Kingston Safeguarding Adults Board

Annual Report

2019/20

Introduction from the Chair

I am pleased to present the annual report of Kington Safeguarding Adults Board (KSAB) for 2019/20, my first as the Independent Chair.

The Covid-19 pandemic emerged in the last few weeks of this reporting year so despite its wide ranging impact, it will not be detailed in this report. It would however be remiss of me not to reference it in my introduction. I would like to offer my condolences to all whose lives have been affected by the pandemic in so many different ways. I have been speaking regularly to local partner agencies, and the response, under the most challenging circumstances has been Herculean. So many people, both professional and volunteers have performed roles outside of their usual experience. Often at short notice they continue to respond with courage and determination to protect and support those in need. Thank you.

Over the past year KSAB has continued to develop, building on an already good partnership. The three sub-groups have met regularly and have progressed the work of the Board. The Community Reference Group, in partnership with Kingston Healthwatch has continued to develop with funding in place to improve how we listen and learn from those using local services. A local Vulnerable Adult Multi-Agency (VAMA) Panel has been introduced, which enables agencies to meet and discuss the most challenging cases, aiming to keep those with care and support needs safe.

The KSAB strategy for (2016 to 2019) ended last year and the KSAB Development Day in October provided for a detailed conversation on new strategic objectives, which have now been agreed by the wider Board and are published on our website.

Workforce development is one of my own particular aims. People are kept safe when strategies are implemented and people on the front line are supported to be the best 'Safeguarders' they can be.

To achieve this aim KSAB has implemented a Common Safeguarding Objective, the Kingston Safeguarding Practice Awards (KiSPA) and has adopted the system of seven minute briefings. You can read about these in more detail later in the report.

In its annual report a Safeguarding Adults Board must report on the findings from Safeguarding Adult Reviews (SAR). In this reporting year KSAB has completed one SAR and commissioned a further two. Details of the completed review are documented in this report.

I would like to thank all members of KSAB for their engagement and support, especially during times of reduced resources, increased demand and large scale organisational change. In particular I would like to thank the chairs of the KSAB Sub-groups, Peter Warburton, Su Fitzgerald, Grahame Snelling and Clair Kelland for their dedication and expertise and to the Board Support Officer for her work co-ordinating the Board.

I hope that you enjoy reading this annual report and find it useful and informative.

Richard Neville, Independent Chair
Kingston Safeguarding Adults Board

Kingston Safeguarding Adults Board (KSAB)

Achievements 2019-2020

- Introduction of the Safeguarding Common Objective, which is…

  "Safeguarding, the protection of people at risk is everyone's business. Risk comes in many forms and is not always obvious"

  We ask all our staff:
  - To demonstrate an understanding of Safeguarding within your role;
  - To be proactive in identifying people at risk;
  - To take responsibility, assess and take positive action to keep people safe;
  - To fully report and refer, both internally and to relevant partner agencies.

- Introduction of the Kingston Safeguarding Practice Awards

  - This year KSAB has introduced the Kingston Safeguarding Practice awards (KiSPA). These recognise good safeguarding practice and are a way to identify, reward and learn from good practice. Any KSAB member can nominate staff for their safeguarding work and the KSAB statutory members will consider and recognise those that meet the threshold. Good practice is shared through the Board newsletter

- Publication of a quarterly KSAB Newsletter

  - The newsletter is published following a KSAB board meeting, reporting on the content of the board meeting and providing a method of delivering safeguarding news and developments

- Introduction of Kingston Vulnerable Adult Multi-Agency meeting

- Continued development of the Community Reference Group in partnership with Kingston Healthwatch to enable the service user's voice to be heard.

- New KSAB vision and strategic objectives agreed

- Audit Challenge Event completed

- 3 SAR referrals considered, one SAR completed and published with an action plan to implement the recommendations; 2 commissioned and in progress

- Seven Minute Briefing (7MB) methodology was adopted to allow managers to deliver a short briefing to staff on key topics. They can also be used to support reflective discussion with practitioners. 7MB's are borrowed from the FBI! Research suggests that 7 minutes is an ideal time span to concentrate and learning is more memorable as it is simple and not clouded by other issues and pressures. Their brief duration should also mean that they hold people's attention, as well as giving Managers something to share with their staff.

  The following 5 briefings were published:

  - London Fire Brigade Checklist
  - Cuckooing
  - Domestic Abuse
  - Clare's Law
  - Scams/Fraud

KSAB Sub-Groups

Training Sub-Group

The principal aim of the Training Sub-group is to provide assurance to the SAB that the multi-agency workforce in Kingston is well trained to a high level of competency within the training frameworks set out nationally or by parent organisations.
The sub-group is also charged with ensuring that lessons learnt from SAR's or other learning reviews is appropriately disseminated across the partnership.
A final aim is to ensure that training opportunities are provided that can support the voluntary sector and front-line volunteers both to deliver services safely and quickly identify concerns and what to do about them.
From the end of 2019 it was planned that the sub-group would produce a fresh Training Strategy, and this remains part of the current two-year work plan.
The purpose of the strategy will be to consolidate in one place the SAB's overarching ambition for a wide range of high quality, multi-level opportunities, together with planned critical learning dissemination.
The strategy will also identify how the Adult Safeguarding knowledge base will be widened in the diverse communities of Kingston, as well as the means to recognise individual or group learning that has made a difference.
The strategy will not, however, simply be a list of what agencies plan to offer. Rather it will also aim to capture the means of demonstrating how the learning from the training will be implemented and the difference it will make in terms of keeping adults in Kingston safe.

Communications Sub Group

In 2019/20 the sub group continued with a focus on delivering safeguarding messages to the residents of Kingston. The sub group have continued to meet on a quarterly basis.
A scams public event to raise awareness of scams was planned for March 2020 but this was cancelled due to the pandemic.
The police who are members of the Board have developed a series of posters and information to raise awareness of financial scams. These were promoted via the council website and on screens in council building accessible to the public as well as being promoted on the Clinical Commissioning website.
The group have taken on board learning from Safeguarding Adults Reviews (SAR's). This learning has been the basis for developing and publishing 7 minute briefings (7MB).
All 7MB and completed SAR's are now published and available on the councils safeguarding adult's web pages.
As the landscape of safeguarding is always changing we continually face new challenges and this year we have been challenged in the way we work in communicating safeguarding messages.
The safeguarding board strives to give the best service to the residents of Kingston and to improve efficiency and reduce duplication. In order to improve efficiency, the communication sub-group has been working more closely with the neighbouring borough board's sub groups. This joint working supports sharing of resources and utilises joint intelligence across a wider area that supports the promotion of adult safeguarding and raised public awareness of safeguarding issues.

Safeguarding Adults Review (SAR) Sub-Group

The SAR Sub-group considers cases where there has been a death or serious incident in the borough, of an adult with care and support needs, where a failure or possible failure to work together to promote the safety and prevent neglect, abuse or harm to an individual has been identified.
The Group recommends to the board whether the criteria are met for conducting an independent Safeguarding Adult Review (or SAR).
In this last year, work has been undertaken on 1 SAR, written by an independent author and these are now published on the Board's website. SARs are written to provide learning for all organisations which provide support to adults with care and support needs; they are not about apportioning blame to individuals or agencies.
The Board takes SARs very seriously and continues to have oversight on the recommendations, expecting feedback from agencies on what they have done to ensure that any mistakes are not repeated and that all staff learn from the Review.
SARs are published on the KSAB website. The group is working on 2 more SARs in this coming year.

SAR Report - Mrs L

SAR: Mrs L

Mrs L had lived independently, with minimal support, in her home until she was admitted to Hospital in July 2013 with an infected leg ulcer. She transferred to a local Nursing Home in August 2013 with high dependency physical health care needs. She experienced a significant deterioration in her physical and mental health.

This, combined with non-acceptance by her of some essential care and treatment, culminated in her admission to Kingston Hospital and her death in November 2017.

The SAR explored the wider issues of mental capacity, risk assessment and how agencies might better work together.

The published SAR findings are as follows:

- There is clear evidence that all agencies involved in the care and treatment of L endeavoured to meet her needs address risks in a personalised and professional manner, both individually and through communication with each other. The findings address those areas in which it is considered that agencies, individually and collectively, could have been more proactive in safeguarding L.
  - All agencies involved in the care and treatment of L from April 2017 did not sufficiently recognise the serious escalation in self-neglect (assuming L had mental capacity to make decisions about care and treatment) and the increasing risk that was apparent from around this time.
  - All agencies involved in the care and treatment of L missed an opportunity to further explore possible mental health concerns of depression and dementia, as potential underlying reasons for L declining support.
  - ASC did not provide a timely Safeguarding Adults response in November 2017, particularly in the absence of a multi-agency Safeguarding Adults Planning Meeting, and the lack of clarity about team responsibility.
  - The OPCMHT did not provide a formal, recorded Mental Capacity Assessment in July 2017, in relation to covert medication.
  - The GP did not provide a formal, recorded Mental Capacity Assessment in November 2017, in relation to hospital admission for care and treatment.
  - The Mental Capacity Assessment completed by the TVN in November 2017, whilst this was thorough, recorded and completed in difficult circumstances, was not sufficiently clear by referring to variable capacity without explanation.
  - The OPCMHT did not await the exclusion of delirium, which the Trust considered to be delayed, before discharging L to primary care. The recording of physical care needs, and any potential link to assessed mental health needs could have been more comprehensive.
  - A GP referral to a dietician for specialist support seems to have been warranted from about June 2017, given a consistently poor nutritional intake and the provision of supplementary drinks, tests and monitoring.
  - Whilst the care home endeavoured to meet L's needs, and to engage other agencies, a referral for dietician support should have been considered from June 2017.
  - The care home should have made a prompt referral for TVN support in November 2017.
  - There was an unreasonable delay in the TVN picking up a referral from the care home in November 2017.
  - It is not possible to conclude whether a more coordinated multi-agency response would have led to earlier hospital admission, or if this would have been in L's best interests, and it is inconclusive whether her death due to the sacral pressure ulcer was avoidable or preventable.

The published recommendations, accepted by KSAB are as follows:

- The SAB to oversee a clear procedure and understanding within agencies of multi-agency Safeguarding Adults and risk assessment responsibilities in response to self-neglect; incorporating professional curiosity.
- The SAB to oversee evidence that all agencies have clear Mental Capacity Act procedures, recording forms and training in place.
- The OPCMHT to ensure that there is adequate recording of relevant physical health conditions and that patients are not referred back to primary care until all the required checks are completed.
- GP Practice and the care home to review practice concerning referrals for specialist dietician support.
- The care home to ensure that staff are aware of the need for timely referral for TVN support.
- YHC to ensure that a robust administrative process is in place to receive and promptly respond to referrals for the Tissue Viability Service.

Audit Challenge 2019

The Kingston Safeguarding Adults Board in its role to seek assurance about the quality of safeguarding activity across all partner organisations undertakes an annual audit with all partners. This 'Audit Challenge Event' takes place in the months following the end of the financial year and for 2019 took place on two occasions to ensure that all partners had the opportunity to contribute and discuss the improvements that have been made. The Safeguarding Adults at Risk Audit Tool has been developed by the Local Government Association (LGA) and Association of Directors of Adult Social Services (ADASS) in conjunction with NHS England. The KSAB was pleased to note the high levels of assurance identified across the local Kingston partnerships in health and social care.

Several partners reported improvements in the previous year in 'Making Safeguarding Personal' and information sharing arrangements. There was improved representation from partners at the KSAB. The KSAB uses the outcomes of the annual audit to influence the coming year's priorities and therefore the Audit conducted influenced the priorities for the Board for 2018/19. These are set out below:

- Continuation of the successful Peer Audit process to seek assurance on partners' approaches to safeguarding
- Deliver on SAR's and share learning
- Improve and analyse data across a number of boroughs
- Ensure that we check the impact of financial challenges on safeguarding
- Improving practice and compliance on the Mental Capacity Act
- Set up a Kingston Vulnerable Adults Multi Agency Risk Assessment Panel.
- Set up Kingston Safeguarding Practice Awards

National Safeguarding Adults Week 2019

National Adult Safeguarding Week occurs annually and focuses on key safeguarding themes. During this event the SAB decided to circulate different themed safeguarding information every day.

The first day focused on the **Safeguarding Common Objective**. This is an objective for individuals with the Kingston workforce, across all KSAB member agencies. The aim being to strengthen the wider partnership and partnership working. The objective was agreed by the Board and all agencies were invited to adopt it. Staff contribution at all levels would be monitored within their organisations through supervision and appraisals. The objective aims to deliver the following:

- Bring people together to work collaboratively and improve outcomes.
- A positive statement of intent to make safeguarding everyone's business
- Reinforces the commitment to safeguarding and the aims of the SAB.

Hoarding and Self-neglect was the second theme which affects 2-5% of the population. Symptoms include emotional attachment and distress over parting with obsessions; allowing possessions to interfere with day to day life, relationships and social isolation. This often begins with trauma or loss, parental attachment and control issues. The first indication is often highlighted as a result of a safeguarding concern and received without the individual's knowledge. They may not recognise the level of self-neglect or the impact their behaviour has on themselves or others. Concerns are usually raised when the situation is at crisis stage and there needs to be partnership working to avoid this between agencies.

The third day was focused on **Learning Disabilities Mortality Review** (**LeDeR**) which is the first national programme aimed at making improvements to the lives of people with a learning disability. The programme is co-ordinated by the University of Bristol and commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England.

The aim is to drive improvements in the quality of health and social care services and to reduce premature mortality and health inequalities. Each borough across London has a 'LeDeR contact' who are usually employed by the CCG. They are the main link and lead for all the work as well as receiving notifications of death, allocations and oversight and reviews of deaths and leading on learning from review.

Fraud & Scams was the next theme as vulnerable people are the most at risk. Some of the most common types are Online Shopping; Advance Fee; Investment Fraud, Door to Door/Bogus Traders; Payment Fraud; Romance Fraud; Computer Software Fraud; Courier Fraud.

Criminals can hide their number. Caller ID is not proof of identity. If unsolicited contact is received, take 5 mins to verify their claims via a trusted method. Always report scams, fraud and cyber-crime.

Remember, out of the blue, no thank you!

Lastly, the focus was on **Homelessness, Modern Slavery/Human Trafficking**. Rough Sleeping is devastating, dangerous and isolating. On average, rough sleepers die at just 44 years old. People living on the street are more likely to have been victims of violence and are at risk of taking their own life.

Modern Slavery is described as a 'serious and brutal crime in which people are treated as commodities and exploited for criminal gain'. The Modern Slavery Act 2015 encompasses human trafficking as well as slavery, servitude and forced or compulsory labour. Slave masters use whatever means they can to coerce, deceive and force individuals into a life of abuse, servitude and inhumane treatment. Exploitation can be forced labour, sexual exploitation, domestic servitude and forced criminal activity.

Partner Key Achievements 2019/20

Royal Borough of Kingston - Adult Social Care

- Common Objective is being worked into the case supervision document review work which will enable this objective to be considered when discussing safeguarding cases in supervision with staff. This is governed by the Quality Assurance and Framework Monitoring Group
- A Senior Safeguarding Practitioner role was secured and they came into post in September 2019. They have led on provider concerns, safeguarding partnership development, audit and MSP work.
- We secured the Healthwatch CRG and MSP pilot project to run 2020/2021 focusing on outcomes within LD safeguarding enquiries in the first instance.

Metropolitan Police Service (SW BCU)

- South West BCU police continues to work closely with partners to improve our response to vulnerable people in our communities. We have recently developed a new cuckooing protocol, including clear referral pathways for police and other professionals and tactical options for officers, to better identify and support victims of cuckooing and target perpetrators.
- The BCU aims to professionalise Adult Abuse work: we have appointed a dedicated Detective Inspector to lead on Adult Abuse, who will look to strenthen our response and engagement, raise the adult abuse agenda within policing locally, develop a network of subject matter experts around adult abuse and embed learning from SARs.
- We have adopted the Common Safeguarding Objective to make safeguarding a key performance indicator for our staff. SW BCU continue to be fully engaged with the SAB executive and SAB sub group meetings and other multi agency panels including MARAC and CMARAC.

Your Healthcare (YHC)

- In 2019-20 YHC achieved its goal to develop cohesion across child and adult safeguarding. This enhanced the "Think Family" approach to safeguarding and ensuring streamlined processes through a joint policy approach.
- YHC has worked with Public Health and developed a suicide prevention information leaflet for staff. This will enhance awareness and understanding of how to respond to concerns around suicide risk.
- YHC has worked closely with partners to support the implement the Vulnerable Adults Multi-Agency Meeting (VAMA) in Kingston.
- YHC has worked with partners across the South West Sector to share good practice on the implementation of the Mental Capacity Act. This links significantly with working to support people who are at risk of self neglect. Our commitment being to support service user rights and work with them to safeguard their health and welbeing.
- YHC has agreed to adopt the common safeguarding objective and is finalising how these will be incorporated formally into our documentation.

London Community Rehabilitation Company (CRC)

- London CRC remains committed to partnership working to safeguard vulnerable adults, whether they be service users, victims or members of the public i.e. we participate in Kingston's local risk management panels, including MARAC and IOM. We also work in partnership with the YOS to support young men and women who are transitioning to adult services. London CRC is also working more closely with the NPS as we move towards reunification in June 2021.
- To reduce risk and to support service users to transform their lives, London CRC delivers intervention programmes i.e. Making Amends programme that has a restorative justice focus. We also support service users who present with vulnerabilities, such as substance misuse or poor emotional wellbeing, to engage with recovery services and to develop their protective factors.
- London CRC continues to invest in learning and development. Local and pan-London Public Protection Boards are a forum where case studies are examined and learning points integrated into policy and practice. More staff are being trained to utilise a specialist domestic abuse assessment tool (SARA 3); we recently held a successful lecture series about tackling coercion and control; and participation in multi-agency training is also encouraged i.e. training to combat county lines and exploitation offered by Kingston Council.

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

- Trauma Informed Care - The Director of Nursing and Quality has established a Clinical Reference group to develop 'Trauma Informed Care' skills Trust wide. To support this initiative they commissioned co-production groups to develop Trust wide policies on Domestic Violence & Abuse, Sexual Safety on In-Patient services, and Restrictive Practices.
- Domestic Violence: Ending the Silence - The group has coproduced a comprehensive new policy to increase everyone's awareness of domestic abuse. It will support staff to make routine enquiries about domestic abuse and make sure staff provide caring, skilled and appropriate responses. In December 2019 the Trust held its first Domestic Abuse Conference - a well-received multi-agency event - major success!
- Sexual Safety - This new policy aims to promote sexual safety through the development of a culture that encourages and models mutual respect in relationships between staff members, between staff and patients, and between patients. The Trust has joined the NHSE/NHSI National Collaborative to embed the highest standards and improve inpatient services' sexual safety.

- Restrictive Practices - This updated policy provides a guide to understanding the impact of the use of restrictive practices on patient's care. This makes sure the patient receives the appropriate level of care and support, while promoting their physical and emotional wellbeing.

Kingston Hospital NHS Foundation Trust

- KHT implemented the Safeguarding Link Practitioner Study Day in 2019. This takes place three times a year and includes representation from not only the wards, but also from occupational therapy, physiotherapy, outpatients and phlebotomy. Members of the Multi-Disciplinary Team showcase their speciality and how safeguarding plays a part in providing holistic care to patients. The number of link practitioners have risen over the past year, and they are being empowered through these sessions to share their knowledge with their areas to promote communication about safeguarding.
- KHT secured funding for a Learning Disabilities Liaison Practitioner within the Trust at the end of 2019. Advert delayed briefly due to COVID-19. However, this role will help give the latest evidence based care to patients, specialist training to staff on learning disabilities and also help strengthen ties with community services.
- Following involvement in a SAR last year, the safeguarding team felt that an emphasis on self-neglect and the importance of recognising early signs of this can provide a better outcome for our patients. Self-neglect was highlighted in staff training and paved the way for an open discussion on Professional Curiosity. A policy has since been put together for release in 2020/21.
- In preparation for Level 3 Adult Safeguarding Training, it has been discussed that the Common Safeguarding Objective will be included in staff appraisals. This will go hand in hand with increasing safeguarding adults training compliance, and keeping the focus on up to date evidence based practice.

National Probation Service (NPS)

- The NPS (London-wide) continues to work in a multi-agency way, discussing service users at a range of multi-agency panels as appropriate. This work is supported through a programme of audits and reviews.
- The MOJ is embarking on unification of NPS and CRC to form one national service. This will give us an opportunity to standardise and enhance safeguarding across the board with all service users.
- Increased training opportunities and staff uptake have resulted in greater awareness of safeguarding of vulnerable groups, including women, young adults, ex-military personnel and transgender service users.
- The NPS implemented the common safeguarding objective, by encouraging staff to complete training, being proactive in identifying vulnerable adults, whether they be services users or others, and referring such adults to appropriate services for assessments.

Kingston Clinical Commissioning Group (CCG)

- The CCG employed a young person with a learning disability to work at the CCG and to support the quality team and CCG with office tasks. The safeguarding team and the CCG are really pleased that they can provide support and mentor a young person to gain work experience and office skills which will help them in their future work and career.
- The CCG now have 2 new GP Leads, one for adult and children's safeguarding and the other specifically for people with a learning disability. Both these roles will enable the safeguarding team to have even better focus and support for primary and secondary care with service users who have a learning disability or who may be at risk and need safeguarding support.
- The setting up and running of the SWL Safeguarding Adults Lead Forum. The Forum has been set up to address any practice, performance and operational issues arising in safeguarding in health and social care across the SWL sector as well as sharing best practice and providing support and advice to members. The membership includes all safeguarding leads from the health economy across SWL as well as Safeguard Leads/representation from each of the 6 SWL Boroughs.
- The Designate Safeguarding Adults Lead for Kingston CCG was approached by Camden SAB to undertake a SAR for a person with a learning disability who had been a Camden resident with multiple health and social care needs. The Kingston CCG designate chaired a learning event, attended by all services involved in the persons care, to review the care timeline leading up to the persons death and identify where things went well and where things didn't go well. Following on from the event the Kingston CCG designate wrote a full report on the process that included learning and recommendations from this SAR. This report was also presented to the Camden Safeguarding Partnership Board in January 2020 and is published on the web site.
- The Common Safeguarding Objective - due to the recent CCG merger across all 6 SW London Boroughs, the Common Objective implementation will need to await the reorganisation of the new HR services. However, the common objective is promoted via the direct face to face training of CCG staff by the Designate safeguarding leads.

Kingston Healthwatch (KHW)

2019/20 was a successful year for Healthwatch Kingston (HWK) in terms of its involvement with the Adult Safeguarding agenda in Kingston. HWK's board lead for Safeguarding now chairing the SAB Training sub group, this places HWK at the heart of strategic thinking about adult safeguarding, at a particularly challenging time. In terms of HWK's priority setting for 2020/21, safeguarding is now an over-arching standalone item, with its influence spreading widely across all other priority areas.

Of particular note in 2019/20, HWK achieved the following:

- HWK significantly raised its local profile through consolidating the work of the Community Reference Group designed to capture the voice of the service user. This meant a regular series of open meetings until the end of 2019 with slightly increased numbers of service users attending. These sessions also identified some professional challenges, highlighting issues about consent, capacity and reporting in the public interest. Face to face work was suspended in March 2020 and efforts are being made to identify how best to capture service user responses about their experience of safeguarding as instances of domestic abuse and neglect in particular are on the increase.
- HWK's successful work in this area has been recognised by the local authority who have chosen to invest in a pilot project designed to learn about whether 'Making Safeguarding Personal' is being achieved in Kingston. The pilot project has been designed by the HWK team working in partnership with the RBK Adult Safeguarding Team, and a dedicated staff member has been appointed to coordinate delivery. The delivery framework will include a requisite invitation to service users to respond to a tailored consultation process. This was due to go live at the beginning of April 2020, but the current Covid-19 pandemic impacted upon this. However a refreshed delivery plan has now been agreed, and information sharing protocols confirmed.
- On the strength of HWKs commitment to enabling supporting the voice of safeguarding service recipients to be heard, HWK were invited by Healthwatch England to assist with the planning and delivery of the annual London Safeguarding Adults Conference which took place in February 2020 under the auspices of the London Association of Directors of Adult Social Services (LADASS) and its Improvement Board. HWK's lead board member presented a workshop which showcased Kingston's experience and subsequently our Chief Officer has been invited to lead for London Healthwatches in this area of work and chair future conference planning groups. This is significant London-wide recognition for HWK's work in this field.

Incorporating safeguarding as one of the key priority work areas for 2020/21, HWK has adopted the Common Safeguarding Objective at an organisational level. It is built into all aspects of our operational planning and is a standard item on all our board meeting agendas. The board has agreed for our Chief Officer to become more involved in London safeguarding activity as described above, which demonstrates a strong commitment for the next two years. In due course, as job descriptions are reviewed, HWK will look for opportunities to ensure that the principles enshrined in the CSO are made explicit at a personal level.

London Fire Brigade (LFB)

- Kingston Borough Fire Fighters continued to provide Home Fire Safety Visits (HFSV) albeit with a reduced capacity due to the Covid pandemic. Since the last report Firefighters have engaged in a variety of additional community based activities in order to support local charities and community groups during the pandemic. As things returned to a degree of normality crews carried out a directed number of HFSVs specifically targeting those considered at high risk and only following an additional Covid risk assessment of these residents all of these visits being delivered to high risk P1 people.
- LFB Kingston continued to meet with partners albeit via Teams/Google meet and teleconference, where possible and when conditions allowed meetings were held in person in risk assessed locations. We remain committed to our safeguarding obligations and reconfirm our commitments to respective safeguarding boards and communities ensuring all will receive the best possible service at this given time. This includes the additional training activities that further support the Fire Safety Strategy written for this board. This includes providing training for Partners, writing and delivering where requested a 7 minute fire safety learning/briefings. This has already been delivered to some departments, and we hope to further expand this to increase the exposure to all of our partners in the borough where possible. This has also been used in Wandsworth & Richmond and supports closer partnership working in all 3 Boroughs. In addition to this officers in the borough received additional training in Safeguarding Children, Gangs vulnerability and exploitation and Dementia Awareness. This knowledge and training has been cascaded down in order to upskill station based staff.
- LFB officers have held a meeting with the Adult Safeguarding Team as part of a pilot in Surbiton. This will hopefully complete the referral loop and provide crews with feedback following referrals to the safeguarding team. (This was one of the areas in need of improvement in the Audit challenge).
- Our HFSV partnership referrals have continued to increase with direct contact ensuring an almost immediate response to any referrals received. This has led to more vulnerable people receiving bespoke fire safety advice in the home and smoke alarms where needed, and making them safer in their homes.

Strategic Objectives 2020/2021

The Kingston Safeguarding Adults Board (KSAB) provides strategic leadership for multi-agency adult safeguarding across the borough of Kingston. This strategy is in accordance with the Care Act 2014.

In order to respond to the main drivers and to uphold the principles, the Kingston Safeguarding Adults Board have identified three key priorities:

- To enable and support the communities and workforce of Kingston to embed a safeguarding culture.
- Strengthen wider partnership and collaboration
- To enable the sharing of lessons learned and promote consistent and effective practice

Work and activities to deliver the strategic objectives will be recorded in the Business and Annual Work Plan.

How to report a safeguarding concern

The Care Act 2014 puts 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.

Safeguarding duties apply to 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.

If you have a concern regarding an adult, and it appears that the above 3 points are met, complete the Safeguarding Adults Concern Form and email to Safeguarding & Access Team on (adult.safeguarding@kingston.gov.uk)

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