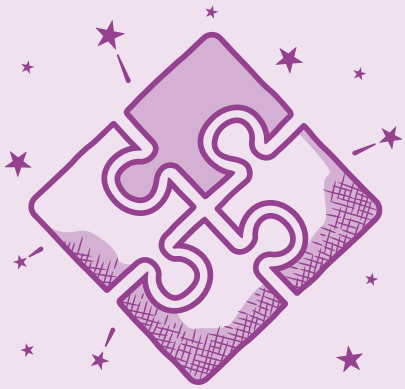
The review noted three key areas where this was relevant:

- The legal powers of housing providers (and others) to restrict activities that lead to fire risk and present risk to other residents living in the same building are not fully clear.
- Mandatory training on fire risk for care workers in registered services is not set out in law.
- Home Fire Safety Visits require the person's consent, which creates a risk that that person's refusal of consent may present a risk to others living in the same building.

What we are doing to respond to the learning

An action plan has been developed to take forward learning and make improvements to services. Areas of development include:

1. Reviewing and developing multi-agency fire safety training, and ensure training is offered across the partnership including provider services, registered social landlords, and the voluntary and community sector.
2. Building a suite of additional learning resources relating to fire safety and awareness of risks which will be available to professionals as well as members of the community.
3. Developing a multi-agency fire safety framework to provide frontline staff with practical guidance to support the effective management of fire risks. This will bring together risk assessment tools, referral pathways and provide guidance around best practice including mental capacity considerations and balancing individual rights with rights of others.
4. Seeking assurance from partner agencies that effective fire safety measures are included within relevant care and support and risk assessment documentation, that information about fire risks is shared effectively across agencies and that the recommendations from the review lead to changes being embedded in practice.
5. Raising the issues of national significance around potential gaps in fire safety law with the regional and national Safeguarding Adults Board (SAB) Chairs Network.
6. Facilitating a learning event in 2024 to track progress around practice and service improvements in fire safety practice.



Family and carer perspectives

SARs have an important part to play not only in relation to leading to change and improvements in safeguarding systems and practices, but in highlighting individual human stories and the impact upon adults and their families and carers. Mr D's informal carer was willing to participate in the review and share her perspectives.

Mr D's carer described him as "gentle, very quiet, soft, talented, generous, kind and loving" and that that his initial stroke "shattered him" and he became a recluse, not allowing anyone to support him other than accepting the help that she provided. For Mr D smoking was one of his only pleasures left in life which Mr D said was "all he had". This offered a valuable insight into Mr D as a person, and why he may have struggled to engage with formal support and the services working with him and continued to smoke heavily despite the significant risks created by his disability and change in physical functioning.

Key Points for Learning and Reflection

1. Do you fully consider fire and smoking risks when working with adults with care and support needs? Do you use risk assessment documentation to record risk factors and management actions?

2. Do you ensure information about risks and risk management is shared with all relevant agencies involved? 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?

3. Are you aware of London Fire Brigade's Home Fire Safety Checker and the process to make referrals for Home Fire Safety Visits?

4. Do you feel you have the skills and confidence to have what can be difficult conversations with adults about smoking habits and associated risks?

5. Are you confident in applying the Mental Capacity Act in practice to ensure you consider the person's mental capacity to understand the risks associated with their smoking? Do you feel confident to check the person's ability to physically carry out actions they say they can do – i.e., consider executive capacity?

FURTHER RESOURCES AND READING

To make a referral for a home fire safety visit use the online form below:

London Fire Brigade Home Fire Safety Checklist

London Fire Brigade Person-Centred Fire Risk Assessment

General enquiries with London Fire Brigade: **020 8555 1200** available Monday to Friday 8.30am – 5.30pm

SAEB Learning Briefings:

- Fire Safety and Safeguarding
- Emollients and Smoking
- Telecare and Fire

SAEB Escalation Policy

London Multi-Agency Adult Safeguarding Policy and Procedures

Mental Capacity Act Code of Practice

CONCERNED ABOUT ABUSE OR NEGLECT?

The review and other national SARs have reflected the challenges in striking the balance to respect a person's wish and lifestyle choice to smoke alongside considering the risk to others.

To raise a safeguarding adult concern, contact the Information and Access Teams:

Westminster:
020 7641 2176
adultsocialcare@westminster.gov.uk

Kensington and Chelsea:
020 7361 3013
socialservices@rbkc.gov.uk

For more information about this briefing contact:

Makingsafeguardingpersonal@rbkc.gov.uk

Transitional Safeguarding

Making the case for change in how we meet the needs of young people

The Bridging the Gap briefing published by the Department of Health and Social Care in 2021 raised awareness of the gaps that exist in current system and how this can impact negatively on the experiences of vulnerable adolescents, looked after children and others as they transition between children's and adult's service provision.

Furthermore, learning from Child Safeguarding Practice Reviews (CSPRs) and SARs nationally has highlighted issues around young people transitioning into adulthood and of the need for services to think and work differently in working with young people at risk of exploitation.

> "Transition to adulthood is a particularly challenging and vulnerable time, we may need care and support without having Care & Support needs."

> "I was in care all my life and you really did keep me safe. You wrapped me up tight in bubble wrap…. But I'm 19 now and I kind of feel like I can't move my arms."
>
> Max, care-experienced young adult

> "Now I've left care I get really lonely. That's a big thing for my safety I think, but no one talks about it as safeguarding. Unless you're worried about my child, I won't hear from you [children's services] again."
>
> Aisha, care-experienced young adult

> "I couldn't wait to get to 18. I thought that once I was an adult everything would change. It hasn't worked out that way. I really wish I was a kid again so that you could lock me up."
>
> Kelly, young adult

Quotes from case examples shared by **Dez Holmes**.

Dez Holmes

Director of Research in Practice

The Local Safeguarding Childrens Partnership and the Safeguarding Adults Executive Board has agreed to look at Transitional Safeguarding and sought support from Dez Holmes.

Dez is the Director of Research in Practice and champions evidence-informed practice across the children's and adults social care sector. Her particular areas of interest include adolescence, risk, and resilience, safeguarding and participation. She co-authored Mind the Gap, Bridging the Gap and That Difficult Age and leads national work in this area. Dez chairs the Contextual Safeguarding Advisory Group and leads the Tackling Child Exploitation programme. Dez shared key messages from research, encouraging us to think about how we can work together to better meet the needs of older adolescents as they make the transition from child to adult services in social care, education, health and beyond.

At a local level we had reviewed cases that have made us reflect upon just how important this issue is. Making the transition to adulthood is difficult for everyone but can be especially challenging for young people who are vulnerable or leaving care. We recognise that many young people are coming to this transition with a history of having experienced other transitions which impact on the way in which they face moving from children to adults' services across education, social care, health, and the criminal justice system.

Transition into adulthood is recognised as a particularly challenging time for many people, however it is recognised that there is not necessarily robust support in place to support this cohort of young people. Key to this is the fact that support can often end abruptly at 18 as young people are no longer defined as children but equally, they are not eligible for statutory safeguarding adults support or adult social care as they do not have 'care and support needs' as defined by the Care Act 2014. This leaves a situation whereby vulnerable adolescents can 'slip through the net'.

One of the key barriers is around the adult's and children's services not being designed to meet the specific needs of adolescents .Many adolescents will not meet the criteria for adults' safeguarding or social care services, and the right to make unwise decisions may be interpreted in a way that leads to them not being supported. Similarly, it was noted that child protection services are not designed to meet the needs of adolescents who may be at risk of extra-familial harm – any local areas are striving to develop new approaches e.g., Contextual Safeguarding. The research notes that adolescents often present as 'imperfect victims' on the basis that they may partake in risky behaviour, or they may not be compliant when challenged. Consequently, vulnerable adolescents can often be perceived as making unconstrained 'lifestyle choices' and therefore can be subtly or overtly deemed responsible for their own abuse. This can result in them being denied support or also have their choices marginalised.

Who is at risk?

It is recognised that the following groups may require safeguarding or support services in early adulthood but may not access this due to ineligibility or lack of engagement:

- Those with limited qualifications
- Young parents / first time parents without support
- People affected by socio-economic factors such as limited Income / Employment / literacy / Housing
- Local Context (pockets of deprivation / affluence)
- Young people ensnared in or at risk of criminality and/or serious youth violence particularly young males
- People from Black and other minoritised backgrounds facing structural and interpersonal discrimination
- People who are LGBTQ
- People who come from the faith community
- Those young people with mental health needs – particularly where these might not constitute a formal diagnosis
- Social media impact – eating disorders
- People who may be stigmatised by the general public or their local community such as Gypsy Roma Traveller groups
- Young people affected by grooming, coercion or manipulation

Some research highlights that development of those areas of the brain concerned with higher order cognitive processes and executive functions, including control of impulses and regulation and interpretation of emotions, continues into early adulthood; the human brain is not 'mature' until the early to mid-twenties.

In the Bi-Borough we have worked closely with our colleagues from the Local Safeguarding Children Partnership (LSCP) and made good progress over the past year to start to develop our framework which will inform changes to how we work with young people aged 16 – 25 at risk.

A transitional safeguarding steering group was set up in July 2022, with representatives from both partnerships to establish evidence as to what our local need is across Kensington and Chelsea and Westminster, consider how effectively our current services and systems are in identifying young people at risk and what support we currently offer. These discussions have supported the development of a project plan, which is helping the Board to explore opportunities to share more effective ways of working which will have a positive impact on young people's lives and to help them to stay safe into adulthood.

The implementation of the project plan with a focus on understanding local needs, listening to the voice of lived experience and raising awareness about transitional safeguarding amongst SAEB members as well as front-line staff and managers is underway. The progress of the project plan will continue to be monitored by the SAEB and its findings will be reported in next year's annual report.

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.

Making Safeguarding Personal

Safeguarding Ambassadors are the Boards Super Heroes.

They continue to play a lead role in bringing safeguarding risks to the attention of the Board and support ensuring that Making Safeguarding Personal is a golden thread throughout all the work that we do.

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

1. improve awareness of safeguarding across all communities.
2. culturally competent safeguarding and support.
3. close working with the voluntary sector.
4. listening and collaborating with service users by experience.

Strategic Priority 1

Leading, Listening, Learning

Aim: To promote a culture of continuous learning across our Safeguarding partnership where we recognise and support the challenges to learning particularly within our Safeguarding Adult Review process.

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.

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

Strategic Priority 2

Quality & Performance

Aim: To ensure that safeguarding arrangements for adults at risk work effectively through quality assurance mechanisms and an increasing use of multi-agency safeguarding data.

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.

1. shared safeguarding goals and wellbeing responsibilities partnership wide that seek assurance across all safeguarding agendas.
2. understanding what the most prevalent abuse types are and doing something about it.
3. 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.

Strategic Priority 3

Developing Best Practice

Aim: To ensure practitioners across the partnership, including our provider services and voluntary and community sector are equipped to support adults appropriately where abuse, neglect and exploitation is suspected or has taken place.

To promote, encourage and disseminate information about best practice, in relation to referrals, making safeguarding personal (MSP) and all frontline work.

Work to ensure that best practice is embedded across all agencies, in safeguarding adults.

Multi-agency training that promotes competency-based learning, development opportunities and best practice.

1. develop resources to support staff in helping to prevent abuse or neglect and responding to safeguarding concerns.
2. ensure the Partnership has robust and relevant multi-agency data to shape practice and priorities and effect change where required.
3. work collaboratively across the partnership on projects with a vested interest and to ensure that learning is embedded across all relevant agencies e.g Self-Neglect and Hoarding.

Strategic Priority 4

Communities Keeping Themselves Safe

Aim: To create an inclusive and diverse safeguarding culture, which is informed by what is most important to specific community groups.

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, Involvement, Prevention and Early Intervention.

1. shared safeguarding goals and wellbeing responsibilities partnership wide that seek assurance across all safeguarding agendas.
2. understanding what the most prevalent abuse types are and doing something about it.
3. 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 Collaboration of Clinical Commissioning Groups (NWL CCGs)
- 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)
- Local Account Group and Safeguarding Ambassadors

Financial Contributions

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.

In the Bi-borough we benefit greatly from representation from all organisations to our subgroups and Financial Contributions. Thanks goes to

- The North West London Integrated Care system (NWL ICS) contribution of £20,500.00 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.

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.

Our members

- London Fire Brigade
- Adult Social Care and Health
- Metropolitan Police
- North West London Collaboration Integrated Care System (NWL ICS)
- 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)
- The Royal Marsden NHS Foundation Trust
- Imperial College Healthcare NHS Trust
- The Advocacy Project
- Community Safety (Local Authority)
- Westminster City Council
- Housing (Local Authority)
- Royal Brompton and Harefield HNS Foundation Trust
- Department of Work & Pensions
- Trading Standards
- Public Health
- Adult Social Care (Local Authority)
- Local Account Group
- Healthwatch Central West London
- Chelsea and Westminster Hospital Foundation NHS Trust
- Royal Borough of Kensington and Chelsea

> If it just doesn't feel right, tell someone.

Rose Hayles

Safeguarding Ambassador, Local Account Group Member shares her views on safeguarding residents of the Bi-borough

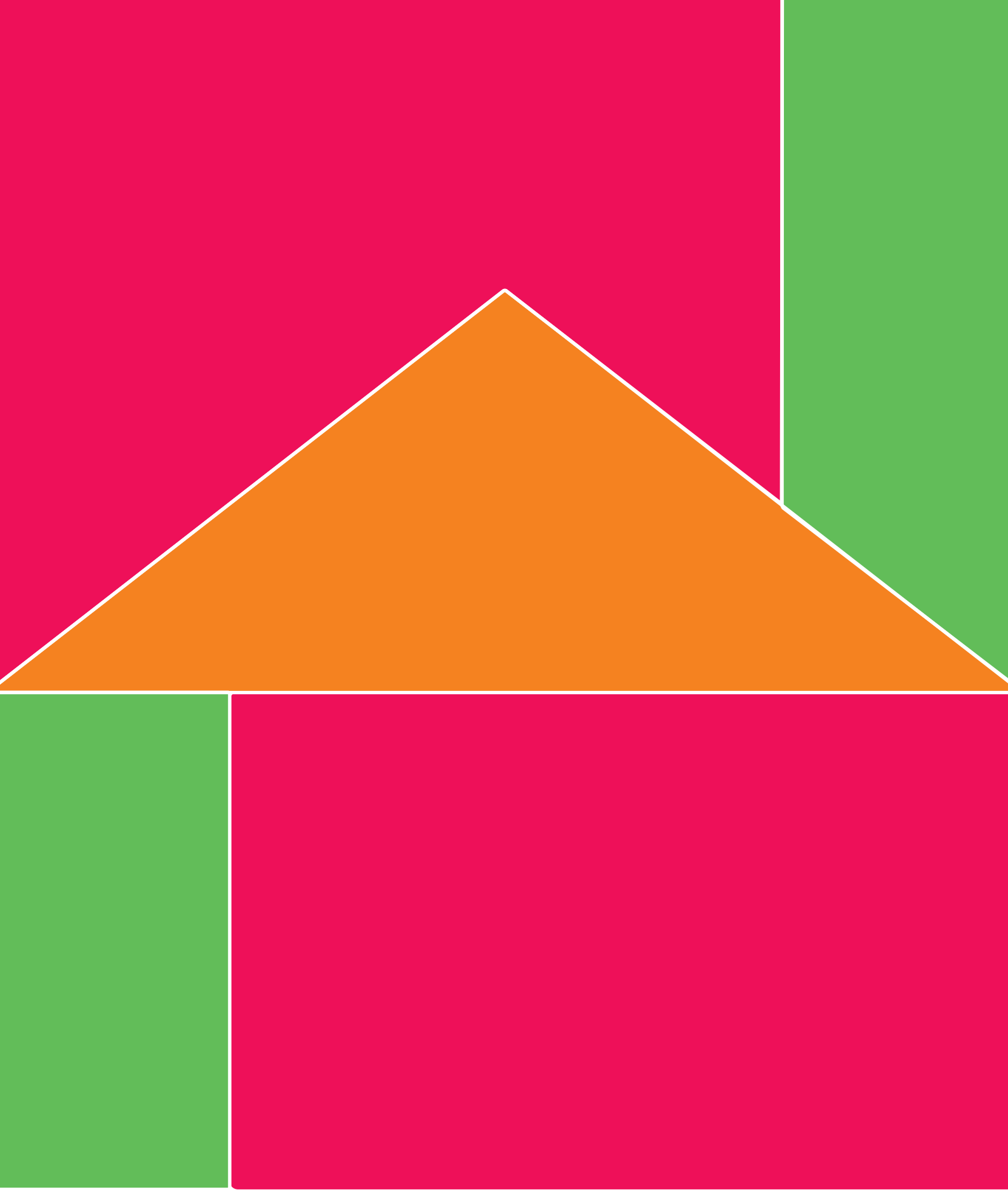
Safeguarding is about protecting adults from abuse and neglect, which can be physical, emotional, sexual, and financial.

It can be hard for people to talk about what is happening to them but they may disclose abuse to you and forbid you to tell anyone else. They are often subjected to pressure and fear of the consequences. However, if you feel that this person is experiencing, or at risk of, abuse or neglect and is unable to protect themselves and **if it just doesn't feel right, then please tell someone.** We can all help people to stay safe from abuse by being curious so if you notice something or if someone raises a concern, listen and if you see anything that just doesn't feel right, you can tell someone.

Who can you tell?

- Your Family
- A Police Officer
- Adult Social Care
- A Friend or Someone you Trust
- A Nurse or Doctor
- Anyone that supports you

Your role is not to investigate or enquire, just be curious and pay attention to how people look and behave.



THE ROYAL BOROUGH OF
KENSINGTON
AND CHELSEA

Safeguarding Adults
Executive Board

City of Westminster