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

Frank Butau – Lead for Safeguarding Adults and Learning Disabilities

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

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

Management of allegations against staff

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

Safeguarding Adult Priorities for forthcoming year include:

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

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

Policy development for sexual safety of NHS staff.

Leading, Listening and Learning

In this section:

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

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

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

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

Catherine Knights

Director of Quality, central and North West London NHS Foundation Trust, Co-Chair of the Safeguarding Adults Case Review Group

Trish Stewart

Associate Director of Safeguarding, Central London Community Healthcare NHS Trust, Co-chair of the Safeguarding Adults Case review Group

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

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

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

Key achievements this year

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

SAEB Learning and Development programme

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

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

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

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

Learning from conversations with Families involved in Safeguarding Adult Reviews

Joan's Legacy

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

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

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

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

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

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

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

- Property Policy review to prevent patients belongings from going missing

  Imperial College Healthcare Trust

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

  Imperial College Healthcare Trust

- Pressure Care Awareness

  Westminster ASC

- Glasses/hearing aids alert system

  Royal Marsden

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

  Imperial College Healthcare Trust

- Improvements to engagement with families

  ASC Safeguarding

- Specific Reasonable Adjustments

  Royal Marsden

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

  London Ambulance Service

SAR referrals in 2022 – 23

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

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

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

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

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

Learning lessons and achieving change from Fatal Fires:

Thematic Safeguarding As Review - Fatal Fires

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

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

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

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

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

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

Thematic Safeguarding Adults Review Learning Briefing

Learning from Fatal Fire Deaths

BACKGROUND

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

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

SHARING LEARNING

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

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

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

THE REVIEW

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

The review examined the following areas of practice:

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

Key findings and learning points

Learning from Fatal Fire Deaths

MEN'S CARE AND SUPPORT

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

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

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

MENTAL CAPACITY

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

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

EXECUTIVE CAPACITY

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

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

EVERYONE'S BUSINESS

Fire safety is everyone's business!

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

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

CHALLENGES

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

The review noted three key areas where this was relevant:

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

What we are doing to respond to the learning

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

1. Reviewing and developing multi-agency fire safety training, and ensure training is offered across the partnership including provider services, registered social landlords, and the voluntary and community sector.

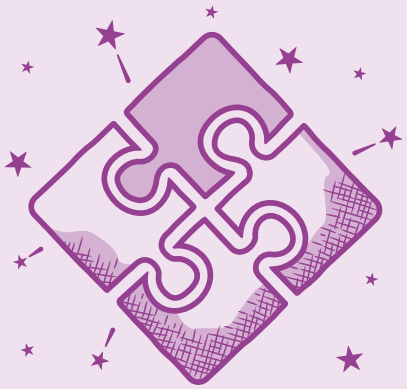
2. Building a suite of additional learning resources relating to fire safety and awareness of risks which will be available to professionals as well as members of the community.

3. Developing a multi-agency fire safety framework to provide frontline staff with practical guidance to support the effective management of fire risks. This will bring together risk assessment tools, referral pathways and provide guidance around best practice including mental capacity considerations and balancing individual rights with rights of others.

4. Seeking assurance from partner agencies that effective fire safety measures are included within relevant care and support and risk assessment documentation, that information about fire risks is shared effectively across agencies and that the recommendations from the review lead to changes being embedded in practice.

5. Raising the issues of national significance around potential gaps in fire safety law with the regional and national Safeguarding Adults Board (SAB) Chairs Network.

6. Facilitating a learning event in 2024 to track progress around practice and service improvements in fire safety practice.



Family and carer perspectives

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

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

Key Points for Learning and Reflection

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

2. Do you ensure information about risks and risk management is shared with all relevant agencies involved? How do you ensure all relevant agencies are involved in discharge / care and support planning? How do you ensure that agreed actions are monitored and followed up?

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

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

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

FURTHER RESOURCES AND READING

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

London Fire Brigade Home Fire Safety Checklist

London Fire Brigade Person-Centred Fire Risk Assessment

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

SAEB Learning Briefings:

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

SAEB Escalation Policy

London Multi-Agency Adult Safeguarding Policy and Procedures

Mental Capacity Act Code of Practice

CONCERNED ABOUT ABUSE OR NEGLECT?

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

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

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

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

For more information about this briefing contact:

Makingsafeguardingpersonal@rbkc.gov.uk

Transitional Safeguarding

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

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

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

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

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

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

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

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

Dez Holmes

Director of Research in Practice

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

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

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

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

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

Who is at risk?

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

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

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

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

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

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

Safeguarding Executive Board Strategy 2022-2025

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

Making Safeguarding Personal

Safeguarding Ambassadors are the Boards Super Heroes.

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

Service user engagement

- Ensuring that adults are being supported and encouraged to make their own decisions on how to keep themselves safe.
- Sharing experiences and best practice through collaborative and bespoke safeguarding training and community events.
- Collaborating with our Safeguarding Ambassador to ensure their voices are heard in the communities and London wide.

Making safeguarding everybody's business

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

Strategic Priority 1

Leading, Listening, Learning

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

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

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

Sharing learning to prevent harm and abuse.

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

Strategic Priority 2

Quality & Performance

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

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

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

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

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

Strategic Priority 3

Developing Best Practice

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

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

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

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

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

Strategic Priority 4

Communities Keeping Themselves Safe

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

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

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

Communication, Involvement, Prevention and Early Intervention.

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

Big thank you to the members of the Safeguarding Executive Board

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

Financial Contributions

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

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

- The North West London Integrated Care system (NWL ICS) contribution of £20,500.00 per borough, per year.
- The Mayor's Office for Policing and Crime who provide an annual contribution of £5,000 to each borough for the local safeguarding adult board.

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

Our members

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

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

Rose Hayles

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

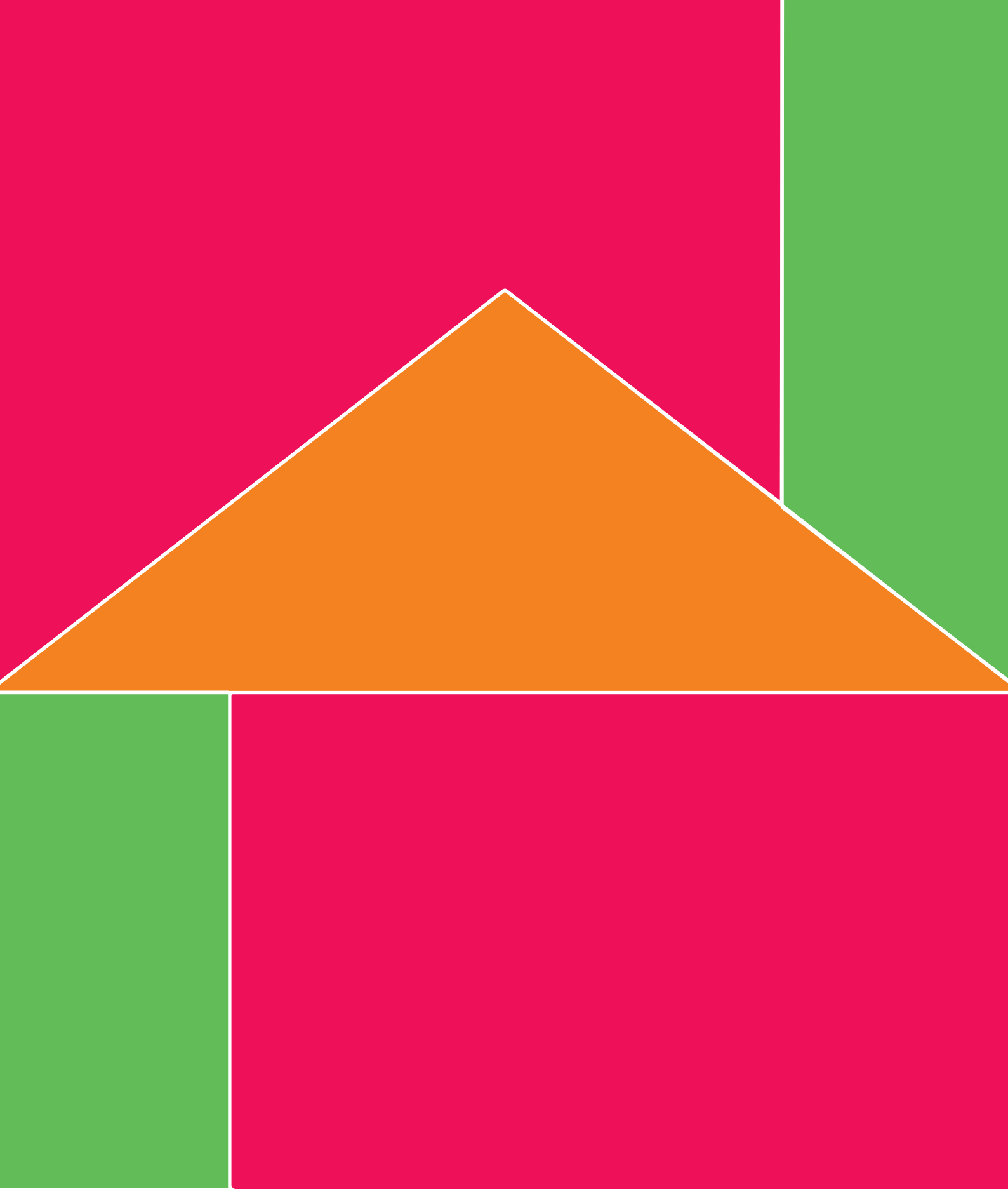
Safeguarding is about protecting adults from abuse and neglect, which can be physical, emotional, sexual, and financial.

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

Who can you tell?

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

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



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