Kingston Safeguarding Adults Board

THE ROYAL BOROUGH OF KINGSTON UPON THAMES

Kingston Safeguarding Adults Board

Annual Report 2022-2023

METROPOLITAN POLICE

NHS South West London

FAIRER KINGSTON · FAIRER KINGSTON

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1. Chair's Foreword

Welcome to the Kingston Safeguarding Adults Board Annual Report for 2022-2023.

In July 2022, I was privileged to commence my role as Independent Chair for the Safeguarding Adults Board. I would like to thank Peter Warburton, Designated Nurse for Safeguarding Adults, who chaired the Safeguarding Adults Board admirably between 2021-2022.

When I commenced my role, I was immediately struck by the commitment of Safeguarding Adults Board members to find ways to do the best in safeguarding adults throughout Kingston, without the use of extensive resources.

I joined the Safeguarding Adults Board following an independent review of the Board's systems and processes. The reviewer recognised that Kingston SAB had a *"committed, talented and broad-based partnership"* which should be celebrated and that there had been considerable achievements which could be strengthened through improved resources.

In particular, the reviewer commented on how Kingston Safeguarding Adults Board and Healthwatch Kingston have led the way for making the voices of people with lived experience heard. I want to use this as the basis of the Safeguarding Adults Board's assurance processes for the future.

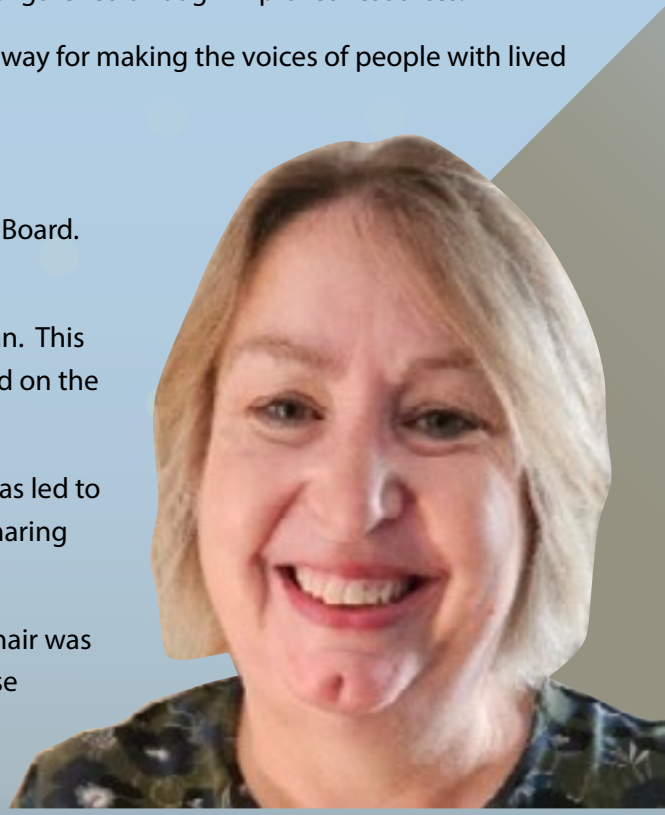
The reviewer made recommendations in relation to:

Leadership and Governance: develop an Executive Group to guide the overall strategic direction of the Safeguarding Adults Board. This has been achieved and has enabled the main Safeguarding Adults Board to focus on the strategic priorities.

Assurance and Accountability: to use a development day to refresh the Safeguarding Adults Board strategy and business plan. This has been achieved. However, we have more to do in developing our thinking in relation to an audit strategy. We have worked on the communication plan but need to refresh the Safeguarding Adults Board webpage to make it more accessible.

Funding and Capacity: there has been recognition of the need for more support to manage the SAB. I am pleased that this has led to the agreement for the recruitment of a Board Business Manager. The Safeguarding Adults Board is also looking at ways of sharing resources with neighbouring SABs, where it would be of benefit.

In addition to working on the findings from the Safeguarding Adults Board review, one of my first actions as Independent Chair was in relation to facilitating the publication of the three Safeguarding Adult Reviews (SARs) that are included in this report. These reviews were undertaken during the height of the Covid-19 pandemic which meant there were considerable challenges to bringing agencies together to obtain the most productive learning. I thank the reviewers for their work on the SARs and



for the learning they have provided. I have used these as the focal points for the two SAB meetings I chaired in the latter half of 2022-2023. SARs can provide a window on the system in Kingston and so these are good starting points for the refreshed SAB to gain assurance that safeguarding meets the Care Act 2014 requirements.

For two of the SARs, the full reports were published; for one SAR, an executive summary was published. It is the decision of a SAB to determine whether the wider learning is best achieved through full publication or executive summaries. It is vital that the wider learning is taken forward beyond the individual's experience.

I am pleased that the Executive Group of statutory members (Local Authority, Police and ICB) has been established. This group has supported me by acknowledging the need for a Board Business Manager who can facilitate the work of the SAB, especially in taking forward the learning from SARs, commissioning of new SARs, and refreshing the SAB structure of workstream/sub-groups. As we end 2022-2023, I would especially like to thank Andrew Wadey, Detective Superintendent, Public Protection Lead South West Borough Command Unit, who is moving on. Additionally, as this annual report has been completed, I was saddened to hear that Sharon Houlden, Executive Director for Adult Social Care, has been unwell, and has decided to take retirement. Sharon has been extremely enthusiastic and responsive to my ideas for the SAB development. On behalf of the SAB, I would like to wish her all the best for her future.

This means that 2023-2024 will be a time for continuity and change, developing new structures, as agreed at the Development Day in December 2022, and working with some new colleagues. I look forward to working with the executive leadership across the strategic partners. I am pleased that Fergus Keegan, Director of Quality for the ICB, will be continuing to be the strategic lead for health, and with other SAB members, will provide consistency to the Board.

Additionally, the SAB will be monitoring the progress of the Local Authority in demonstrating, under the Clinical Quality Commission (CQC) duty to assess, how they are meeting their social care duties under the Care Act 2014. The SAB will take a specific focus on how the diversity of the population is reflected in the work of all partners, to ensure that there is equity across the borough.

I would like to endorse this report and hope that the citizens of Kingston recognise the commitment and work that the agencies have achieved to promote the safeguarding of adults who are at risk during the Covid-19 pandemic and international events since then.

Nicky Brownjohn
Independent Chair for Kingston SAB

2. What is Adult Safeguarding?

The Care Act 2014 put adult safeguarding on a legal footing. 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, including, where appropriate, having regard for their views, wishes, feelings and beliefs in deciding on any action.

The Care Act 2014 requires Safeguarding Adults Boards to hold partner agencies to account for how they work together to protect adults from abuse and neglect.

Types of Abuse

It is the responsibility of all agencies to recognise and respond to indicators of adult abuse or neglect. When there is a concern that an adult with care and support needs is unable to protect themselves when experiencing or at risk of abuse or neglect, then the local authority has a responsibility to undertake an enquiry under section 42 of the Care Act 2014. This will involve any agencies working with the adult. The adult will be central to the enquiry, with their views being integral to the work.

3. What to do if you are concerned about an Adult at Risk

If you have a concern regarding an adult, and it appears that the following 3 points are met, complete the online web-based Safeguarding Adults Concern form here.

An adult who:

- Has needs for care and support (whether or not the Local Authority is meeting any of those needs)
- Is experiencing, or at risk of, abuse or neglect
- As a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

The Royal Borough of Kingston Adult Social Care Safeguarding & Access Team can be contacted on:

Telephone: **020 8547 5005**

Email: **adult.safeguarding@kingston.gov.uk**

Out of Hours: 020 8770 5000

If it is a criminal offence, please contact the police on 101 or if an emergency on 999.

4. Hearing the voices of those with lived experience: What we have done/ What we need to do

At the KSAB Development Day in December 2022, the Board members committed to have a golden thread of the voice of those with lived experience throughout the SAB work. In January 2023, the SAB asked members to talk about how their agency learned from feedback from individuals and their families. We used the Connie Safeguarding Adult Review as a basis for our reflections. There is more to do for 2023-24:

Every SAB will feature lived experience through SAR learning or Healthwatch	**Develop the Communications Strategy**	**Contact community groups to raise awareness of safeguarding**	**Continue the Making Safeguarding Personal project**

5. Making Safeguarding Personal – Healthwatch Kingston MSP Project

The Royal Borough of Kingston upon Thames (RBK) Adult Social Care Service has previously commissioned Healthwatch Kingston to collect independent feedback from people who have experienced engagement with the Kingston adult safeguarding process. This commission continued successfully during 2022/23, under Kingston Safeguarding Adults Board.

Healthwatch Kingston co-produced with Adult Social Care a survey tool which set out to find out:

How involved people felt during their safeguarding process	**If people felt listened to during their safeguarding process**	**If people were happy with their outcomes**	**What helps people feel listened to, involved and happier with their outcomes.**

Overall response

People happier and safer after receiving support from Adult Social Care

More can be done to improve including people in the process: all agencies communications, advocacy offer

Due to be published, read the Healthwatch Kingston Making Safeguarding Personal End of Year Report 2022-23 here.

6. KSAB Vision and Principles

Our Vision for individuals within the community of Kingston is to be able to live a life free from abuse and neglect.

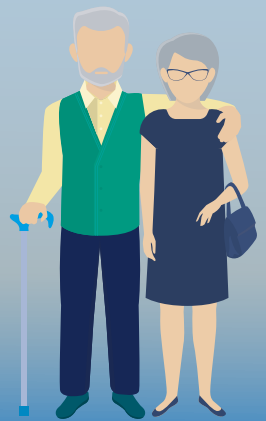
Over the past few years the KSAB has developed a common objective and 9 key principles.

6.1 KSAB Common Objective

In the 2019-2021 strategic plan, the KSAB agreed to commit to a common objective. This will remain in place for 2023-2025:

- To continue to build and strengthen the partnership through all staff across all agencies being assigned the same objective.
- The objective is given to each member of staff by their line manager, and their input and activity to meet the objective is monitored and assessed through supervision and the agencies annual appraisal system.
- The objective sets out how individuals can:
    - Demonstrate an understanding of Safeguarding within their role;
    - Be proactive in identifying people at risk
    - Take responsibility, assess and take positive action to keep people safe
    - Fully report and refer, both internally and to relevant partner agencies

The common objective has also been complemented by the 9 key principles.



6.2 Kingston SAB 9 Key Principles (developed by the Communications workstream/sub-group)

1. We believe that safeguarding is everyone's business.
2. We commit to safeguarding and promoting the wellbeing of adults
3. We will act in partnership with other key agencies to take action without delay when abuse or neglect is suspected.
4. We know how to recognise and report safeguarding concerns and issues.
5. We believe that adults should be involved in all decisions affecting their lives with choice and control in how they live their lives.
6. We support adults, families and advocates to understand and engage in safeguarding processes and enquiries.
7. We will ensure that outcomes of safeguarding enquiries are meaningful to all adults and their families
8. We promote a culture where safeguarding is openly discussed, and training is encouraged.
9. We learn from reviewing our safeguarding practice and embed this into our practice.

From these principles every member of the KSAB was asked to pledge their commitment to safeguarding adults

Quotes from Pledges

7. SAB Development: Strategic Plan and Priorities

7.1 Strategic Priorities

In December 2022, the SAB members came together for a development session. This enabled the SAB to reflect on what is done well and where it needed to strengthen its approach. Each member committed to the 9 key principles.

The following comment by the Executive Director for RBK summed up the thinking for the day that the SAB commits to:

"Working in partnership to do the best we can for the citizens of Kingston"

7.2 Statutory Duties of the Safeguarding Adults Board

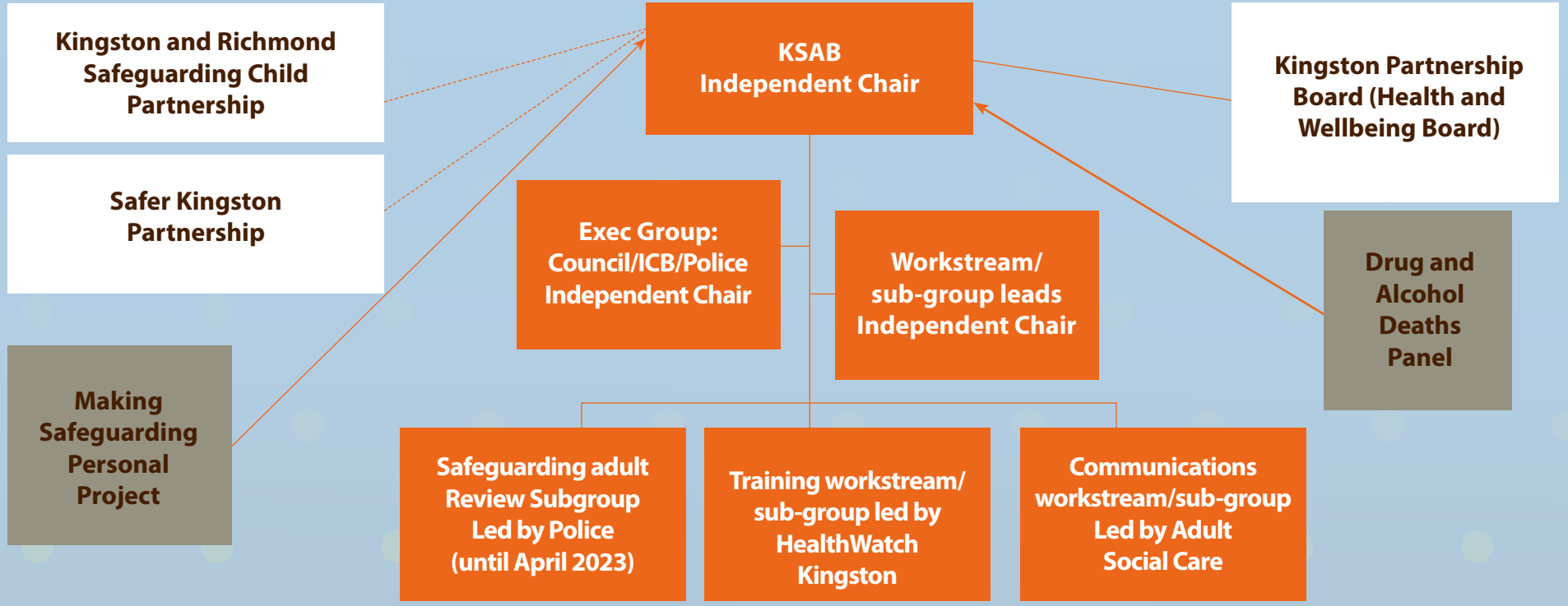
- To publish a Strategic Plan that sets out what the board has achieved and what it aims to achieve for the next year
- To publish an Annual Report detailing what the SAB has done during the year to achieve its main objective and implement its strategic plan, and include learning from any Safeguarding Adult Reviews
- Carry out Safeguarding Adult Reviews

7.3 Strategic Priorities for 2023-2025

The SAB has agreed the following priorities for 2023-2025. These will form the basis of the SAB work plan and agenda. The priorities will be reviewed annually.

1. Adults at Risk are at the core of all prevention work undertaken by the Kingston Safeguarding Adults Board
2. Improve the outcomes for those individuals who have experienced abuse or neglect by committing to the 9 key safeguarding principles for Kingston
3. Use the learning from Safeguarding Adult Reviews to continually improve practice across Kingston-We learn from reviewing our safeguarding practice and embed this into our practice.

8. Kingston SAB Structure and Partnership Links



This shows the structure of the SAB including its subgroups and other groups that report into the SAB. The white boxes show the links with other Kingston Multi-Agency Partnerships.

9. SAB Work and Achievements

9.1 Overview

Safeguarding Adults Agency Pledges	**Self Neglect and Hoarding Guidance**	**Agreed Priorities and strategic plan for 2023-2025**
New Independent Chair in post	**Making Safeguarding Personal Project**	**Safeguarding Adult Reviews published**
Informed Kingston Suicide Prevention Strategy	**Training Strategy**	**Learning from the deaths of people who have struggled with substance misuse**

9.2 Training and Communications workstream/sub-groups

- In 2022/23, and post pandemic, for the Training workstream/sub-group, attention shifted towards reviewing and revising the partnership Training Strategy, which was re-published in September 2022. The purpose of the strategy is to underpin the importance of learning in each partner organisation and across the partnership as a whole. A well-trained workforce, responsive to learning that stems from new policy and practice developments, is a key element of safe practice. It is the Board's ambition that the partnership becomes a learning community confident in its full understanding of adult safeguarding and able to demonstrate appropriate skills at all levels.
- The strategy recognises that partner organisations will already have training schemes in place linked to their own professional disciplines and therefore it describes expected minimum standards, the need for diverse delivery arrangements and promotion of the means to assess the impact of training.
- In December 2022, at the Board Development Day, a decision was taken to refresh the workstream/sub-group structure and instead, recognise more dynamic workstream/sub-groups. The Training workstream/sub-group is now primarily focussed on aiming to ensure that the learning from Serious Adult Case Reviews (SARs) is properly disseminated across the partnership through the targeted delivery of learning events or adjustments to courses if necessary. This work will develop further in 2023/24.
- In addition, through the workstream/sub-group programme, subject expert sessions have been planned and delivered on a variety of topics throughout the year. It is also within the scope of the programme to plan events or publicise learning opportunities that represent new practice initiatives or planned responses to local concerns.

- The workstream/sub-group programme also continues to recognise the importance of supporting the voluntary sector to deliver foundation level training and awareness raising sessions that bring the key messages of adult safeguarding to a wider community audience.
- In 2023/24 our aim is to enhance the reach of the training workstream/sub-group and develop more activity with the other SAB workstream/sub-groups and other partnerships across Kingston.
- The Communications workstream/sub-group has led on the work to develop the safeguarding pledges and has formulated a communication plan to support the work of the SAB.
- For 2023-24, the workstream/sub-group will lead on the plan for Adult Safeguarding week to raise awareness about safeguarding in the community and with businesses.

10. Safeguarding Adult Reviews(SARs)

10.1 Summary of Cases and Findings/What has changed in Kingston

Safeguarding Adult Reviews (SARs) are commissioned under the Care Act s44 when an adult dies and the SAB knows or suspects that the death resulted from abuse or neglect, and there is reasonable cause for concern about how agencies worked together to safeguard the adult.

The purpose of having a SAR is not to re-investigate or to apportion blame, to undertake human resources duties or to establish how someone died; its purpose is:

- To establish whether there are lessons to be learned from the circumstances of the case about the way in which local professionals and agencies work together to safeguard adults;
- To review the effectiveness of procedures (both multi-agency and those of individual organisations);
- To inform and improve local inter-agency practice;
- To improve practice by acting on learning (developing best practice); and
- To prepare or commission a summary report which brings together and analyses the findings of the various reports from agencies in order to make recommendations for future action.

During 2022-2023 three Safeguarding Adult Review (SARs) were completed and published on the Kingston SAB webpage. The learning from these SARs continues to be a key feature of SAB meetings to provide assurance that learning is being embedded in practice and policy.

Three further SARs were commissioned and will be completed during 2023-2024. The SAB is monitoring the progress of the SARs to ensure that any learning is enacted in a timely manner, without waiting for the completion of the reviews. A particular area of note for the SAB will be considering how referrals for SARs are being submitted and whether this is reflecting the diversity of the population.

10.2 "Ella" SAR

In February 2019 Kingston SAB agreed that Ella's experience met the criteria for a mandatory SAR because Ella had died, and it was suspected that her death was a result of abuse or neglect. There were also concerns about how agencies across multiple boroughs had worked together to safeguard Ella.

Ella died in her early 20's from heart failure. Safeguarding adult concerns had been expressed by several organisations, as, supported by her mother, Ella sought to engage with many private and NHS services to manage a range of reported health conditions that included having a brain tumour. The safeguarding concerns included whether there was an element of Fabricated or Induced Illness (FII) in Ella's presentation. Ella's post-mortem examination revealed no brain tumour. The coroner stated there was no evidence that she had any physical illness.

The KSAB commissioned the Social Care Institute for Excellence (SCIE) to undertake the review. The review was completed and signed off by the KSAB in August 2022. In line with the Care Act statutory guidance, the SAB committed to publish the learning within this Annual Report and considered whether to publish the report in the interest of transparency and disseminating wider learning. The SAB concluded that an executive summary report would provide the wider learning sufficiently to provide a 'window on the system'.

An Executive Summary was completed which was published on the KSAB webpage.

The findings focused on:

- The lack of guidance for Adult Social Care in responding to FII as an adult safeguarding issue
- Lack of guidance for GPs and other health professionals on FII as an adult safeguarding issue
- Insufficient legal literacy to support necessary intervention in cases of FII in young adults
- GPs not sharing information in cases of suspected FII in young adults due to advice from the Medical legal organisations.
- Private health providers not having centralised access to NHS GP data, preventing information sharing
- Use of system to identify and cascade concerns in the prescribing of controlled drugs.

In February 2023, the KSAB Chair and members of the SAR workstream/sub-group met with key members of the Kingston and Richmond Safeguarding Children Partnership to use Ella's case as an opportunity to learn together across the Adult and Children services, and to consider how local expertise can be developed in relation to FII. This is being progressed for a learning event during 2023-24.

However, Ella's experience was not confined to Kingston and the findings were very much focused on national learning. It is crucial that national guidance for adult social care and health professionals working with adults is taken forward. This is needed to give professionals the tools to support them in undertaking constructive investigations when there are concerns regarding potential fabrication of illnesses by adults.

10.3 "Connie" SAR

Connie was a 92-year-old woman who had experienced a long-term history of depression. She lived independently in her home after the death of her husband, with regular visits by her daughter. Connie fell in her garden in 2019 and was admitted to Kingston Hospital with an inoperable fractured left hip. Subsequently, she was discharged to a Nursing Home in Kingston with high dependency care needs and pain management. A few weeks after her admission, Connie was discovered by carers with the call bell cord round her neck and she resisted its removal. The incident did not come to the attention of her family, Adult Social Care (ASC), Continuing Health Care (CHC) and Connie's GP for some weeks. Investigations were undertaken by the agencies involved but a referral was made to the SAB for a SAR to be commissioned to consider the wider learning for agencies in how they worked together to safeguard Connie.

Connie's death, in 2019, was unrelated to the issues in the SAR. Connie's experience has been a significant feature in the learning for the whole SAB.

An independent reviewer was commissioned to undertake the SAR. The reviewer liaised with Connie's family and the multiple agencies involved in Connie's care. The conclusion of the SAR led to 10 recommendations being made in the final report. The recommendations have been grouped to support the SAB to monitor progress of actions.

10.3.1 Kingston Hospital: Mental Health Assessment and Discharge Arrangements

- Kingston Hospital already has a Quality and Improvement Project which has and is working on the discharge process (D2A), discharge summaries and nurse transfer letters to ensure that all information is shared on discharge.
- A monthly Mental Health Operational Group, which focuses on early identification of patients with mental health concerns. The group is made up of many different hospital professionals including Ward Matrons and Safeguarding Lead, there is a specific slot in these meetings to discuss any concerns on the wards. Through this group it has seen improvements/increase in staffing, with more mental health nurses, closer links between the liaison team and ward staff, better communication and sharing of information. As a result of increased staffing within the liaison team, more referrals have been accepted and advice is given to wards where there are concerns regarding a patient's mental health. Further work to be taken forward from this group is to develop a 'grab guide' which will then feed into the work being completed in relation to discharge/discharge summaries.
- A further working group is being developed which will be orthopaedic focussed and will involve, but not limited to, OT, physio, safeguarding. Part of the work from this working group will be to develop a further 'grab guide' in relation to inoperable fractures.

10.3.2 Integrated Care Board (ICB) (previously CCG): End of Life Pathway

- In relation to how the end-of-life (EoL) care pathway in Kingston meets the NICE requirements - the ICB has a self-assessment audit which highlights where each area is achieving or working towards set goals for the end-of-life care pathway. There is also a local EoL care steering group where local EoL care work and partnership working is monitored and supported as well as having a local Kingston and Richmond lead for this area.

10.3.3 Monitoring of Care Providers

- RBK ASC Commissioning have refreshed the Joint Intelligence Group which has now been renamed The Care Governance Board (CGB) and have updated ToR. The purpose of the CGB is to have a collective responsibility to oversee and manage overall quality and risk across the whole care provider market in Kingston. The chair of the CGB has previously presented at the SAB. The Commissioning Quality Assurance Team complete regular visits to care homes and nursing homes and these are completed jointly with safeguarding and ICB/health professionals when required.

10.3.4 Training in relation Mental Capacity Act/Deprivation of Liberty Safeguards

- All partner agencies should provide evidence of this training within their own organisations or to be incorporated within the review that the training workstream/ sub-group will complete within 2023 - this was originally completed in 2021.
- Care and nursing homes - requirements in relation to training is set out in the service specification for residential and nursing care service. Which is monitored through contract monitoring and quality assurance visits.

10.3.5 Adult Social Care (ASC)

- A review of the local safeguarding adults' arrangements for Kingston and Partners. Where a safeguarding concern is received regarding a person that is fully funded/ part funded under the continuing healthcare framework, the local authority will coordinate the process.
- The local CHC team will hold the Safeguarding Adults Enquiry Contributor (SAEC) role under the duty to cooperate. The local arrangements to be reviewed by the end of 2023.
- In relation to risk management arrangements, the Kingston Vulnerable Adults Multi Agency (KVAMA) panel, which was developed from learning in a previous Kingston SAR, continues. There is now a risk assessment within the KVAMA referral. This risk assessment has also been used to re-develop the stand-alone risk assessment that is used within ASC Social Work practice.

10.3.6 Suicide Prevention

At the January 2023 KSAB a presentation was delivered in relation to the Suicide Prevention Strategy. SAB partners are active members of the steering group.

10.3.7 Hearing the voices of individuals and their families

The Making Safeguarding Personal Feedback Project continues in conjunction with Healthwatch Kingston to gather the views of individuals who have been through the safeguarding process. This is monitored through the SAB. In January 2023, Healthwatch presented their findings from the project as well as their routine work with the community, and this led to discussions with SAB members about how they all learn from complaints and feedback. The SAB committed to keep the voice of individuals at the core of their work and to hear families' views through SARs.

10.4 "John" SAR

John was a young man who took his own life whilst at university. He had had recent major losses in his life and a history of emotional instability as well as coping with other challenging life events. He had multiple health care agencies involved in his support network and he presented to these agencies when he was in times of feeling suicidal and unable to cope as well as at times when he was feeling mentally well. He was prescribed medication to stabilise his mental health and he also used class A and B street drugs for recreational purposes.

The John SAR identified several areas for learning for local services, for the Kingston SAB and areas for learning at a national level. The report identified issues and risks when a person such as John presented to multiple agencies and where these agencies communication systems did not sometimes link up, as well as some agencies having differing criteria of scoring and monitoring risk.

The main themes for learning from John were:

- Mental Health Risk assessment to include how individuals research suicide methods.
- Improve information sharing between agencies when an individual withdraws from the service provided by one agency:
    - Agencies now have information on other involved agencies within the initial referral, and this is discussed at duty supervision especially of the person is deemed high risk. As an outcome notification is made to other involved agencies that the person has withdrawn from treatment.
    - Agencies have now developed a protocol to inform other involved agencies when a person withdraws from treatment, and this is also discussed at duty management supervision.
    - Risk assessments within involved teams have been reviewed as a result of this SAR and necessary changes and updates have been made.
    - The review highlighted the need for improved communication between mental health agencies and the local university. This has led to a working group being set up between mental health agencies and the local university to map out current support for students with mental health needs. A pathway for students with mental health needs has been developed to screen students who may need access to the wellbeing service.

Recommendations for the Kingston Safeguarding Board included:

- raising awareness around the use of suicide methods at a local and national level,
- raising awareness of the higher risk of suicide of young people who have been adopted and experienced adverse childhood experiences and trauma including challenges and discrimination faced by younger LGBTQ+ people.

Following the completion of the SAR, training sessions were held across South West London to facilitate the learning for a wide range of practitioners. The findings were also presented to the Kingston Suicide Prevention Group to highlight risk of self-harm and suicide of younger LGBTQ+ which has been noted and referenced in the Suicide Prevention Strategy.

11. Safeguarding Activity in Kingston-upon-Thames

11.1 General Population data

Kingston has a general population of 168,063 (ONS Census 2021). 67% of the population are aged between 15-64, with 14% aged 65 years of over (ONS Census 2021). Of note, the age group between 30-50 years is higher in Kingston than the national figure.

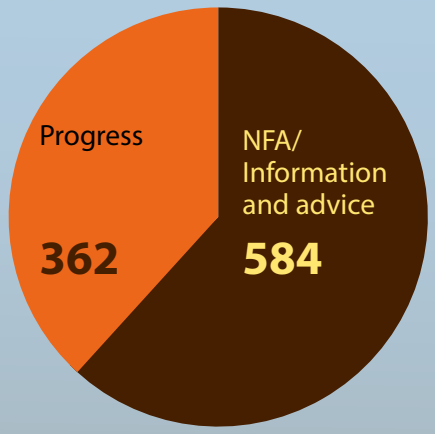
Kingston has a multicultural population. The broad ethnic groups are 17.8% Asian, Asian British or Asian Welsh; 2.8% Black, Black British, Black Welsh, Caribbean or African; 5.4 % mixed or multiple ethnic groups; 68.3 white; 5.7 other (ONS Census 2021).

For 2023-24, the SAB will seek to gain more understanding of the safeguarding activity and outcomes for individuals from diverse backgrounds.

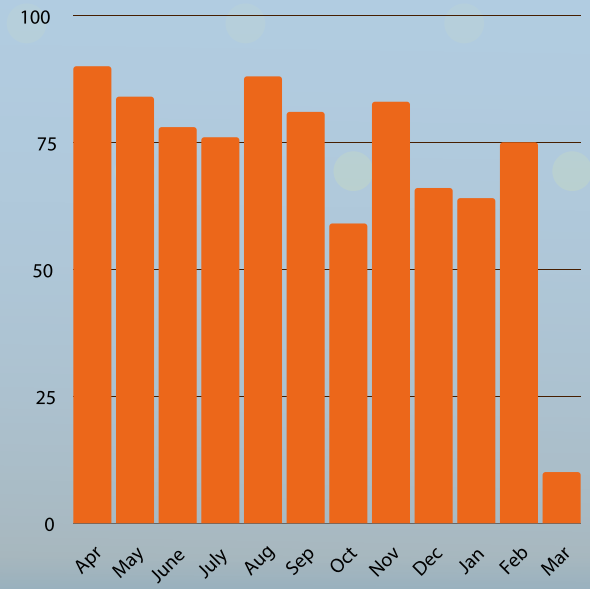
11.2 Safeguarding data for 2022-23

The KSAB considers the quarterly data provided by ASC. During 2023-24 there will be a focus on strengthening the multi-agency data and intelligence available to support the KSAB to meet its Care Act requirements to hold partner agencies to account for how they work together to protect adults from abuse and neglect.

Safeguarding totals for 2022/23



Totals by month for 2022/23

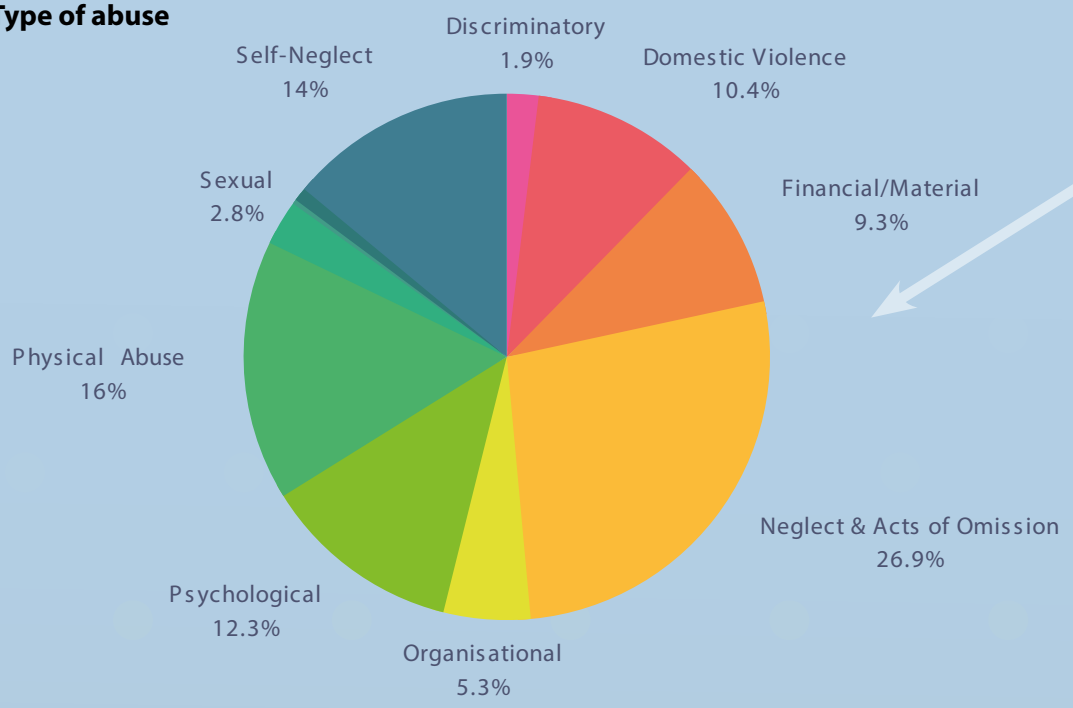


RBK Access Team triages all safeguarding concerns received. They will review information supplied and obtain further information to determine whether a safeguarding enquiry is needed. Depending on the situation, Access may take urgent action to safeguarding before sending to the most appropriate team to undertake the enquiry. Concerns can come from all types of organisations as well as the public using an online reporting for, email or telephone call.

Following the Connie SAR, there have been changes to how the care provider market is monitored. During 2023-24, the SAB will seek assurance on the impact of the work undertaken to reduce neglect and acts of omission.

The SAB has focused on developing self-neglect guidance. During 2023-24, the SAB will review what impact the guidance has had and identify what further measures are needed to prevent self-neglect and protect those who are at risk of harm.

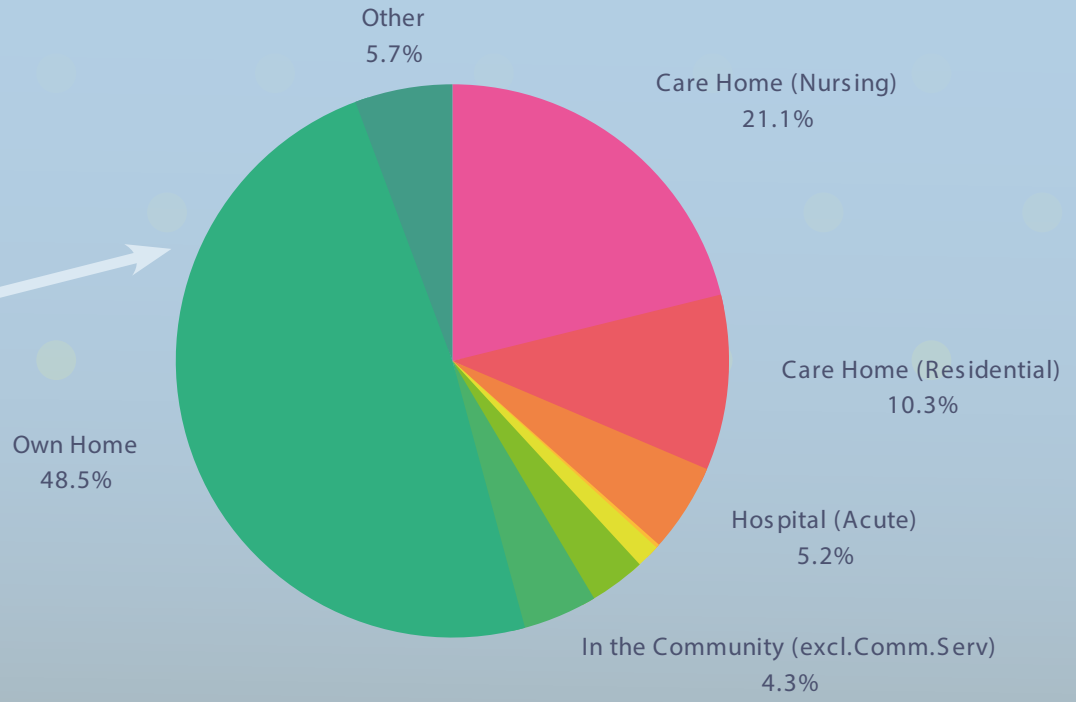
Type of abuse



Neglect and Acts of Omission was the most reported type of physical abuse, followed by Physical and Self-neglect.

These types of abuse are similar as the most reported in the previous year.

Location of Abuse



Most safeguarding concerns reported for this year took place in a person's own home, followed by Care Home (Nursing).

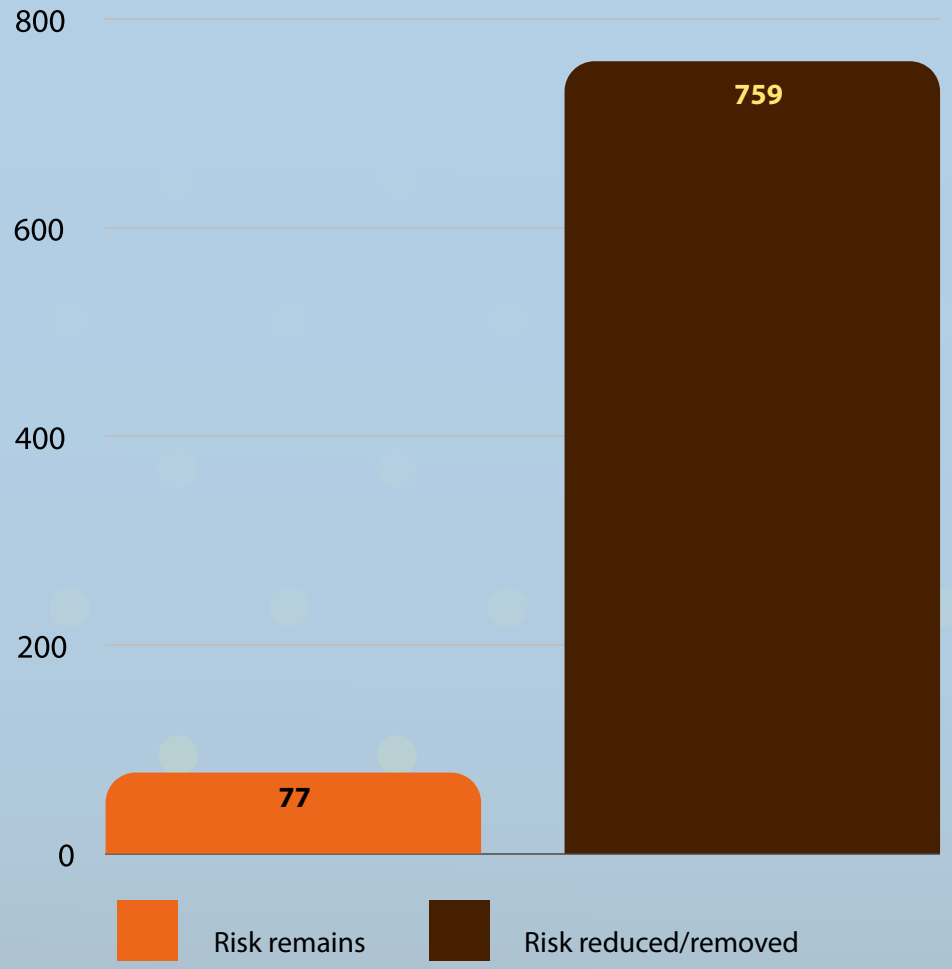
This is similar to the previous year's data.

Safeguarding intervention in RBK supports people to be safer. This is because most of our safeguarding intervention enables risk to be reduced or removed.

For those where risk remains, we have multi-agency panels to monitor and discuss risk such as our Vulnerable Adult Panel.

The Safeguarding Adults Board acknowledges the work achieved by the Multi-Agency Vulnerable Adult Panel (KVAMA) to keep those at most risk of harm safe. During 2023-24, the SAB will seek to gain more evidence of the impact of the KVAMA work through a data and intelligence workstream/sub-group.

2022/23 Risk Outcomes



12. Safeguarding Work Achieved By Partners

12.1 Adult Social Care

- We have developed and launched the Person in a Position of Trust (PiPoT) Framework & Toolkit for staff. This framework sets out how to manage allegations and concerns around People in Positions of Trust who work with Adults who have care and support needs. We have shared this framework and toolkit at our ongoing quarterly Safeguarding Adult Managers (SAM) meetings to raise awareness of the process.
- We have completed the planning and undertaken a pilot of Safeguarding Adults Case Audits. The new audit cycle will commence in Quarter 1 23/24 and will be completed on a quarterly basis. Findings from these Safeguarding Adults case audits will be reported back to the SAB quarterly.
- Leadership of self-neglect guidance development for the KSAB
- Coordinated the safeguarding pledges for the KSAB
- Supported the coordination and management of the KSAB

12.2 Community Housing

- The Housing Options Service continues to collaborate with colleagues in Public Health as part of the Kingston United for Ukraine group who are leading on providing assistance and support to households arriving in Kingston having fled the war in Ukraine. During 2022/23 the Housing Options Service received 55 approaches from Ukrainian households seeking housing solutions and on 31 March 2023, 14 households were accommodated by Housing Services comprising 20 adults and 26 children.
- In addition to support for Ukrainian households, Community Housing has been working with colleagues in Public Health to provide accommodation for seven Afghan nationals as part of a wider commitment Kingston has of being a City of Sanctuary within our commitment to the Afghan Citizen Resettlement Scheme (ACRS). Homes are being sourced outside of the Council's own supply of accommodation for the benefit of Afghan nationals and are anticipated to be available early in 2023/24 with Community Housing providing management resources.
- In relation to the provision of emergency accommodation the demand from homeless households approaching Community Housing at a point of crisis required our service to provide 353 new placements. In 2021/22 the figure was 265 placements into emergency accommodation, a 33% increase in demand.
- In helping manage this level of demand, Community Housing's ability to procure homes in the private rented sector to prevent homelessness was impacted by changes in market conditions. However, in a less favourable private sector market only 12 homes were procured in 2022/23, in order to prevent households from becoming homeless with the Council's Tenant Finder Service (TFS). This was a significant decrease from 39 homes procured in 2021/22 and reflects the significant nature of changes in the private rental market with reduced supply and inflationary rents. This reduced supply of homes is further reflected in only 18 homes being procured for

our Private Leasing Scheme (PLS) and 18 homes lost to the PLS portfolio of temporary accommodation with over 20 PLS properties under notice with occupiers asked to vacate where owners are seeking their properties return as a consequence of changes to the private sector rental market.

- Work is being undertaken at a corporate level to look at these issues and find potential opportunities and solutions to address the lack of supply of homes within the private rented sector.
- Whilst Housing Services continue to progress in regeneration of the Cambridge Road Estate requiring residents to decant into vacant social housing, Community Housing continued to let social housing to homeless households. 89 homeless households were provided affordable homes to rent within social housing in 2022/23.

12.3 Public Health: Drug and Alcohol Report

- In December 2021, the government published a new 10-year drug strategy 'From harm to hope: A 10-year drugs plan to cut crime and save lives', the first ever drug strategy to commit the whole of government and public services to work together in a new longer-term approach to reverse the national upward trajectory of drug use, drug-related deaths and drug-related crime.
- In response to the Drug Strategy RBK has established a process of Drug and Alcohol Death Reviews in 2022. The panel meets twice a year, and the process is led by Kingston Public Health Team. The panel reports to the Safeguarding Adults Board (with a dotted line to the Strategic Partnership for Alcohol and Drugs). Partners include SWL & St George's Mental Health NHS Trust, Kingston Police, KWS, KCAH, the Young People's Substance Misuse Service, Kingston Hospital, ASC, SPEAR and the Coroner.
- The public health team has also recently introduced a drug and alcohol-related deaths surveillance software for partners. The purpose of the software is to enable the recording of drug and alcohol-related deaths that occur inside and outside of treatment and to enable multi-agency input and collaboration to understand, derive lessons from, and implement action to address and reduce drug and alcohol-related deaths.
- The Public Health Team is committed to working closely with the SAB to share learning from the Panel across wider partners in Kingston.

12.4 Homes for Ukraine

- The Homes for Ukraine scheme is a national programme enabling people fleeing war in Ukraine to stay in the UK for up to 3 years and be sponsored by someone (the host) from the UK. The sponsor must offer accommodation for the first 6 months of their stay in the UK (in their own home or in self-contained accommodation), and the sponsor must undergo certain local authority checks to ensure their suitability to host guests. The Home for Ukraine programme is a unique national programme placing people from a war situation into people's homes in the UK. Thus, vulnerable people are staying with people that they do not know and in a new country where they are not familiar with sources of help. Kingston residents have come to the fore and have stepped up to support Ukrainians in need. Over 350 people from Ukraine are now being hosted in Kingston under this programme, 90% of whom are women and children.

- Soon after the national programme was announced, national government set out some checks that councils must do to try and ensure the suitability of hosts and the local accommodation being offered (see guidance for Councils). The checks (accommodation suitability, DBS and a post arrival 'welfare check') completed on sponsors in Kingston borough have highlighted a few cases of concern that have required a local decision to be made on the suitability of someone to be a 'host'. While some suitability criteria are clear (e.g. the host must have a spare room - and if they do not have this, cannot be a host - and we fail the proposed host for the programme, other situations which usually occur after someone has arrived, are less clear. There is limited national guidance on the criteria for what is considered unsuitable and thus, methods have had to be agreed for local decision making on these, sometimes complex, in borough situations. In Kingston, based on some initial early cases, it was agreed that some sort of panel decision making process was needed to bring in the views of a range of parties who could help inform a decision. Thus, in order to ensure a robust risk assessment of any hosts of concern, the new 'KUU (Kingston United for Ukraine) Risk Assessment Panel' was developed in June 2022 with partners in Adult and Child Safeguarding, Community Safety, Housing and the Police. A paper outlining this planned approach was taken to, and approved by the Kingston Adult Safeguarding Board in the summer of 2022. At the panel, a review of the information available is conducted and a special scoring matrix used related to that information. Based on this, the panel makes a decision on behalf of the Council about whether a Kingston resident is considered suitable and safe to host a Ukrainian guest under the scheme, and any additional actions that should be taken.
- Unfortunately, the panel has had to review cases where people who have applied to be hosts have a history of abuse and domestic violence. The panel has also considered other complex and challenging situations. In all of these, the panel has worked to keep new arrivals from the very difficult situation in Ukraine safe while in Kingston. All officers involved in the Ukraine response in Kingston are being vigilant to any signs or suspicions of safeguarding issues. We also ask that any partner agencies that have any concerns report these via their own standard safeguarding procedures as well as notifying ukraine@kingston.gov.uk.
- If you have any further questions or suggestions about the programme, please do not hesitate to contact us via email. For further information about the Kingston programme, visit the Kingston Council Ukraine webpages.

12.5 Healthwatch Kingston

- Healthwatch Kingston (HWK) have once again had a successful year 2022/23 in terms of its involvement with the adult safeguarding agenda in Kingston and across London. HWK's board lead for Safeguarding continues to a member of and regularly attends the KSAB meetings and chairs the SAB Training workstream/sub-group. With the roll-out of a revised strategic training plan, this aims to place the voice of those with lived experience at the heart of strategic thinking about adult safeguarding.
- HWK has continued to be an active member of the wider Kingston Safeguarding Adults partnership, where we have represented local people and regularly update the Board about our safeguarding related project work, the Making Safeguarding Personal project and the London Safeguarding Voices (LSV) group. When the Safeguarding Adults Board invited partner organisations in Kingston to join and sign a pledge to uphold adult safeguarding responsibilities, we were pleased to do so. Healthwatch Kingston was delighted to share our dedication to the Kingston Safeguarding Adults Pledge.

12.6 Healthwatch: London Safeguarding Voices (LSV)

The LSV group brings together people with lived experience of safeguarding, to help shape safeguarding across the city. The key ambition of the London Safeguarding Adults Board (LSAB) is to firmly embed LSV in their work to ensure it is co-produced and more person-centred.

The LSV want to keep things as simple as possible and stay away from jargon. Their message is simple – '**safeguarding is everyone's business**'. Everyone needs to know what safeguarding means, what signs of abuse and neglect to look out for and know how to report an 'adult at risk' concern in their London borough.

The LSV continue to meet three times a month to share lived experiences of safeguarding. This group is chaired by Stephen Bitti, Healthwatch Kingston CEO and co-ordinated by Hen Wright, Healthwatch Kingston Projects and Outreach Officer for Safeguarding.

The promotion and success of the LSV group has resulted in lots of requests for them, as people with lived experience of safeguarding, to help with adult safeguarding projects and conferences, not only across London, but nationally too:

- The LSV helped plan and deliver LSAB Conference 2022
- Meaningful involvement in London Peer Reviews
- Input into the London ADASS Care Workforce Strategy
- Review of the Pan London Multi Agency Adult Safeguarding Policy and Procedures document
- Work in reducing coercive control within domestic abuse cases

The LSV also completed a series of Safeguarding Adults Easy-Read booklets for use by services in RBK.

There are three booklets that can also be adapted by other local authorities across London for their specific safeguarding referral procedures and phone numbers, and links to local council websites 'how to raise a safeguarding concern' in each borough.

Keeping Adults Safe from Abuse

Speaking up About Abuse

Reporting Abuse

Learn more about the work of the LSV or to join as a volunteer: **London Safeguarding Voices: End of Year Update Report 2022-23 | Healthwatch Kingston**

12.7 Kingston Hospital NHS Foundation Trust

- During 2022/23 we introduced Safeguarding Adults Level 3 training to staff bands 6 and above, and for all maternity staffing. There is a strong focus within this training on the Mental Capacity Act, early identification of safeguarding concerns, and the process of a safeguarding enquiry from a hospital perspective. We have welcomed feedback from staff and the training has adapted accordingly.
- The safeguarding team includes our Independent Domestic Violence Advisor (IDVA) who has helped deliver domestic abuse training to our Emergency Department staff and support our patients and staff with referrals and advice. Our multi-disciplinary team has expanded further with the Medical Safeguarding Adult/MCA Lead post now being filled as a joint position with HRCH.
- Our hospital Learning Disability Liaison Service has also expanded to two permanent members of staff. They continue to promote equity in health, and support both inpatients and outpatients.
- We will continue to focus on delivering training for safeguarding including self-neglect, the Mental Capacity Act, and domestic abuse in 2023/24.

12.8 London Fire Brigade

- London Fire Brigade's Kingston Team comprises of two Station Commanders and one Group Commander. The Adult Safeguarding lead for the Borough is based at New Malden with links directly into LFB's wider safeguarding community. Through collaborative working with our partners within the borough, it is our intention to have a joint approach to protect our vulnerable adults within our communities.
- All station-based personnel are training annually on all aspects of Community Safety including Safeguarding. A new strategy is to be completed for Home Fire Safety Visits, for the most vulnerable the target is to complete the visit within four hours of notification based on a person-centred approach with levels of risk associated. This can also include referrals to key partners to highlights any concerns or help required for the occupants.
- LFB has recently embraced the Professional Curiosity Initiative which promotes referrals to other key partners that would not normally have been standard practice.
- Within the borough we have Ambassadors of the White Ribbon Initiative, every fire station within London has been designated as a safe haven for vulnerable persons when in need.

12.9 Metropolitan Police

12.9.1 Leadership and Structure

- SW BCU continue to rise to the challenges raised by the policing around adults at risk, who meet the criteria of the Care Act 2014 and the challenges of signposting and supporting those adults who do not meet the criteria by police still have concerns for. Safeguarding of vulnerable people is a priority for the SW BCU, regularly reflected in the Police Public Protection Plans. SW BCU retain a high level of oversight and governance for adults at risk, led by the Public Protection lead, Detective Superintendent Ian Cameron. The D/Superintendent holds a quarterly Public Protection Vulnerability Board, attended by all key BCU command areas who report on safeguarding activity, risks and issues. The D/Superintendent is supported by three Detective Chief Inspectors, who lead on reactive, proactive and partnership investigations. This structure enables safeguarding adults to be championed throughout the SW BCU, supported by thematic leads for particular safeguarding concerns, such as the impact of mental ill health and when people are missing.

- SW BCU are committed to working with partners and have regular and consistently engaged at senior level with the KSAB throughout the reporting year, as one of the three statutory partners. We also chair the various sub committees, working together with other key partners, to review and quality assure policies and recommendations, in correlation with audit compliance and identifying learning.

12.9.2 Activity, initiatives and operations

- The appointment of a dedicated Detective Inspector to lead on Adult Abuse has been significant in the roll out of the Vulnerability Assessment Framework (VAF) as a tool to assist MPS police and staff in identifying vulnerability in members of the public that they encounter. The focus being to apply the VAF at the earliest stage in order to maximise opportunities for early intervention to prevent someone becoming a victim or suspect at a later stage. There is ongoing work around professional curiosity and compliance of Merlin ACN (Adult Coming to Notice) reports. Earlier in the year the Commissioner set out his Turnaround Plan to be delivered over the next 2 years regarding fulfilling the Met's mission of More Trust, Less Crime and High Standards through our core policing activities. The Turnaround Priority of strengthening work in Public Protection and Safeguarding is intended to see significant impact within the adult safeguarding space. SW BCU continues to be fully engaged with the Safeguarding Adults Board Executive and Safeguarding Adults Board workstream/sub-group meeting and other multi-agency panels such as the Multi-Agency Risk Assessment Conference and Community Multi-Agency Risk Assessment Conference.

- The introduction of the Predatory Offender Unit and the re-invigoration of Operation Vigilant has been a key Police tactic in disrupting potential VAWG perpetrators in public spaces, before they offend. The operation also forms a key part of the ongoing Police work to re-build trust and confidence in our communities. The POU have lead on regular Operation Vigilant deployments with the aim of tackling and preventing the commission of serious sexual offences and violence against women and girls within the night time economy. A mixture of plain clothed officers and high visibility officers from local town centre team and special constables have effectively worked together to target perpetrators, with no victim blaming. The Operation involves liaison and communications between Police and licenced premises staff to enable the deployments to flex and respond to any presenting VAWG issues and target any potential perpetrators that are located. The operation is intelligence lead and in recent months a 15% decrease in VAWG offences has been seen.

- In December 2022 SW built on the excellent working relationship with business partners in the delivery of the Innovation Hub day. The Innovation Hub Day focused on working with business partners to ensure safety of the public in the night time economy and building on the relationship between SW BCU and partners to collaboratively and proactively keep streets safer. The day was attended by representatives from partner agencies, business partners and the local community together with police representations from Public Protection and uniform strands across the SW.

12.10 South West London Integrated Care Board

The safeguarding adult's team comprises of 6 designate professionals each responsible for their own sovereign borough (Croydon, Kingston, Merton, Richmond, Sutton, and Wandsworth) but now as an ICB we are also more focused on the broader picture looking across SW London. We work together as a team to focus on themes that affect all areas of adult safeguarding such as domestic violence. We also as individuals take the lead on areas of specialism such as learning disabilities for the whole of the ICB. We are a small but strong team, and we meet regularly to support each other with local and national updates on safeguarding and provide regular peer supervision within the team and to colleagues in provider services.

12.10.1 National Adult Safeguarding Week November 2022

Starting on the 21st November 2022, for safeguarding adults week, the team worked together to set up and run a series of online webinars and presentations for all staff across the health and social care economy covering a variety of current safeguarding topics. Sessions were presented by guest speakers from NHS England and local authorities as well as members of the safeguarding adult's team. Some of the topics covered were:

- Exploitation and gang violence
- Transitional safeguarding
- Self-neglect (What's new?)
- Domestic abuse and the elderly
- Lessons learned from Domestic Violence and Domestic Homicide reviews
- Presentation of Kingston Safeguarding Adults Board, Safeguarding Adults Review of a young person who took their own life.

These sessions were advertised locally and on national websites and forums and were well attended by people from a broad spread of professional backgrounds from across the country.

12.10.2 NHS England Safeguarding Adult Review Trackers and heat maps

The Safeguarding adult's team have been working with NHSE England to provide information and support on the safeguarding adult review tracker system which collates all information from SAR's nationally and brings together all themes and learning in one place making this information more accessible and centralised. This also applies to "heat maps" which are templates that highlight issues and concerns when incidents are reported on. Heat maps are an effective way of identifying where concentrated areas of concern in adult safeguarding are occurring geographically and what these concerns entail.

12.10.3 Learning from Lives and Deaths of people with a Learning Disability and Autistic People previously known as "The learning Disability Mortality Review (LeDeR)"

- The LeDeR programme was set up to review all deaths of people with a learning disability in every locality across England and now includes all people who are diagnosed as being autistic. The LeDeR programme has direct links to adult and child safeguarding and therefore is directly linked to the adult safeguarding team.
- The aim of the reviews are to identify areas of good practice but also to identify where there is a need for improvement in services. This information is used to support changes in practice across the whole health economy in SW London but can be used to influence changes at a national level depending on review findings.
- The ICB is charged with running the Learning from Lives and Deaths programme which includes employing and overseeing a small team of trained specialist reviewers, allocation of reviews following notification from NHSE of any deaths of people with a learning disability and/or autism, chairing local steering groups and supporting learning and recommendations into actions and service changes. The LeDeR programme for SW London ICB is overseen by the Kingston Safeguarding Adults Designate who provides the links between relevant teams across the ICB and links with NHSE LeDeR national team and provide supervision and support to all LeDeR reviewers.
- There are no backlog of reviews and local steering groups receive presentations from reviewers of cases in each borough that the reviewer has undertaken. Areas of good practice and areas for improvement/development are presented and recommendations given and discussed by the group members. This information is recorded and monitored, and action plans are developed for each area which are reviewed at each steering group.
- The 2022/2023 LeDeR annual report is currently being drafted ready for publication in September 2023.
- Kingston and Richmond Half Day Safeguarding Training for GPs

    - At a local level the ICB designate adult and children's professionals for Kingston and Richmond, as well as our named GP safeguarding lead, work together and continue to provide important support and advice to all GP colleagues in both boroughs as well as running the quarterly GP half day Safeguarding Adults and Children's.

    - Some of the more recent topics that we have covered in the half day training have been.

    - Learning from a Safeguarding Adults Review of a young person who took their own life

- Understanding single point of access

- Update on PREVENT and national threats from terrorism

- Radicalisation and extremism

- How to keep children and young people safe online

12.11 Your Healthcare

- In 2022/23 Your Healthcare raised a consistently high number of safeguarding concerns from direct observation or through disclosures made to practitioners. The most prominent areas of concern were those of neglect, self-neglect and domestic abuse. In addition, concerns related to its own services remained low.
- The Safeguarding Team is made up of both Adults and Child Safeguarding Practitioners and continues to take a "Think Family" approach to safeguarding. Examples of this are the co-production of the "Was Not Brought" policy which guides staff in responding to a situation where a service user of any age, who needs assistance to attend an appointment has not attended. This avoids inappropriate discharges where a choice may not be being made by the service user themselves. Also the Joint Safeguarding and Domestic Abuse policy provide a single policy, covering all ages.

Key achievements within the year were;

The implementation of routine questions for domestic abuse across all services

Working within the multi-disciplinary teams to identify concerns of potential self-neglect; and agreeing how to respond to those concerns in a way which ensures the service users' choice, wishes and beliefs were central to the risk assessment and plan.

Increasing staff knowledge & awareness of safeguarding through level 3 training, rapid reads and guidance material, video briefings on policies, and the addition of safeguarding to supervision templates and team meeting agendas.

13. How to contact the SAB

If you need to contact The Royal Borough of Kingston Safeguarding Adult Board, they can be contacted via email on ksab@kingston.gov.uk

Thank you for reading

Kingston Safeguarding Adults Board