Public Document Pack

City of Westminster

Committee Agenda

Title:	**Family and People Services Policy and Scrutiny Committee**
Meeting Date:	**Monday 27th January, 2020**
Time:	**7.00 pm**
Venue:	**Rooms 18.01 & 18.02 - 18th Floor, 64 Victoria Street, London, SW1E 6QP**
Members:	**Councillors:** Jonathan Glanz (Chairman) Margot Bright Nafsika Butler-Thalassis Peter Freeman Patricia McAllister Emily Payne Selina Short Aziz Toki

Members of the public are welcome to attend the meeting and listen to the discussion Part 1 of the Agenda

Admission to the public gallery is by ticket, issued from the ground floor reception. If you have a disability and require any special assistance please contact the Committee Officer (details listed below) in advance of the meeting.

An Induction loop operates to enhance sound for anyone wearing a hearing aid or using a transmitter. If you require any further information, please contact the Committee Officer, Tristan Fieldsend, Committee and Governance Officer.

Tel: 078 1276 0335; Email: tfieldsend@westminster.gov.uk
Corporate Website: www.westminster.gov.uk

Note for Members: Members are reminded that Officer contacts are shown at the end of each report and Members are welcome to raise questions in advance of the meeting. With regard to item 2, guidance on declarations of interests is included in the Code of Governance; if Members and Officers have any particular questions they should contact the Head of Committee and Governance Services in advance of the meeting please.

AGENDA

PART 1 (IN PUBLIC)

1. MEMBERSHIP

To note any changes to the membership.

2. DECLARATIONS OF INTEREST

To receive declarations by Members and Officers of the existence and nature of any pecuniary interests or any other significant interest in matters on this agenda.

3. MINUTES **(Pages 5 - 10)**

To approve the minutes of the meeting held on 25 November 2019.

4. CABINET MEMBER UPDATE **(To Follow)**

To receive an update on current and forthcoming issues within the portfolio of the Cabinet Member for Family Services and Public Health.

5. SUPPORT FOR YOUNG CARERS IN WESTMINSTER **(Pages 11 - 16)**

To receive a report providing an overview of the support for young carers that is provided in Westminster.

6. DRAFT LOCAL SAFEGUARDING CHILDREN BOARD ANNUAL REPORT 2018/19 **(Pages 17 - 54)**

To receive a report providing an overview of the work of the Board during 2018-19.

7. SAFEGUARDING ADULTS EXECUTIVE BOARD ANNUAL REPORT **(Pages 55 - 80)**

To receive the sixth Annual Report of the Safeguarding Adult Executive Board (SAEB).

8. 2019/20 COMMITTEE WORK PROGRAMME AND ACTION TRACKER **(Pages 81 - 96)**

To consider topics for the 2019/20 work programme and note the Committee's action tracker.

9. REPORTS OF ANY URGENT SAFEGUARDING ISSUES

Verbal Update (if any).

10. ANY OTHER BUSINESS

To consider any business which the Chairman considers urgent.

Stuart Love
Chief Executive
17 January 2020

This page is intentionally left blank

MINUTES

CITY OF WESTMINSTER

Family and People Services Policy & Scrutiny Committee

MINUTES OF PROCEEDINGS

Minutes of a meeting of the **Family and People Services Policy & Scrutiny Committee** held on **Thursday 25 November 2019** in Rooms 18.01 and 18.02, 18th Floor, 64 Victoria Street, London SW1E 6QP.

Members Present: Councillors Jonathan Glanz (Chairman), Margot Bright, Nafsika Butler-Thalassis, Peter Freeman, Patricia McAllister, Selina Short and Azizi Toki

Also present: Councillor Heather Acton.

1. MEMBERSHIP

1.1 It was noted that Cllr Toki had replaced Cllr Carman as a member of the Committee. The Committee expressed its thanks to Cllr Carman for her valuable contributions to its work and provided a welcome to Cllr Toki.

1.2 Apologies were received from Cllr Emily Payne.

2. DECLARATIONS OF INTEREST

2.1 There were no declarations of interest.

3. MINUTES

RESOLVED:

3.1 That the Minutes of the Family and People Services Policy and Scrutiny Committee meeting held on 17 October 2019 be approved.

4. CABINET MEMBER UPDATE

4.1 Councillor Heather Acton (Cabinet Member for Family Services and Public Health), provided a briefing on key issues within her portfolio. The Committee

also heard from Bernie Flaherty (Executive Director, Adult Social Care and Health), Sarah Newman (Interim Executive Director of Children's Services), Senel Arkut (Head of Health Partnerships and Development), Houda Al-Sharifi (Interim Director of Public Health), Nicky Crouch (Interim Director of Family Services), Michelle Hill (Special Programmes Director) and Dominic Stanton (Acting Director of Adult Social Care).

4.2 The Committee received the update and held detailed discussions on the following topics:

- Meals on Wheels – It was confirmed that following the end of the Sodexo provided Meals on Wheels service a significant amount of work had been undertaken to ensure service users' needs had been reviewed with new care plans or alternative arrangements put in place. All service users affected had been contacted after the end of the previous service to ensure that their needs were being met. The Committee discussed the costs to the users of the new arrangements. The Committee were pleased that there had been no complaints since the service ended. It was confirmed that there would be a review three-months post cessation of services.

- Adapted Housing – The Committee was interested to learn of the interaction between services with regard to ensuring older people and those with physical disabilities were provided with suitable adapted housing. It was noted that there was a high level of interaction between all the relevant services including Housing and Adult Social Care. Efforts were being made however to develop an even more cohesive relationship between all parties to further enhance the offer to service users.

- Residential Care Homes – Garside House Nursing Home (a service provided by Sanctuary Care Ltd) was currently the subject of a Police investigation and the home had been inspected subsequently by the Care Quality Commission (CQC). Once the findings were publicly available these would be shared with the Committee. Beachcroft House was linked to the current SHSOP project contract and it was likely there may be an impact on its planned opening of Summer 2020.

- Oral Health – The Committee was pleased to note a campaign was underway, using Change4Life branding, which was aiming to communicate to residents that children under the age of 18 could get free dental treatment. It was commented that community notice boards located throughout the borough could be utilised to further disseminate the message. In addition, it was suggested that work be undertaken with the Community Champions to ensure a consistent message was communicated to residents. It was also noted that dental care was free during pregnancy and for 12 months after a baby was born.

- Sexual Health – On 1 April 2019 the Committee had received a report detailing the sexual health services provided within Westminster. The Committee had been particularly interested to learn about a trial underway using a medication called PrEP which helped prevent people from developing HIV. It was confirmed that the Council was continuing to support the trial and an update on its progress would be provided to the Committee.

5. WESTMINSTER'S YOUTH JUSTICE, STRATEGIC PARTNERSHIP PLAN 2019-2022 – A PATHWAY TO POSITIVE CHOICES

5.1 Jayne Vertkin (Head of Early Help) introduced the report which outlined Westminster's Youth Strategic Partnership Plan for 2019-22. The Committee also invited Sarah Newman (Interim Executive Director of Children's Services) and Nicky Crouch (Interim Director of Family Services) to join the discussion on this item.

5.2 The Committee was interested to note the report which covered a 3-year period and detailed the work undertaken to develop localised responses in assisting children and young people maximise their outcomes. An overview was also provided of the work of the Youth Offending Team (YOT) which was a multi-agency team which sat within Family Services and worked closely with the full spectrum of Children's Services from early intervention through to more specialist services.

5.3 The Committee was informed that the number of young people aged 10—17 entering the Youth Justice System for the first time had reduced between October 2017 and September 2018 from the same period the previous year. However, the complexity, nature of the offences and rates of reoffending of the remaining cohort remained a challenge. Difficulties had been experienced in reaching and engaging with this cohort, 50% of which were not in education, employment or training. As a result, the YOT would be carrying out a targeted piece of work, following a scoping exercise, to look at the young people that had reoffended and determine any missed opportunities.

5.4 In response to questions from the Committee it was explained that the strategy was underpinned by a relational and trauma informed approach. This would focus on understanding the reasons for the behaviour, rather than just the result of the behaviour, and support young people to make and sustain change. This whole system approach to youth justice targeted early interventions, placed the children first and engaged them in activities to prevent them entering the Youth Justice System. This included significant school inclusion work being undertaken targeting those children of Primary School age identified as at risk of exclusion. The Committee was pleased to note that the number of young people entering the justice system in Westminster had reduced 3 years in a row which suggested that the early intervention strategy was proving effective. It was explained that as

part of this work an Early Help Strategy had recently been developed and this could be circulated to the Committee

5.5 A discussion was held over engagement work carried out with different communities, in particular the Kurdish community. It was confirmed that currently there was not a specific charity relating to the Kurdish community however engagement work with it was being commenced. This was being undertaken through Youth Hubs, partnership working with the Police and the introduction of a new Community Engagement Officer to begin to identify the main concerns of this specific community and explore options to address these concerns. The Committee welcomed this development and requested an update be provided at the next meeting on progress in engaging with the Westminster Kurdish community.

5.6 The issue over young people classified as 'Not in Education, Employment or Training' (NEETs) was highlighted by the Committee who was interested to learn what efforts were being made to engage them. It was confirmed that a NEET Panel had been established to identify and address concerns regarding this issue. Their work involved significant crossover with the Integrated Gangs Unit (IGXU). The Committee noted that 75% of young people referred to the service were continuing to engage with it and 62% had subsequently returned to employment or educational training. Information on the work of the IGU was provided including the workshops it delivered to schools. The Committee expressed interest in the workshops and requested that the possibility of attending a future event be explored.

5.7 The Committee stressed the importance of coordination between the various stakeholders and Council services, in particular the education and employment services, in order to ensure there was integrated working which provided appropriate support and opportunities for young people who had needs which were impacting on their life choices. The Committee expressed its thanks to the Officers for all their hard work in this area and on the positive progress being made.

6. LOOKED AFTER CHILDREN AND CARE LEAVERS REPORT: INDEPENDENT REVIEWING SERVICE

6.1 Angela Flahive (Head of Safeguarding, Review and Quality Assurance) introduced the report which provided quantitative and qualitative evidence relating to Westminster City Council services for Looked After Children in 2019/19, as required by statutory guidance. The Committee also invited Sarah Newman (Interim Executive Director of Children's Services) and Nicky Crouch (Interim Director of Family Services) to join the discussion on this item.

6.2 The Committee noted that as of 31 March 2019, 209 children and young people were Looked After by Westminster City Council. Whilst the total number remained static the composition of the care population within Westminster was changing. The number of children coming into care from the generic population of children under 13 years of age was reducing and the numbers of Unaccompanied Asylum-Seeking Children arriving in Westminster was increasing. This was creating numerous complex safeguarding issues. It was highlighted that 490 Looked After Children Reviews had been undertaken in 2018/19 with 96% of children over 4 years of age contributing to their statutory review. The Committee welcomed that the voice of the child/young person was key to all discussions and care planning arrangements. It was advised that the introduction of minutes for review meetings in the form of a letter to children was being valued by both children and professionals. It helped to ensure that the child/young person was kept at the centre of the reviewing process, that the minutes were personal, that the language was clear and that the plan was purposeful. It was confirmed that an anonymised example of the minutes could be circulated to the Committee.

6.3 In response to questions from the Committee it was explained that in 2018/19 the majority of children aged 14 plus coming into care were placed in supported lodgings. This reflected the high number of unaccompanied minors coming into Westminster who were primarily aged 16 to 17 years old. Unaccompanied Asylum-Seeking Children (UASC) accounted for 73% of adolescent care entrants. Care planning and reviewing for children originating from other countries brought additional levels of complexity in relation to issues such as establishing jurisdiction, use of interpreters and cultural needs, all of which required additional time to ensure effective care planning. The increase in the number of UASC since 2016/17 had greatly impacted upon the Council's overall current LAC and Care Leaver populations. It had led to an increase in caseloads which had resulted in several challenges for the Independent Reviewing Officers (IRO) in undertaking the wide range of quality assurance activity. Planning to address these challenges was currently taking place and this included introducing enhanced working with UASC and additional IRO capacity into 2020. The Committee welcomed an invitation to attend a site visit to the supported housing provision for older children.

6.4 The Committee was provided with an update on the fostering service. It was explained that there was a wide selection of carers who were profiled, along with the children, to ensure there were suitable matches. It was recognised that challenges remained in instances when children required emergency placements. All efforts were made however to match children ethnically and religiously taking into account the child's wishes and feelings.

6.5 Further information was provided on the detailed safeguarding work undertaken with those children and young people who were identified to be most vulnerable. Assistance was provided to carers around planning and keeping children safe as

well as to the young person themselves. Each child would have a personalised safety plan, so if the child was deemed to be vulnerable to exploitation they would know where they could go to seek assistance and support.

6.6 The Committee expressed its thanks to the officers for an excellent report and all their hard work in a very challenging and complex area. The Committee expressed its willingness to engage further with the Looked After Children Service and suggested it be informed of any potential areas where it could observe some of the valuable work being undertaken.

7. 2019/20 COMMITTEE WORK PROGRAMME AND ACTION TRACKER

7.1 Lizzie Barrett (Policy and Scrutiny Officer) presented the Committee's 2019/20 Work Programme and Action Tracker.

7.2 The Committee reviewed the draft list of suggested items and were provided with a brief update on the task group established to focus on Young People's Mental Health and Technology.

7.3 The Committee noted the action tracker and requested minor alterations to the designations on the recommendation tracker.

RESOLVED:

1) That the Work Programme be noted;

2) That the action be noted; and

3) That the recommendation tracker be noted.

8. REPORTS OF ANY URGENT SAFEGUARDING ISSUES

8.1 The Committee received an update from Nicky Crouch (Interim Director of Family Services) with regards to the timescales of a recent recommendation for a Child Safeguarding Practice Review following a serious incident which had occurred in Westminster. The Committee welcomed a suggestion that an example of a review be circulated for information.

The Meeting ended at 8:42pm.

CHAIRMAN: _____ DATE: _____

City of Westminster

Family and People Services Policy & Scrutiny Committee

Date:	27 January 2020
Classification:	General release
Title:	Support for Young Carers in Westminster
Report of:	Nicky Crouch, Family Services Director ncrouch@westminster.gov.uk 02076412028
Cabinet Member Portfolio:	Family Services and Public Health
Wards Involved:	All
Policy Context:	Thriving Communities

1. Executive Summary

1.1.This report provides an overview of the support for young carers that is provided in Westminster. In the report we will: provide a definition of a young carer; outline our legal responsibilities to young carers; explore the methods of identification for this cohort; explain our assessment process and show what support we are offering to young carers in Westminster.

2. The definition of a young carer

2.1. A young carer is defined as 'a person under 18 who provides care for another person of any age, who may be physically or mentally ill, elderly, frail, disabled or who misuses alcohol or other substances', (Children and Families Act 2014 Section 96). A young carer becomes vulnerable when their caring role impacts upon their emotional or physical well-being and their prospects in education and life. Some are not only losing their childhoods, they are also missing out on vital school and training. This will have a negative impact on the rest of their lives.

2.2. The Children's Society (2013) analysis of young carers, who took part in a Longitudinal Study, found that they are:

- one and a half times more likely to have a special educational need or long-standing illness or disability.
- one in 12 are caring for more than 15 hours a week.
- more likely to miss school and tend to have significantly lower educational attainment at GCSE level.
- more than one and a half times as likely to be from black, Asian or minority ethnic communities and are twice as likely to not speak English as their first language.
- more likely than the national average to be not in education employment or training after leaving school.

2.3. The Children's Commissioner has put a spotlight on Young Carers and has published - *Young Carers, The Support provided to Young Carers in England* (December 2016). The data gathered for this report has highlighted considerable variability in the execution of statutory duties. As a part of this report, young carers identified four areas of support as being particularly important for them. These are:

- To be able to be a child;
- To be listened to and to have their views taken into account;
- To have someone they can talk to;
- For professionals to be aware and understand them.

3. **Legal responsibilities**

3.1. The regulatory environment has changed in recent years. Changes to the Care Act in 2014 and to the Children and Families Act in 2014 (and again in 2015) have extended and specified further the requirement for Local Authorities to assess young carers' needs for support.

3.2. The 2014 amendment to the Children and Families Act imposed a duty on Local Authorities to assess whether young carers in their area have needs for support and, if so, to assess what those needs are. Previously, a young carer had to request such an assessment; this amendment requires Local Authorities to carry out an assessment of a young carer's needs for support on request or on the appearance of need.

3.3. The Young Carers (Needs Assessments) Regulations 2015 (2015 amendment to the Children and Families Act) provide further detail about how Local Authorities must carry out the aforementioned duty.

3.4. The changes to the Care Act in 2014, although relating mostly to Adult Carers, also require Local Authorities to look at family circumstances when assessing an adult's need for care. New rules were introduced for working with young carers in order to plan an effective and timely move to adult care and support.

4. Prevalence and identification

4.1. The identification of young carers is fraught with challenges and this complicates the estimation of the number across the country. The 2011 Census asked respondents questions about caring responsibilities. 'Young unpaid carers' were defined as those aged 5 – 17 years old providing some level of unpaid care. Using this definition, there were 166,363 young people in this category, an increase of nearly 20% (from 139,188) in 2001. These census figures are based on self-identification by young carers and their families, many of whom may not recognise their caring responsibilities. In 2010 the BBC suggested a figure of 700,000 based on a survey of 4,029 children in 10 UK secondary schools. The actual figure nationally remains unknown.

4.2. The 2011 Census recorded 1588 young carers aged under 24 years in Westminster. This is a 19% increase in young carers since the 2001 census. It is difficult to get a true reflection of the exact numbers of Young Carers (aged under 18) because of the age range used in the Census (up to 24).

4.3. In Westminster, as in other Local Authority areas, we are dependent on schools, Police, GPs and other agencies to identify young carers. Our experience is that often a referral will be received for a related issue, like school attendance, and an assessment will highlight that the young person is a young carer. However, it is important to note that our Short Breaks team support 550 families and, by default, non-disabled siblings are likely to take on some level of caring. The issues these siblings face are varied. They include: not spending time with their parent alone; having to learn to fend for themselves earlier than would be expected and being a second pair of hands supporting parents with their siblings' practical care.

5. Assessment

5.1. In Westminster, all young people referred as young carers, (or where referred through another route and subsequently identified as a carer) are assessed to determine the level of one-to one support needed and to inform a Family Plan. Staff use additional specialist questionnaires that are designed to fully assess the extent of caring responsibilities. There is an agreement that practitioners can contact Adult Social Care or the Disabled Children's Team to enquire as to whether they are working with a parent or sibling and to request a whole family approach to assessments.

6. Support

6.1. Family services link young carers into a range of activities that our services work closely with through the Family Hub model. These are:

6.1.1. The local charity *Dream Arts* runs *Carer's Express*, a group programme with a therapeutic arts approach for young people aged 11-19 who give emotional

and/or practical support to a loved one. *Carer's Express* takes place primarily over the school holidays. It involves creative workshops at galleries, museums and other cultural hubs, plus trips to see plays and musicals, and meals out together, with discussion on what it means to be a 'young carer'. The group recently planned and presented an interactive presentation to professionals about their experiences and needs.

6.1.2. *Family Lives* offers a young people's support service for young carers aged 10-15, with one to one sessions with the young person and separate support for their families. There are also group sessions and activities and trips in school holidays.

6.1.3. This year, Bessborough Family Hub has worked with the arts charity *Create* to provide a series of three-day workshops for young carers facilitated by professional artists. The young people have produced short films, sculptures, animations and photographs linked to their experiences of growing up in Westminster. This project, which *Create* runs in a number of local authority areas, has recently won a national award.

6.1.4. The Short Breaks service run groups and fun sessions for siblings of disabled children as a part of their offer.

7. Data

7.1. To ensure that we accurately reflect the number of young carers, we have recently created a new field on our children's services database so that we can collect data on numbers. This will take time to embed, especially as many young carers are identified through other services and being a young carer is not the presenting issue.

8. Next steps

8.1. We have identified an existing staff member to act as a champion for young carers across the department. The aim of this champion role is to increase awareness of young carers amongst schools and GPs and to improve our reporting methods to make the collection of data easier.

If you have any queries about this Report or wish to inspect any of the Background Papers, please contact Jayne Vertkin:
number: 020 7641 5745
email: jvertkin@westminster.gov.uk

Appendix 1 – case study

M is a 13-year-old child.

Reason for referral: The initial reason for the referral was M's school attendance.

Assessment stage: An Early Help Family Practitioner met with mother and Child M and convened a Team around the Family (TAF) meeting. At this initial TAF the mother was very open about her physical health issues and how Child M supports her when she is unwell, which has, in turn, impacted on school attendance. Mum also flagged that she found it difficult communicating with the school.

The Early Help Family Practitioner used the Maca Panoc assessment tool with Child M. This is a specialist assessment tool aimed at identifying young carers. During this process Child M also expressed that she wanted more contact with her father.

Planning: The plan aimed to achieve the following:

- For mum to understand the long-term impact for Child M if she continued to miss school.
- To work with adult social care to review mum's care package.
- To support Child M to access support activities outside the home.
- To explore increased contact with the father.

Outcomes:

- Child M has started accessing *Carer's Express* run by *Dream Arts* and 1:1 support offered by *Family Lives*. *Family Lives* work with both mother and Child M around parenting issues. They give Child M a space to share her concerns or any difficulties at school.
- Child M's school attendance has improved.
- Mum's care package hasn't changed but mother is still considering what she would like this to look like.
- Contact with father has increased. This was achieved through support from the family therapist.

This page is intentionally left blank

Family and Peoples Services Policy and Scrutiny Committee

Date:	27 January 2020
Classification:	General Release / Confidential
Title:	Draft Local Safeguarding Children Board Annual Report 18/19
Report of:	Jenny Pearce, Local Safeguarding Children Board Independent Chair
Cabinet Member Portfolio	Family Services and Public Health www.westminster.gov.uk/cabinet)
Wards Involved:	All / Specific
Report Author and Contact Details:	**Emma Biskupski, LSCP Business Manager** emma.biskupski@rbkc.gov.uk

1. Executive Summary

The Local Safeguarding Children Board (LSCB) Annual Report is a report of the work of the multi-agency safeguarding children partnership across Hammersmith & Fulham, Kensington and Chelsea and Westminster. It gives an overview of the work of the Board during 18-19, including our key priorities, learning from case reviews and multi-agency audits.

2. Key Matters for the Committee's Consideration

The LSCB annual report is provided for information.

3. Background

Local Safeguarding Children Boards are required to publish an annual report of their work. The LSCB covering Hammersmith & Fulham, Kensington and Chelsea, and Westminster has completed the annual report detailing our work against our key priorities:

- reducing the harm of domestic abuse and coercive control
- tackling peer on peer abuse (including child sexual exploitation)
- hearing the voice of children and young people.

The report gives an overview of the multi-agency training that we provide to the children's workforce across Hammersmith & Fulham, Kensington and Chelsea and Westminster.

The report also notes the work of our Child Death Overview Panel that reviews the child deaths, both expected and unexpected across the three local authorities, and the future changes expected this year in the development of a larger CDOP footprint.

This is the last annual report of the Local Safeguarding Children Board in its current form, as from October 2019, the LSCB was replaced by the Local Safeguarding Children Partnership. This is in line with the statutory guidance in Working Together to Safeguard Children 2018 which states that the named Safeguarding Partners (the Local Authorities, the Clinical Commissioning Groups, and the Police Basic Command Unit) must set out their local multi-agency safeguarding children partnership arrangements.

If you have any queries about this Report or wish to inspect any of the Background Papers, please contact Emma Biskupski
emma.biskupski@rbkc.gov.uk

Local Safeguarding Children Board

Hammersmith & Fulham | Kensington and Chelsea | Westminster

ANNUAL REPORT 2018-2019

Table of Contents

Introduction from the LSCB Independent Chair

Independent Chair

Jenny Pearce

Welcome to this year's Local Safeguarding Children Board (LSCB) annual report for 2018-2019.
This was an important year as changes in legislation and related statutory guidance for safeguarding children set out the need to develop the new safeguarding children partnership arrangements that must be in place from October 2019.

We have worked to consult with key stakeholders to consolidate the work of the LSCB, and to ensure that we are ready to implement the new changes.
The legislation requires the Police, local Authority and Health Commissioners to lead safeguarding children arrangements which will then be scrutinised by an independent scrutineer. This means that the title of my role will change from Independent Chair to Independent Scrutineer.

Addressing these changes has been a productive exercise and plans are in place to build on the strong partnerships that already exist to safeguard children. With the LSCB becoming the Local Safeguarding Children Partnership (LSCP), we will retain quarterly partnership meetings with the wide body of agencies holding responsibility for safeguarding children, ensuring that this shared responsibility is embedded in practice across all agencies.

In my role as Independent Chair, I have noted and am encouraged that all our local partners want to keep hold of the strong partnership relationships so that information sharing and regular updating on safeguarding concerns can continue.

Over the year our work has addressed a number of safeguarding concerns, including the continued recognition of the impact of the tragedy of the fire at Grenfell Tower. We have worked to our three safeguarding children priorities, addressing peer on peer abuse, the impact of domestic abuse and engaging with children and young people. Examples of this work are outlined within the report. Very sadly we have worked with a number of cases involving knife crime and will be following up on some through learning events and case reviews. As across the country, knife crime, peer on peer violence and the criminal exploitation of children is a significant problem, raising the need for strong multi-agency partnership working. To facilitate this we have set up an LSCB subgroup looking specifically at 'Safeguarding Adolescents'. This, alongside other subgroups, reports to the quarterly safeguarding children board meetings, ensuring that all partners learn from and engage with the ongoing safeguarding concerns across the three boroughs. The work of the LSCB will continue as we transition into the new arrangements and I look forward to continuing to work with colleagues to work towards safeguarding children now and in the future.

The local picture

Hammersmith and Fulham

Approximately **35,150** children and young people aged 0 to 19 years live in Hammersmith and Fulham. This is **19%** of the total population in the area.

Kensington and Chelsea

Approximately **29,801** children and young people aged 0 to 18 years live in Kensington and Chelsea. This is less than **19%** of the total population in the area.

Westminster

Approximately **44,465** children and young people aged 0 to 19 years live in Westminster. This is less than **19%** of the total population in the area.

Local Safeguarding Data 2018/2019

6141 Referrals to Children's Social Care (**1668** LBHF / **2234*** RBKC / **2239** WCC)

271 Children were subject to a Child Protection Plan (**159** LBHF / **51** RBKC / **61** WCC)

Neglect and **Emotional Abuse** are the most frequent reason for children being placed on a Child Protection Plan in 2018-2019

Domestic Abuse continued to be the main parental risk factor leading to children becoming subject of a Child Protection Plan, and Neglect, Mental Health, Alcohol and Substance Misuse are also significant factors.

553 children were Looked After (**251** LBHF / **93** RBKC / **209** WCC)

Peer on peer is most common model of CSE but **online grooming and exploitation is also a concern.**

1 serious incident notification made to the National Child Safeguarding Practice Review Panel, which will be a **Serious Case Review** in Hammersmith and Fulham

106 face to face multi-agency safeguarding children training workshops attended by **1760** delegates

5 Designated Safeguarding Lead for Schools Training Sessions

5 Designated Safeguarding Lead for Schools Networking Forums

3 Safeguarding Training workshops for School Governors

1 Safeguarding Training workshop for Tri-Borough Music Hub, attended by **55** music tutors attending schools in all three boroughs.

61 schools in Hammersmith and Fulham, **97%** were rated Good or better

39 schools in Kensington and Chelsea, **100%** rated Good or better

59 schools in Westminster, **93%** rated Good or better

*The children's services bespoke case management system in RBKC records all contacts and referrals about children so the referrals data appears higher. The case management systems in LBHF and WCC are able to distinguish between contacts and referrals.

Governance and Structure

All local authority areas were required by law to have a Local Safeguarding Children Board and ours spans the three local authorities of Hammersmith & Fulham, Kensington and Chelsea and Westminster. This is a statutory partnership established following the Children Act 2004, and follows the 'Working Together to Safeguard Children 2015' statutory guidance and the revised statutory guidance in 'Working Together to Safeguard Children 2018', which was published in July 2018.

Our LSCB is chaired by an Independent Chair, Jenny Pearce. The Board meetings take place quarterly, as do the subgroup meetings.

The main functions of the LSCB (as per Working Together to Safeguard Children 2015) were to:

- Develop policies and procedures for safeguarding and promoting the welfare of children in the local area
- Communicate the need to safeguard and promote the welfare of children, raising awareness of how this can be best done and encouraging all to do so
- Monitoring and evaluating the effectiveness of what is done by the local authorities and their Board partners individually and collectively to safeguard and promote the welfare of children
- Participating in the planning of services for children in the local area
- Undertaking reviews of serious cases and sharing the lessons learnt.

Development of the new Local Safeguarding Children Partnership

The future of the multi-agency safeguarding partnership was reviewed by the Board, in light of the revised statutory guidance 'Working Together to Safeguard Children 2018', published in July 2018 following the new Children and Social Work Act that received Royal Assent in 2017. This sets out the new framework for the delivery of multi-agency safeguarding arrangements which the Safeguarding Partners were required to publish in June 2019, ahead of implementation by October 2019.

Safeguarding Partners
A *safeguarding partner* in relation to a local authority area in England is defined under the Children Act 2004 (as amended by the Children and Social Work Act, 2017) as:
(a) the local authority
(b) a clinical commissioning group for an area any part of which falls within the local authority area
(c) the chief officer of police for an area any part of which falls within the local authority area

The Independent Chair held a number of meetings with the local authority Chief Executives, Directors of Children's Services, Police and Clinical Commissioning Group, as well as wider partners to develop the new model. This development work continued through to October 2019, when the new Local Safeguarding Children Partnership held its inaugural meeting. The agreed structure for the LSCP can be found on p11.

The new Local Safeguarding Children Partnership will retain the three key priorities from the Local Safeguarding Children Board which can be found on page 10.

In addition, the new partnership aims to build stronger relationships and joint working opportunities with other strategic partnerships across the three local authorities, including:

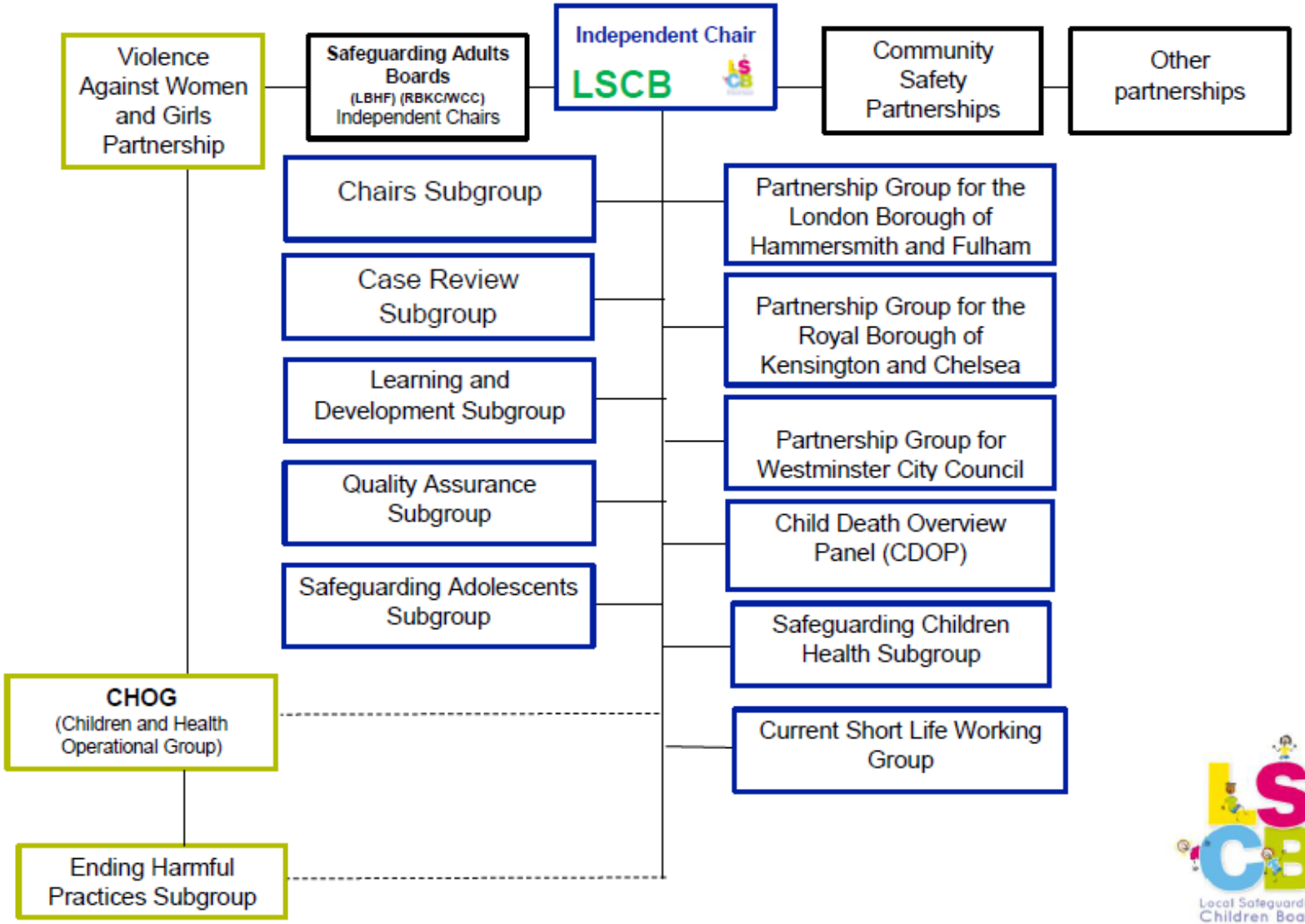
- the Community Safety Partnerships – tackling serious youth violence and knife crime and sharing the learning from Domestic Homicide Reviews (DHRs).

- the Violence Against Women and Girls Partnership – tackling domestic abuse and harmful practices

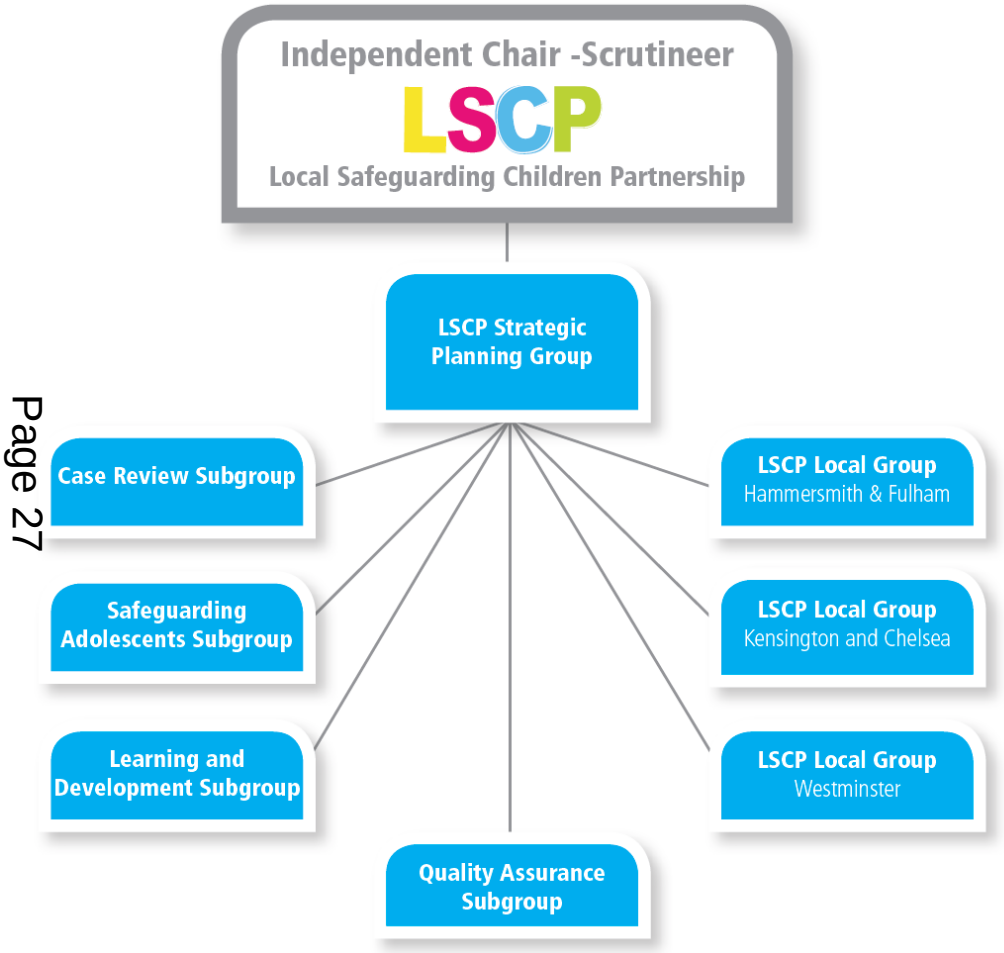
- the Health and Wellbeing Boards

- the two Safeguarding Adults Boards – developing a 'Think Family' approach, and work around transitional safeguarding as we know that young people can still be vulnerable when they turn 18.
  We plan to host some joint learning events between the Local Safeguarding Children Partnership and the two Safeguarding Adult Boards on these two topics.

LSCB structure until September 2019



LSCP Structure from October 2019



Other strategic partnerships the LSCP will liase with

- **Safeguarding Adults Board** Hammersmith & Fulham
- **Safeguarding Adults Executive Board** Kensington and Chelsea, Westminster
- **Community Safety Partnership** Hammersmith & Fulham
- **Safer K&C Partnership** Kensington and Chelsea
- **Safer Westminster Partnership** Westminster
- **Violence Against Women and Girls Partnership (VAWG)** Hammersmith & Fulham, Kensington and Chelsea, Westminster
- **Health & Wellbeing Board** Hammersmith & Fulham
- **Health & Wellbeing Board** Kensington and Chelsea
- **Health & Wellbeing Board** Westminster

LSCB Priorities 2018-2019

The new LSCB Chair and Board members agreed to retain the current three key priorities for our work across the partnership.

These include:

Priority 1 – Reducing the Harm of Domestic Abuse and Coercive Control

What is Domestic Abuse?

Any incident of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to: psychological, physical, sexual, financial, emotional.

Controlling behaviour is a range of acts performed by the abuser and designed to make their victim subordinate and/or dependent.

Coercive behaviour is an act or pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used by the abuser to harm, punish or frighten their victim.

The Police and the Local Authority Safeguarding Leads for schools worked together to begin planning the roll out of Operation Encompass. This is a scheme whereby the Police in the Multi-Agency Safeguarding Hub (MASH) contact schools to notify them of specific domestic abuse concerns that may have arisen overnight. This would allow the schools to provide the appropriate pastoral care for children following an incident that they may have witnessed or heard at home.

The LSCB formally endorsed the roll out of Operation Encompass in January 2019.

The Children and Health Operational Group (CHOG), a shared subgroup of the LSCB and the Violence Against Women and Girls Partnership has led on the awareness raising of domestic abuse across the partnership. Its role is to encourage the implementation of the Co-ordinated Community Response (CCR) model in children and health agencies.

The CHOG Coordinator left on 31.03.2018 and there was a gap whilst recruitment decisions were made. The new coordinator started in October 2018 and since then, key successes include:

- the subgroup meetings have been revised and well attended
- the subgroup has agreed a theory of change and a data set to review.
- the subgroup has also reviewed the new Pathfinder project across the three boroughs.
- Domestic abuse training was provided to 49 staff at Royal Brompton Hospital
- The CHOG coordinator has attended the Westminster Early Help Strategy Launch
- The CHOG coordinator has co-delivered a workshop on domestic abuse and children at the Hammersmith & Fulham Partnership Group
- Supported the planning for the potential launch of the Safe and Together Model across the partnership

In addition, the VAWG partnership was successful in a bid to be part of the National Pathfinder project, leading innovative approaches to tackling violence against women and girls in the health economy, in acute health trusts, mental health trusts and community based IRIS programmes in GP practices. The Pathfinder project will help to identify good practice and develop guidance in the form of a 'toolkit' which will enable others to achieve a model response to domestic abuse in health settings.

Planned work for 2019-2020

The Safeguarding Children Partnership will continue to monitor the roll out of Operation Encompass across schools, including schools in the independent sector.

The Safeguarding Children Partnership will explore the possibility of using the Safe and Together Model. This child-centred model provides a framework for multi-agency practitioners to work alongside survivors of domestic abuse, and better intervene with perpetrators, in order to keep the child/ren safe and together with the non-abusing parent.

Priority 2 – Tackling Peer on Peer Abuse (including Child Sexual Exploitation)

What is Peer on Peer Abuse?
Peer on peer abuse occurs when a young person is exploited, bullied and / or harmed by their peers who are the same or similar age; everyone directly involved in peer on peer abuse is under the age of 18. 'Peer-on-peer' abuse can relate to various forms of abuse (not just sexual abuse and exploitation), and it is important to note the fact that the behaviour in question is harmful to the child perpetrator as well as the victim. There is no clear definition of what peer on peer abuse entails. However it can be captured in a range of different definitions:

Domestic Abuse: relates to young people aged 16 and 17 who experience physical, emotional, sexual and / or financial abuse, and coercive control in their intimate relationships;

Child Sexual Exploitation: captures young people aged under-18 who are sexually abused in the context of exploitative relationships, contexts and situations by a person of any age - including another young person;

Harmful Sexual Behaviour: refers to any young person, under the age of 18, who demonstrates behaviour outside of their normative parameters of development (this includes, but is not exclusive to abusive behaviours);

Serious Youth Crime / Violence: refers to offences (as opposed to relationships / contexts) and captures all those of the most serious in nature including murder, rape and GBH between young people under-18.

What is Child Sexual Exploitation?
Child sexual exploitation is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate, or deceive a child or young person under the age of 18 into sexual activity a) in exchange for something the victim needs or wants and/or b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact. It can also occur through the use of technology.

Contextual Safeguarding Learning Event for the LSCB: At the July LSCB Board meeting, Dr Carlene Firmin from the Contextual Safeguarding Network and the University of Bedfordshire was invited to share her presentation on contextual safeguarding to the partnership. Contextual safeguarding is an approach to understanding and being able to respond to young people's experiences of significant harm outside of their families, for example within their peer groups, in schools, online and in their neighbourhoods. Additional spaces were made available so that key practitioners from across the partnership could also attend to learn more about this approach.

Following this, the local authorities convened a contextual safeguarding working group to review and pilot tools to promote a contextual safeguarding approach to their work.

Safeguarding Adolescents Subgroup:
This year, the LSCB convened a new Safeguarding Adolescents Subgroup. Over the past year, the subgroup has considered the following:

- a mapping exercise to understand the different forums across the three local authorities where children and young people are discussed and whether there is a way to rationalise these.
- A bid to the Contextual Safeguarding Network for support in developing our approach to Contextual Safeguarding. Ultimately, this expression of interest was not successful, however, it did lead to our involvement in the Beyond Referrals Project, working with four schools to develop appropriate responses to harmful sexual behaviours.
- A thematic Learning Review from Croydon LSCB on vulnerable adolescents
- A report from the National Working Group for Sexually Exploited Children and Young People report on sexual exploitation and the transition between children's and adults' services.
- Feedback from young residents about local youth services

Operation Makesafe:
In February 2019, the Police and CSE leads, along with Designated Nurses, health and voluntary sector partners collaborated to deliver CSE training and awareness raising sessions at two conferences for local hotels across the three local authorities, as well as taking part in Operation Makesafe, a Police-led initiative to test CSE awareness in hotels which was run for the third time in March 2019.

Taith Project:
The three local authorities and partners have worked to roll out the Taith project, in partnership with Barnardo's. This is a trauma informed service that aims to work with young perpetrators of harmful sexual behaviour, to reduce offending behaviours and provide opportunities for therapeutic support. Referrals to the Taith project in all three boroughs have increased over the past year.

MASE (Multi-agency Sexual Exploitation Panel): The MASE Panel covering the three boroughs meets monthly, chaired jointly by the Police and Local Authorities. This is attended by the Local Authority CSE Leads and multi-agency partners. MASE meetings focus on victims, perpetrators and locations of concern, and themes as per the London CSE Protocol published in June 2017. This year, planning began to extend the remit of MASE to include child exploitation and gang involvement, and multi-agency partners were consulted on how this might work effectively, to aid in mapping trends and disrupting harmful behaviour.

Safeguarding Adolescents at Risk Panel (SARP): SARP was launched in June 2019 to merge all panels of at-risk young people to one comprehensive multi-agency panel. SARP aims to streamline our current safeguarding practices and support better identification of risk and information sharing for some of our most vulnerable children and young people in Hammersmith and Fulham.

One Life No Knife Projects:
Planning began for an engagement event for parents and carers to discuss knife

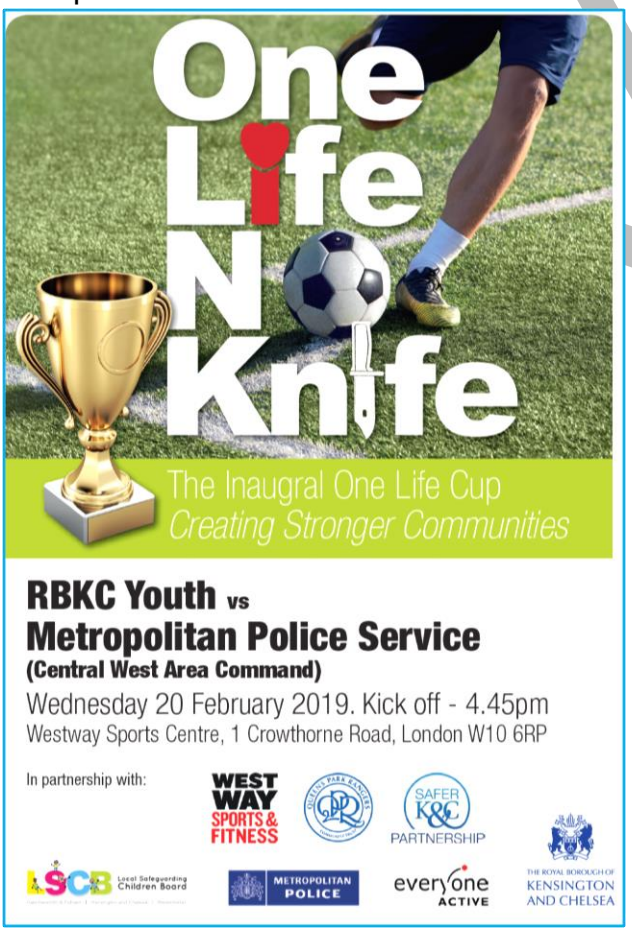
crime and serious youth violence in Hammersmith and Fulham, in preparation for an event that we aimed to host in the summer of 2019. Regrettably, difficulties in securing a suitable venue and date to accommodate key stakeholders led to a delay and we are now hoping to host this in the spring term of 2020.

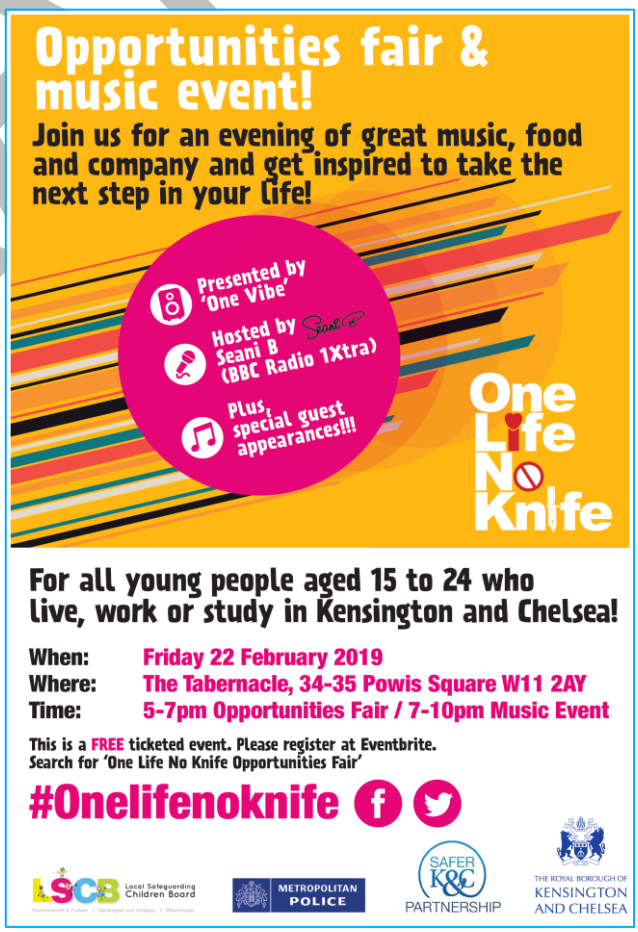
Case Study

In order to build on the One Life, No Knife work that was undertaken in Kensington and Chelsea last year, in February 2019 the police Basic Command Unit hosted a friendly football match between young people in Kensington and Chelsea and officers. The aim was to help build better relationships between young people and a key statutory service and share some important safeguarding messages with our young residents in the borough. The young players beat the police officers with the final score being 14 goals to 2!

Following this, the Safer K&C Partnership, together with the Royal Borough of Kensington and Chelsea and the Police hosted an opportunities fair for young people. This brought together a variety of employers and education providers, to showcase local opportunities for young people to consider. The employers present included British Airways, the British Army, the BBC, Chelsea Football Club, Queens Park Rangers Football Club, the London Fire Brigade and Chelsea and Westminster Hospital. The education providers who attended included Hammersmith & West London College, Imperial College, Thames Valley University and St Charles College. A total of 92 people attended, 60 of whom were young people.

A further engagement event for parents and carers, and young people, is also planned for 2020.





Flyers for the One Life, No Knife events in Kensington and Chelsea.

Case Study

Operation Makesafe

This is a Police-led operation to target child sexual exploitation (CSE) across the three local authorities in order to:

- to test local hotels' recognition and response to possible CSE situations from the Operation Makesafe training that they had previously received.

- to share the findings with the hotels to identify opportunities for learning,

How we did it:
Each hotel was visited after school, with different pairings of adult and child (Police Cadets). The main objective of the adult was to try and book a hotel room for them and the child and to pay for this using cash.

The adults were encouraged to give indicators of CSE during the booking process if the opportunity arose, such as being reluctant to provide ID, asking if the room would be available for only a few hours, and to talk for the child if they were spoken to by staff.

Following this, the hotel staff and general manager were debriefed by Police CSE officers and multi-agency partners.

The latest operation took place across three evenings in March 2019, following the two CSE awareness conferences for hotels held in February 2019.

This year, we noted an improved response from hotels to CSE concerns, compared to when the Operation was run the previous year.

Background:
Operation Makesafe was a policing test purchasing initiative to identify hotels susceptible to being locations for Child Sexual Exploitation (CSE). The Operation was derived from intelligence that hotel rooms are used by perpetrators.

Raising Awareness of CSE with local hotels:
To ensure the findings were translated into meaningful action and change, two CSE conferences, hosted in a local west end hotel were planned and organised. The Head of Safeguarding in the Metropolitan Police Service at the time, and the Assistant Director of Family Services from Hammersmith & Fulham opened the conferences. Barnardo's Nightwatch Scheme, Local Authority CSE leads, specialist sexual offences investigators and police licensing officers also spoke at the conferences. The events also included very powerful testimony from survivors of CSE.

Around 100 hotel owners, managers and supervisors from hotels across the three local authorities attended the conferences, which took place on the 4th and 11th of February 2019.

The conferences won 'hearts and minds' leading to hotels across the three local authorities being less receptive to perpetrators of CSE.

To end the event, attendees from the hotels were invited to sign a 'Statement of Intent' for their establishment to:

- Challenge guests where signs of CSE were apparent.
- To only accept bookings with official identification.
- To support the Police and report anything suspicious.
- To implement training for their staff to spot signs of exploitation.

Planned work for 2019-2020

Beyond Referrals Project: LSCB Partners are keen to develop a greater understanding about Contextual Safeguarding and hope to pilot some work with four schools in Westminster and Kensington and Chelsea with the Beyond Referrals project, in partnership with the University of Bedfordshire. This pilot aims to support schools to be able to address harmful sexual behaviours in their settings.

Priority 3 – Hearing the voice of children and young people

Our safeguarding self-assessments (Section 11 audits) give some feedback about how partner agencies use opportunities to hear from children and young people.

Multi-agency and single agency audits consider the voice of the child in case work.

This year, our Safeguarding Adolescents subgroup considered the voice of children and young people in relation to safety and security. They told us that they wanted to see youth workers visible in their communities, to have access to advice and information regarding personal safety, to have access to safe spaces for young people and help for young people to steer them away from committing crimes.

Planned work for 2019-2020

The Partnership will re-advertise for the role of Children and Community Engagement Officer.

We also want to build on the One Life No Knife events for young people and potentially expand these across all three boroughs.

Other projects:

Review of Child Protection Conferences and options for alternative pathways:

This year, a project began to review the child protection conference system through a systemic lens and to consider whether there are different ways to doing things that would being greater benefits to families. The review sought to answer the following questions:

- What is the quality of our overall engagement with, and treatment of, families

at the early stages of the child protection process?
- Do families experience our engagement with them as helpful?
- What are families' and professionals' specific experiences of Danger Statements?
- To what extent has the child protection conference system adopted systemic ways of thinking, working and positioning in respect of families?
- Are there alternative pathways to the CP conference route for some families?

Work began to consult with families and multi-agency professionals to help shape proposals. We aim to pilot new approaches in a small number of cases next year.

Quality Assurance

Serious Youth Violence and Exploitation audit:

During 18-19, the LSCB completed a multi-agency audit on Serious Youth Violence and exploitation, looking at our responses to 5 young people in each borough who were considered to be involved in violence or at risk of exploitation.

We held a multi-agency full day workshop took place in October 2019 which was well attended by a range professionals and agencies, in order to discuss the emerging findings and make recommendations for practice.

The recommendations for practice include:

- We need to develop ways of streamlining and effectively managing large professional networks around young people.
- Where young people are in hospital having suffered a serious injury, we should always consider holding the Strategy Meeting at the hospital in order to promote effective information sharing.
- Placement planning for young people aged sixteen plus should consider the full range of vulnerability and risk factors and should address how these will be responded to and mitigated against either by the identified placement or support around the placement.
- When undertaking an assessment or investigation, social workers and their managers should always ask themselves which health professionals or services might be best able to contribute information or help their thinking.
- Where CAMHS have not been able to engage with a family, feedback should be given to the other agencies involved. Where either Early Help or Social Care are already involved, the Team around the Family should review the plan to consider this.
- When working with a young person involved in violence or at risk of exclusion we should always think about younger siblings and future vulnerability or risk.
- Significant information should be fed back to GPs by social workers and other health professionals (e.g. school nursing). This should include the outcomes of any assessment or investigation

Strategic recommendations include:

- The Placements and Fostering and Adoption teams should be included in the strategic groups planning and monitoring our responses to Contextual Safeguarding. This is so that we make sure we are sourcing and using placements with the right expertise where young people are involved in violence and exploitation.
- Forums and panels should be combined wherever possible to consider inter connected risks and vulnerabilities rather than specific issues in isolation (e.g. Missing, Exploitation, Serious Violence etc.)
- CAMHS to consider their approach with families who find it difficult to engage
- The Vulnerable Children's Collaborative (RBKC & WCC) should consider strategies for re-integration to mainstream school for children in alternative education provision so that the Collaborative has oversight and influence of practice in this area.
- Address how we can secure better police involvement in multi-agency auditing

Missing Children audit:

The LSCB also reviewed the single agency audit by Children's Services on Children Missing that was completed in April 2018. This was a review audit to examine practice following a previous audit in October 2017. This audit found that practice had improved around the use of 'grab packs' (which is a two-page document with all the key details of young people who frequently go missing). There was also more consistency around the quality of return home interviews undertaken.

Safeguarding Self-Assessments (Section 11 Audit) findings:

The section 11 audits, a safeguarding self-assessment, are a useful way to check the safeguarding arrangements within agencies and provide the Board with assurance that agencies are doing what they can to ensure the safety and welfare of children.

This year, self-assessment audits were requested from private health care providers across the three local authorities. Providers were able to demonstrate having appropriate safeguarding policies, governing structures and safer recruitment procedures in place. Some providers were able to demonstrate some good work in engaging children and young people.

In addition, preparations were started to re-launch the audit using an online survey tool (Survey Monkey), with the ambition to extend the survey beyond safeguarding leads and managers, to front line practitioners in order to give the Partnership more comprehensive feedback from the multi-agency workforce.

Learning from Case Reviews

The Case Review Subgroup is made up of multi-agency partners including Police, Health and Local Authorities and in 2018-19 was chaired by the LSCB Independent Chair. In 2018-19 the subgroup met and reviewed:

- 5 Serious Case Reviews published by other LSCBs. Issues explored included:
  - How to create safe working cultures within organisations, effective arrangements for responding to allegations/concerns about adults in positions of trust, alongside child focused commissioning practices by national organisations responsible for contracts within the secure estate *(Medway STC SCR, Medway LSCB)*.

  -The importance of young people's individual needs and vulnerabilities being recognised and addressed in thorough assessments and interventions to provide the right support to children at risk of criminal exploitation. The importance of recognising that young people can be both victim and perpetrator. *('Chris' SCR, Newham LSCB)*

  -the complexities of working with non-compliant, chaotic, mobile and duplicitous families, where completing meaningful social work assessments is difficult and the voice of the child is not always captured. The role and influence of a baby's father remained unclear to professionals as information wasn't shared *(Child C SCR, Barking & Dagenham LSCB).*

  - The importance of considering 'safeguarding first' in relation to managing school attendance and of having more than one emergency contact (ideally three adults, which could include friends, family, neighbours) on file for children that is easy to access by relevant staff. The importance of staff actively considering the wider context of a child's life when a child's whereabouts are unknown and understanding how to escalate concerns. *('Chadrack Mbala-Mulo', City and Hackney LSCB)*

-The importance of offering appropriate counselling for parents/carers whenever a child is diagnosed with a disability and that professionals explore their understanding and views towards such disability. That professionals actively consider parents/carers individual cultural background and attitudes towards the provision of services. That there is a consistent process for identifying the key professional in a case and that professionals have the confidence to raise child protection concerns on open cases and escalate concerns. *(Family A, Kingston LSCB).*

- 3 local cases not meeting the threshold for serious case review but where local learning was shared. Issues considered included:
    - responding to a complex case featuring fabricated and induced illness
    - the importance of hospital staff considering the possibility of non-accidental injuries and not delaying safeguarding procedures.
    - the importance of strategy meetings including relevant health staff, especially where a child in an in-patient in hospital and listening to the voice of the child. Importance of discharge planning meetings being well coordinated to ensure patient safety.

- Information regarding the new Child Safeguarding Practice Review Panel and the new requirements for commissioning Child Safeguarding Practice Reviews, to replace Serious Case Reviews, once the LSCB has transitioned to the new safeguarding children partnership arrangements. Once the transition has taken place, the Safeguarding Partners have more flexibility to decide whether or not to commission a Local Child Safeguarding Practice Review.

- The terms of reference for the National Child Safeguarding Practice Review Panel's first national thematic review on adolescents in need of state protection from criminal exploitation.

At the end of the year, the LSCB was sadly notified of one fatal incident involving knife crime. This case will progress to a Serious Case Review.

LSCB partners have also contributed to a Safeguarding Adults Review (SAR), originally commissioned in December 2017 for Kensington and Chelsea, to learn from the case of a vulnerable adult where there was a near miss incident. One of the issues from this case is the importance of practitioners being able to consider a 'Think Family' approach in their work, regardless of whether they work primarily with adults or children. This is an area of work that we hope to embed further across the multi-agency workforce, together with both Safeguarding Adults Boards.

Future plans:

The Case Review Subgroup plans to review how we conduct Rapid Reviews and better disseminate the learning from cases using a new 7 minute briefing template.

LSCB Multi-Agency Training

The LSCB training programme was coordinated by our LSCB Multi-Agency Trainer with support from the Learning and Development Subgroup. Between April 2018 and March 2019, the LSCB delivered **106** face to face training workshops through the LSCB training programme. A total of **1760** delegates attended the workshops from a range of agencies across the partnership, including many in the voluntary sector. Across all of our workshops offered, there was a dip in the number of workshops booked. This is likely linked to a change in how bookings were made in the last quarter of the year. The overall attendance at training (across all workshops) was **68%,** though attendance rates for our core safeguarding workshops was higher, at **72.7%.**

The LSCB training programme raised just over £20,000 in revenue this financial year, a mix of fees for attendance from practitioners in the private sector (60%) as well as fees for non-attendance and late notice cancellations (40%).

The LSCB training programme was split into three main sections:

Mandatory training: this features our three core training workshops which are the Introduction to Safeguarding Children (1/2 day), the one-day Multi-Agency Safeguarding and Child Protection Workshop and the half day Multi-Agency Safeguarding and Child Protection Workshop Refresher.

Specialist training: this features a variety of more specialist topics including Safeguarding Children and Domestic Abuse, Child Sexual Exploitation, Support and pathways for children who have been raped or sexually assaulted, Safeguarding Children and Gang Awareness, Private Fostering Workshops, Staying Safe Online, and Harmful Practices.

Managerial training: this features training such as our Meet the LADO workshop and the Safer Recruitment workshop accredited by the Safer Recruitment Consortium, and Safer Recruitment Refresher workshops.

Further details about our training offer can be found on the link below:
www.rbkc.gov.uk/lscbtraining

The LSCB conducted a training needs analysis in order to help inform the design and commissioning of the training. This involved the LSCB Trainer consulting with partners about their training needs, in order to help us to understand what the emerging needs may be and if we need to expand on or deliver new training topics. This year, safeguarding adolescents was a topic that was requested. The LSCB Trainer coordinated two development sessions with multi-agency practitioners from all three boroughs from health, children's social care and youth offending teams; to create a workshop outline which will be finalised for the 2019-2020 training programme.

The LSCB has hosted three workshops this year to share the learning from Serious Case Reviews, as this was a priority from the previous year. The attendance for these workshops has been lower than we would like, so we are exploring the possibility of hosting shorter lunchtime learning sessions in different workplaces to

increase the take-up next year.

Wherever possible, the LSCB has asked local partners to deliver or co-deliver the training workshops so that local knowledge and expertise can be shared. For example, the delivery of our core training, the 'Multi-agency Safeguarding and Child Protection' workshop, has been co- delivered by the LSCB trainer and four different social workers, three voluntary sector practitioners from Standing Together Against Domestic Violence, and one police officer. There has been a reduction in support to co-deliver our core workshops from some health partners due to a lack of availability, however, we will continue to explore further co-delivery options in the future.

The LSCB monitors the feedback from LSCB training workshops. At every workshop we deliver, we ask delegates to rate the workshop experience, as well as whether the learning outcomes have been met.

Delegates are asked to rate their knowledge and understanding of the learning outcomes before the workshop and after. They are also asked to rate the training experience overall. Below are some quotes from the question "How will this training impact on your practice?" and the "Additional Comments" text box from two of the core training workshops and one managerial workshop:

Introduction to Safeguarding Children Workshop:

- By being more aware of signs of abuse by making the environment safer for children and to be aware of the local authorities to report to.
- Allow me to notice signs of concern and act accordingly
- The knowledge and updated procedures are very key and will help greatly in my role. I can transfer the skills to other roles/volunteering roles
- Keeping vigilant when it comes to the safety of a child. Will be used every day when I am working with children - in school and on our site (museum/gallery)
- More awareness of what to look out for & how to go about reporting it. I run a volunteer programme (architects going into school) so key points can also be included in their training.
- Very good & dynamic
- Great Training
- Course as a whole was very informative and I would recommend to a colleague.

Multi-agency Safeguarding and Child Protection Workshop:

- Really useful day to meet other non-health agency workers. I will be sharing all this information with my colleagues.
- The training fulfilled my expectations of refreshing my knowledge in all aspects of child protection. It was also good to update my knowledge.
- Great engaging and informative training really glad I came.
- Thank you, very good training with loads of relevant information to take back to setting.
- Is great to have such a diverse group to discuss factors with. Very good with references and support groups & organisations. Need to see how it works in practice.
- A significant impact on my knowledge and understanding of all aspects of safeguarding & referrals. Learning from the presenters but also the participants has increased my wider knowledge & understanding, also my confidence.
- Very informative, I feel equipped to take on the role of deputy safeguarding lead at school.
- I felt that the day should be turned on its head. Almost all the important information was presented after lunch with a lot to get through in a short period of time. A very knowledgeable & charismatic facilitator who held the room very well.
- Some parts of the training were lengthy… would be helpful to be more succinct/ concise to keep people's attention.

Meet the LADO

- Much better awareness of when to refer - if come across where it would be relevant to do so.
- Improve my understanding & confidence in working with the LADO & in-house safeguarding team.
- Awareness of LADO's role and to follow policy/procedure for referral or seeking advice. Will be revisiting all London CP procedures.

The Learning and Development Subgroup has attempted to monitor the impact of the training courses that we deliver via the LSCB training programme, however, this has remained a challenge due to the very low numbers of responses that we have received. Delegates are asked to share feedback at the end of each workshop about how what they've learnt will impact on their practice. We also send a smaller number of delegates a follow up email survey (via Survey Monkey) to check the impact three

to six months following their attendance at training. We have noted that still only a small percentage of delegates complete this.

The LSCB Learning and Development Subgroup will challenge this further with line managers in 2019-20.

Future plans:

In 2019-2020, the Learning and Development Subgroup are keen to support the following:

- Workshops regarding the changes that the local authorities are making to the child protection conferences in all three boroughs.
- Workshops on contextual safeguarding and safeguarding adolescents
- Workshops on Modern Slavery and Child Trafficking
- Updating the core 'Multi-agency Safeguarding and Child Protection' workshop with new scenarios and exercises and updated course handbook.

In addition, in 2019-2020, the Learning and Development Subgroup will also need to review the effectiveness of the current learning management system (LMS) that we use for workshop bookings. This new LMS was launched in December 2018 as a result of the local authorities purchasing a new cloud-based human resource management system. The LSCB training team currently has to coordinate bookings across one LMS for Hammersmith & Fulham, and another LMS for the Royal Borough of Kensington and Chelsea and Westminster which is time consuming. In addition, feedback from multi-agency partners suggests that it is not user friendly for practitioners to use as they are not directly employed by the local authorities. This has had an impact on the numbers of practitioners being able to book or cancel training workshops in a timely manner. The new LMS also does not provide the LSCB with the data we would like to be able to monitor the take up of safeguarding training across the multi-agency workforce.

Child Death Overview Panel (CDOP)

The LSCB is responsible for:

- Collecting and analysing information about each child death with a view to identifying:
    - Any case giving rise to the need for a review
    - Any matters of concern affecting the safety and welfare of children in the area of the LSCB
    - Any wider public health or safety concerns arising from a particular death or from a pattern of deaths in the area.
- Putting in place procedures for ensuring that there is a coordinated response by the authority, their Board partners and other relevant persons to an unexpected death.

Note: The responsibility for determining the cause of death rests with the Coroner or the doctor who signs the medical certificate of the cause of death.

The process for reviewing child deaths includes:

- an overview of all child deaths up to the age of 18 years (excluding those babies that are stillborn and planned terminations of pregnancy carried out within the law)
- A multi-agency rapid response meeting which is convened following an unexpected child death in order to make initial enquiries and co-ordinate support to the bereaved family.

Following an unexpected death, a rapid response meeting is normally held within 5-7 days of the death occurring. This is chaired by the Designated Paediatrician for Child Death.

Modifiable factors are defined as those, where, if actions could be taken through national or local interventions, the risk of future child deaths could be reduced.

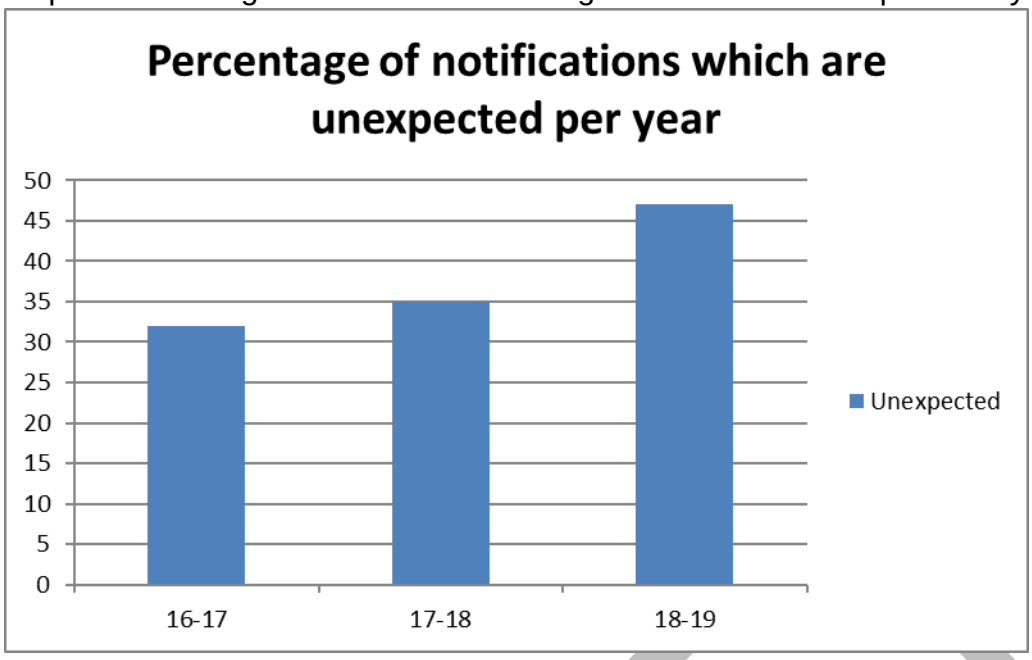
Attendance at the panel from professionals across the range of core membership organisations has generally been very good. There have been difficulties securing regular public health representation due to interim staff being in post following the disaggregation of the three-borough public health team. In their absence, the panel has been chaired by the LSCB Business Manager.

The panel has reviewed child deaths that have occurred across the three local authorities, identifying factors that may have contributed to the deaths along with any modifiable factors. The timing of the reviews is subject to the number of cases relating to a particular theme and other processes such as case reviews, police investigations or an inquest occurring.

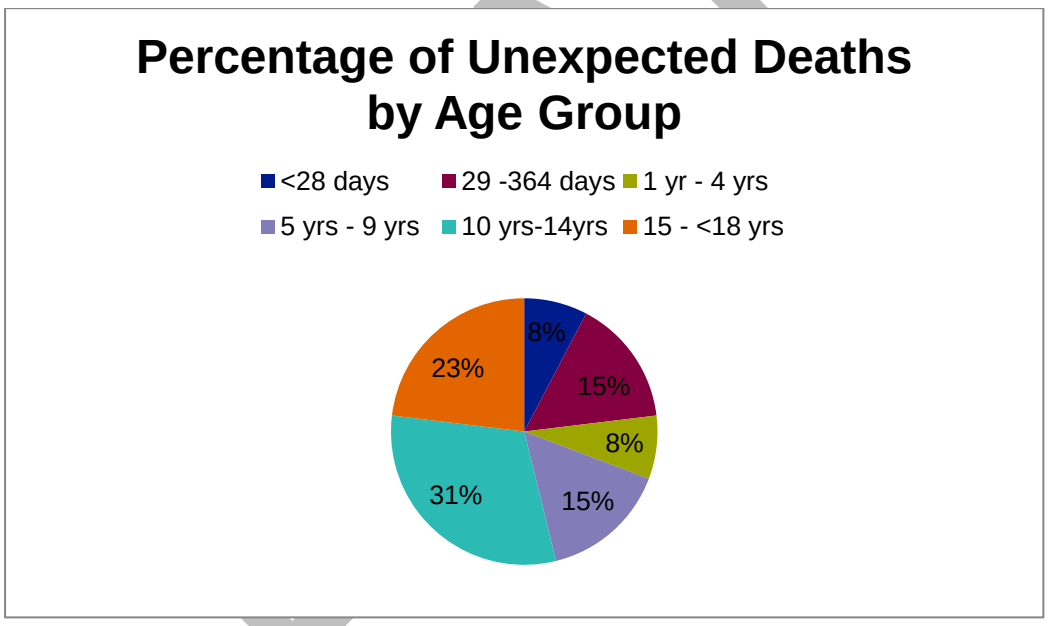
Child Death Notifications:
In 2018-19, the CDOP Panel received 40 child death notifications in total, one of which was a late notification, identified from Inquest schedules, which was not sent to the CDOP by the Coroner at the time of the child's death in 2016.
30 of the notifications were for children ordinarily resident across the three local authorities, and 10 notifications were about children who normally reside overseas.

Unexpected Child Deaths:
In 2018-19, a total of 14 deaths (47%) were unexpected and required a rapid

response meeting to be held. This is a significant increase on previous years.



Over half the unexpected deaths in 2018-19 occurred in children over the age of 10 years, with just under a quarter occurring in infants under 1 year. This is in contrast to 2017-18 where 58% of unexpected deaths were in children under 1 year of age.



Learning from child death reviews:

Relevant learning is cascaded via the health networks in our LSCB area, with the intention that learning from local and national child reviews is incorporated into practice, training and supervision.

Trends and learning identified that may have implications nationally are shared through the national CDOP network.

The future of CDOP and transition to new arrangements

Following the publication of the new 'Working Together to Safeguard Children 2018' in July 2018, and alongside this, new guidance 'Child death review: statutory and

operational guidance (England)' in October 2018, work has been undertaken to help shape a new CDOP service covering the eight north west London boroughs, including: Brent, Ealing, Harrow, Hillingdon, Hounslow, Hammersmith & Fulham, Kensington and Chelsea, and Westminster.

This is because the new statutory guidance requires CDOPs to cover a geographical footprint that would enable a minimum of 60 cases to be reviewed per year. Funding was secured from the Early Adopters funding stream from the DfE for a project manager to help the eight north west London CDOPs to collaborate and develop this new service.

The above guidance sets out the full process that follows the death of a child who is normally resident in England. It builds on the statutory requirements set out in Working Together to Safeguard Children 2018 and clarifies how individual professionals and organisations across all sectors involved in the child death review process should contribute to reviews. The guidance sets out the process in order to:

- improve the experience of bereaved families, and professionals involved in caring for children
  and
- ensure that information from the child death review process is systematically captured in every case to enable learning to prevent future deaths

The new guidance places an emphasis on the Joint Agency Response, which will include home visits by a Child Death Review clinician and senior police officer, as well as bereavement support with the introduction of a new key worker role.

Going forward, CDOP will no longer report directly to the Safeguarding Children Partnership, and instead will report to the Local Authorities and Clinical Commissioning Groups.

LSCB Website and Social Media

The LSCB website statistics show that the most viewed webpages are still the LSCB Training Pages and Safeguarding Contacts Pages. Work to update the LSCB microsite has been held back due to larger web projects being undertaken in the local authority which hosts the pages. However, in 2019-2020, further work is planned to reflect the upcoming changes from the LSCB to the new Local Safeguarding Children Partnership (with logos being updated) and a scrolling carousel of new items on the front page which will signpost visitors to the website to updated content.

Further projects to develop in the upcoming year will be a range of Seven Minute Briefings for practitioners, to help share key safeguarding messages to safeguarding partners.

The LSCB maintains a social media presence on Twitter (@LSCBx3). We have grown our following to 574 followers and continue to use this platform to amplify messages about national safeguarding campaigns such as Safer Internet Day and local initiatives such as our One Life, No Knife events for children and young people, as well as promoting multi-agency training opportunities.


EE WiFiCall
11:55
78%
LSCP x3
581 Tweets
Tweets
Tweets & replies
Media
Likes
LSCP x3 @LSCPx3 · 05/02/2019
This is an easy resource for parents/carers to use with children for #SaferInternetDay2019
Ofcom · 05/02/2019
Today is #SaferInternetDay2019 and we've created a fun, informative worksheet to help parents and teachers have open conversations with children about staying safe online. Check it out: ofcom.in/SID2019
Nearly all of our 8-11 year olds said they would tell a family member if they saw something worrying, nasty, or offensive online.
88% Parent
23% Teacher
19% Friend
3% No-one
2% Police
2% The website themselves
1% Don't know if they would tell anyone


EE WiFiCall
12:08
75%
You Retweeted
IKWRO
@IKWRO
Are you a professional working in Hammersmith & Fulham, Kensington & Chelsea or Westminster? We're running a FREE training on 26th March on the issues of #HonourBasedViolence and #ForcedMarriage. Register here:
Local Safeguarding Children Board
eventbrite.com
Tweet your reply

Appendix 1 – LSCB Membership and Attendance

LSCB Main Board Attendance
2018-19

Role	17th April 2018	17th July 2018	16-Oct-18	22-Jan-19
LSCB Chair	y	y	y	y
Executive Director of Children's Services (Tri and later Bi-borough)	y	y	y	y
Director of Family Services (H&F)	y	y	y	y
Director of Family Services (RBKC)	y	y	y	y
Director of Family Services (WCC)	y	y	y	y
Director of Schools (Asst Director)	y	y	y	y (delegate)
Head of Safeguarding & Quality Assurance, RBKC & WCC	y	y	y	y
Head of Safeguarding & Quality Assurance LBHF	y	y	n	y
LSCB Business Manager	y	y	y	y
Director of Adults Safeguarding (or rep)	y	y	y	y
Housing	y	y	n	y
Police Basic Command Unit (BCU)	y	y	y	y
Probation	y	y	y	n
Community Rehabilitation Company	n	y	y	y

CAFCASS	n	n	n	n
Prisons	n	n	n	n
Ambulance Service	n	n	n	n
Voluntary Sector	n	y	y	y
Lay member	y	y	y	y
NHS England	n	n	n	n
Health CCGs	y	y	y	y
Designated Doctor	n	n	y	y
Designated Nurse	y	n	y	y
Head of Safeguarding, CLCH	n	y	y	y
CLCH Director of Nursing	n	n	n	n
Imperial Director of Nursing	y	y	y	n
Chelwest Director of Nursing	y	y	n	n
WLMHT/West London NHS Trust	y	n	y	y

Appendix 2 – LSCB Budget 2018/2019 Outturn

	LBHF	RBKC	WCC	Total
CONTRIBUTIONS				
Sovereign Borough General Fund	-79,169	-60,740	-77,710	**-217,619**
Metropolitan Police	-5,000	-10,000	-5,000	**-20,000**
Probation	-2,000	-2,000	-2,000	**-6,000**
CAFCASS	-550	-550	-550	**-1,650**
London Fire Brigade	-500	-1,000	-1,500	**-3,000**
CCGs (Health)	-20,000	-20,000	-20,000	**-60,000**
Total Partner Income	**-28,050**	**-33,550**	**-29,050**	**-90,650**
Training income	-6,956	-6,956	-6,956	**-20,867**
Total Funding	**-114,175**	**-101,246**	**-113,716**	**-329,136**
EXPENDITURE				
Salary expenditure	66,003	66,003	66,003	**198,009**
Independent Chair	5,745	5,745	5,745	**17,235**
Training	1,240	1,240	1,240	**3,720**
Other LSCB costs	877	877	877	**2,632**
Total expenditure	**73,865**	**73,865**	**73,865**	**221,596**
Final outturn variance	-40,309	-27,380	-39,850	**-107,540**
BALANCE SHEET				
Reserves Brought Forward	-45,216	-129,650	-81,499	**-256,365**
Adjustment in year				
Contribution to LSCB balance sheet accounts	-40,309	-27,380	-39,850	**-107,540**
Reserves to take forward	**-85,525**	**-157,030**	**-121,350**	**-363,905**

Excluding corporate overhead recharges

Notes: All costs to be shared equally between the three boroughs, with the exception of serous case review expenditure, if any, which is funded from the LSCB reserves in the relevant local authority.

Glossary:

Glossary of terms

Barnardo's Taith model	A service to raise awareness of harmful sexual behaviours and help young people through a structured intervention to build a positive future. It aims to reduce offending behaviours and provides opportunities for therapeutic support.
CAFCASS	Children and Family Court Advisory and Support Service
CAMHs	Child and Adolescent Mental Health Services
CDOP	Child Death Overview Panel: a statutory panel for reviewing information on all child deaths, looking for possible patterns and potential improvements in services, with the aim of preventing future deaths.
Children	Anyone who has not yet reached their 18th birthday. The fact that a child has reached 16 years of age, is living independently or is in further education, is a member of the armed forces, is in hospital or in custody in the secure estate, does not change their status or entitlements to services or protection.
Child protection	Part of safeguarding and promoting welfare. This refers to the activity that is undertaken to protect specific children who are suffering, or are likely to suffer, significant harm.
Child Sexual Exploitation	Child sexual exploitation is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology.
Clinical Commissioning Group (CCG)	A clinically-led statutory NHS body responsible for the planning and commissioning of health care services for their local area.
Community Rehabilitation Company (CRC)	A private law enforcement agency that works alongside the National Probation Service to support offenders to complete their probation orders.
Community Safety Partnership	Community Safety Partnerships were set up under the Crime and Disorder Act 1998. They are made up of representatives from the police, local authorities, fire and rescue authorities, health and probation services, who work together to protect their local communities from crime and to help people feel safer. They address issues including anti-social behaviour, drug and alcohol misuse and re-offending.
Contextual Safeguarding Network	Network from the University of Bedfordshire that brings together practitioners, researchers and policy makers who are committed to protecting young people from harm outside the home. www.contextualsafefuarding.org.uk

Co-ordinated Community Response	An inter-agency approach for responding to domestic abuse, to help local police, law enforcement agencies, the courts and wider community to support victims and survivors of domestic abuse.
DfE	Department for Education – central Government department.
Designated Safeguarding Lead	A practitioner, usually part of the management team, who takes the lead on safeguarding children matters in their team/agency.
Domestic Homicide Review (DHR)	A multi-agency review of the circumstances in which the death of a person aged 16 or over has or appears to have resulted from violence, abuse or neglect by a person to whom they were related, or with whom they were, or had been, in an intimate personal relationship, or a member of the same household as themselves
Early Help	Also known as early intervention, is the support given to a family when a problem first emerges. It can be provided at any stage in a person's life. Early help services can be delivered to parents, children or whole families, but their main focus is to improve outcomes for children.
FGM	Female Genital Mutilation – a harmful practice where the female genitalia are deliberately cut, injured or changed, but there is no medical reason for this to be done.
GBH	Grievous bodily harm
IDVA	Independent Domestic Violence Advisor
IRIS	IRIS is a general practice-based domestic violence and abuse (DVA) training support and referral programme, including training and education and enhanced referral pathway to specialist domestic abuse services.
IGU	Integrated Gangs Unit: a multi-agency unit, aiming to reduce serious youth violence. It consists workers from the local authorities, Met Police, Probation and St Giles Trust, a mental health nurse and employment coach, working together to support young people aged 10-24 who are involved in group violence, or on the periphery of gangs. The team also works with neighbouring boroughs to tackle cross border gang violence.
LADO	Local Area Designated Officer: Local authorities should have designated a particular officer, or team of officers to be involved in the management and oversight of allegations against people who work with children. Any such officer, or team of officers, should be sufficiently qualified and experienced to be able to fulfil this role effectively, for example qualified social workers. Arrangements should be put in place to ensure that any allegations about those who work with children are passed to the designated officer, or team of officers, without delay
LSCB	Local Safeguarding Children Board – a statutory partnership to coordinate the work
LSCP	Local Safeguarding Children Partnership (replaces the LSCB from October 2019)
MARAC	Multi-Agency Risk Assessment Conference: a victim focused information sharing, and risk management meeting attended by all key agencies, where high risk cases domestic abuse cases are discussed.

MASE Panel	Multi-Agency Sexual Exploitation Panel: a multi-agency panel to develop a strategic overview of child sexual exploitation and reduce the risk of harm to children and young people at risk.
MOPAC	Mayor's Office for Policing and Crime
Multi Agency Safeguarding Hub (MASH)	The MASH is a team made up of co-located staff from Children's Social Care, Police and Health from across the three boroughs with links to Probation, Housing and Youth Offending Teams. The MASH provides the capacity, skills and the practical arrangements to collect, analyse and securely store the information held by all partners about children and families that is relevant to an assessment of safeguarding risk. It does this in defined timescales that reflect the level of risk identified.
Private Fostering Arrangements	Private fostering is an arrangement made where someone other than the child's immediate family is looking after a child for longer than 28 days. Examples of private fostering situations include: children with parents working or studying elsewhere; children whose parents are overseas; children on holiday exchanges. Private fostering arrangements should be notified to the relevant local authority children's social care team.
Section 11 Audit	A Self-Assessment audit to allow partner agencies to demonstrate how they meet key safeguarding standards.
Serious Case Reviews (SCR)	A statutory review, required under Working Together to Safeguard Children 2015 when abuse or neglect of a child is known or suspected; and (b) either — (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.
Safe and Together Model	This child-centred model provides a framework for multi-agency practitioners to work alongside survivors of domestic abuse, and better intervene with perpetrators, in order to keep the child/ren safe and together with the non-abusing parent.
Safeguarding Partner	A safeguarding partner in relation to a local authority area in England is defined under the Children Act 2004 (as amended by the Children and Social Work Act, 2017) as: (a) the local authority (b) a clinical commissioning group for an area any part of which falls within the local authority area (c) the chief officer of police for an area any part of which falls within the local authority area.
Standing Together Against Domestic Violence (STADV)	Standing Together support organisations, including the Police, criminal justice partners, social services, healthcare workers and charities, to identify and respond effectively together to domestic abuse.
Think Family	A Think Family approach is the steps taken by practitioners to identify wider family needs which extend beyond the individual they are supporting.
Transitions	This Term relates to the transition between children's and

	adults' services. Young people may still need support when they turn 18. 'Transition' is the period of time when young people are moving from childhood into adulthood. Services for adults are different from those for children, so it's important that young adults get the services they need to live a full life.
Violence Against Women and Girls Partnership (VAWG)	A local strategic partnership that overseas the response to domestic abuse and harmful practices such as FGM.

Family and People Services Policy and Scrutiny Committee

Date:	Monday 27th December
Classification:	General Release
Title:	2018/19 Annual Report
Report of:	Safeguarding Adults Executive Board
Cabinet Member Portfolio	Cabinet Member for Family Services and Public Health
Wards Involved:	All
Policy Context:	For information only
Report Author and Contact Details:	Louise Butler (Head of Service, Safeguarding Adults, Bi-Borough) lbutler@westminster.gov.uk

1. Executive Summary

This is the sixth Annual Report of the Safeguarding Adult Executive Board (SAEB). The multi-agency Board provides leadership of adult safeguarding across the Royal Borough of Kensington and Chelsea and the City of Westminster. The purpose of the Board is to ensure that member agencies work together, and independently, to secure the safety of residents who are at most at risk of harm from others, or through self-neglect.

2. Background

2.1 This is the fourth year that the SAEB has operated under Schedule 2 of the Care Act 2014, and overseeing the statutory duties of conducting Safeguarding Adult Enquiries (Section 42) and Safeguarding Adults Reviews (Section 44).

2.2 The Safeguarding Adults Board has 3 core duties. It must:

- Develop and publish a strategic plan, setting out how they will meet their objectives and how their member and partner agencies will contribute.
- Publish an Annual Report detailing how effective their work has been.

- Commission Safeguarding Adult Reviews (SAR's) for any cases which meet the criteria for these.

2.3 The learning from Safeguarding Adults Reviews and Safeguarding enquiries this year has demonstrated how much can be achieved by working together to tackle issues that may make communities unhealthy or unsafe, and from learning lessons and making changes where these are indicated. The SAEB actively promotes a learning culture and members are transparent, engaged, and accountable to one another, leading to better outcomes for people in need of care and support.

2.4 The report seeks to show how member agencies of the SAEB provide assurance to the SAEB for the ways in which its three strategic priorities (Making Safeguarding Personal; Creating Safe and Healthy Communities; and Leading, listening and Learning) are being promoted within their organisation.

2.5 The report also seeks to demonstrate how the learning from safeguarding enquiries and reviews conducted during the year led, to changes that benefit the safety, health, and wellbeing of local residents. This is particularly where the learning shows there is room for agencies to work more effectively together to prevent abuse or neglect.

If you have any queries about this Report or wish to inspect any of the Background Papers, please contact Louise Butler lbutler@westminster.gov.uk

SAFEGUARDING ADULTS EXECUTIVE BOARD

ANNUAL REPORT 2018/19

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

COURAGE
COMPASSION
ACCOUNTABILITY

City of Westminster

THE ROYAL BOROUGH OF KENSINGTON AND CHELSEA

SAFEGUARDING ADULTS EXECUTIVE BOARD
ANNUAL REPORT 2018/19

CONTENTS

FOREWORD

I am very pleased to introduce the Annual Report for the Bi-Borough Safeguarding Adults Executive Board 2018/19. As the Interim Independent Chair of the Board during that year, I was very grateful to all partners for their contributions to the Board, and their ongoing support.

During the year, the partnership has reviewed and amended its governance structure and developed and agreed a practical business plan to deliver our shared objectives. The plan includes our commitment to working with all agencies, supporting operational services to prevent abuse from happening, and when and where abuse does happen, be assured that all agencies respond appropriately. The Board also held a development day which provided an opportunity for partners to evidence their work to safeguard vulnerable adults. Partners of the Board have continued to support each other, meet our collective commitment to keeping adults safe across the Bi-Borough, and progress delivery of the business plan to support the shared objectives.

In March 2019 a peer review team was invited, through the Association of Directors of Adult Social Services London (ADASS), to complete a review of safeguarding arrangements within the Bi-Borough. The review was a stimulating and rewarding experience. The quality of the work shared and the conversations with the Peer Review Team demonstrated commitment, hard work and professionalism regarding safeguarding adults from all partners.

We have continued to look at information about safeguarding activity in the Bi-Borough to inform our priorities for improvement. We have considered recommendations and lessons learned from Safeguarding Adults Reviews and where relevant, from Children's Serious Case Reviews and Domestic Homicide Reviews to understand what happened, and what needs to change. This has informed the business plan this year and priorities for the future

We continue to raise awareness of safeguarding in the communities of the Bi-Borough, with the help of our service user, community and voluntary groups, especially the 'Local Account Group' and the 'Safeguarding Adults Reference Group'.

This annual report is important because it shows what the Board aimed to achieve during 2018/19 and what we have been able to achieve. It shows that most of the business plan was completed during the year. The annual report provides a picture of who is safeguarded in the Bi-Borough, in what circumstances and why. This helps us to know what we should be focussing on for the future. It includes the High-Level Statement of Intent 2019/2022, which says what we want to achieve during the next 3 years (see page 10).

There continues to be significant pressures on partners in terms of resources and capacity, so we want to thank all partners and those who have engaged in the work of the Board, for their considerable time and effort. In my role as Interim Independent Chair I would like to acknowledge the value of the work of the subgroups in supporting the Bi-Borough Safeguarding Adults Executive Board (SAEB).

There continues to be a lot to do to reduce the risks and experiences of abuse and neglect in our communities and support people who are most vulnerable to these risks. I sincerely hope that Board partners will continue to work together to achieve the Boards objectives with the support and leadership of the new Independent Chair

I hope that you will find this year's Annual Report a helpful and informative read.

Dr Adi Cooper OBE,

Interim Independent Chair, Safeguarding Adults Executive Board 2018/19

WHAT DOES THE EXECUTIVE BOARD DO?

Our Vision

The strategic objectives and work of the Board is based on the following vision:

People in the Royal Borough of Kensington and Chelsea and Westminster City Council have the right to live a life free from harm, where communities:

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

Structure and Membership

The Bi-Borough Safeguarding Adults Executive Board (SAEB) is a multi-agency partnership.

The role of the Board is to assure itself that local safeguarding arrangements and partner agencies act to help and protect adults in its area.

This is about how we prevent abuse and respond when abuse does occur in line with the needs and wishes of the person experiencing harm.

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

- have needs for care and support; and
- are experiencing, or at risk of, abuse or neglect; and
- (as a result of their care and support needs) are unable to protect themselves from either the risk of, or experience of, abuse or neglect.

Our Values and Behaviours

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

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

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

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

The Board is a partnership of organisations working together to prevent abuse and neglect, and when someone experiences abuse or neglect, to respond in a way that supports their choices and promotes their well-being.

The Board does not work in isolation, nor is it solely responsible for all safeguarding arrangements as Safeguarding is everyone's business!

THE SAFEGUARDING ADULTS EXECUTIVE BOARD

Section 43 and Schedule 2 of the Care Act 2014 outlines local authorities' responsibilities to set up a Safeguarding Adults Board in their area.

The Act requires a Safeguarding Adults Board to:

1. Develop and produce a 3-year Strategy and an annual Business Plan in order to direct the work of the Board that reflects its priorities
2. Publish an annual report/accountability statement highlighting the Board's progress and achievements in meeting the objectives in the Strategic Safeguarding Plan and ensuring this is widely reported across partner agencies and organisations.
3. Learn from the experiences of individuals, through undertaking Safeguarding Adult Reviews (SAR's) in accordance with the national guidance of best practice and the Board's SAR's protocol.

The Terms of Reference for the board were reviewed in January 2019 and can be found **here**.

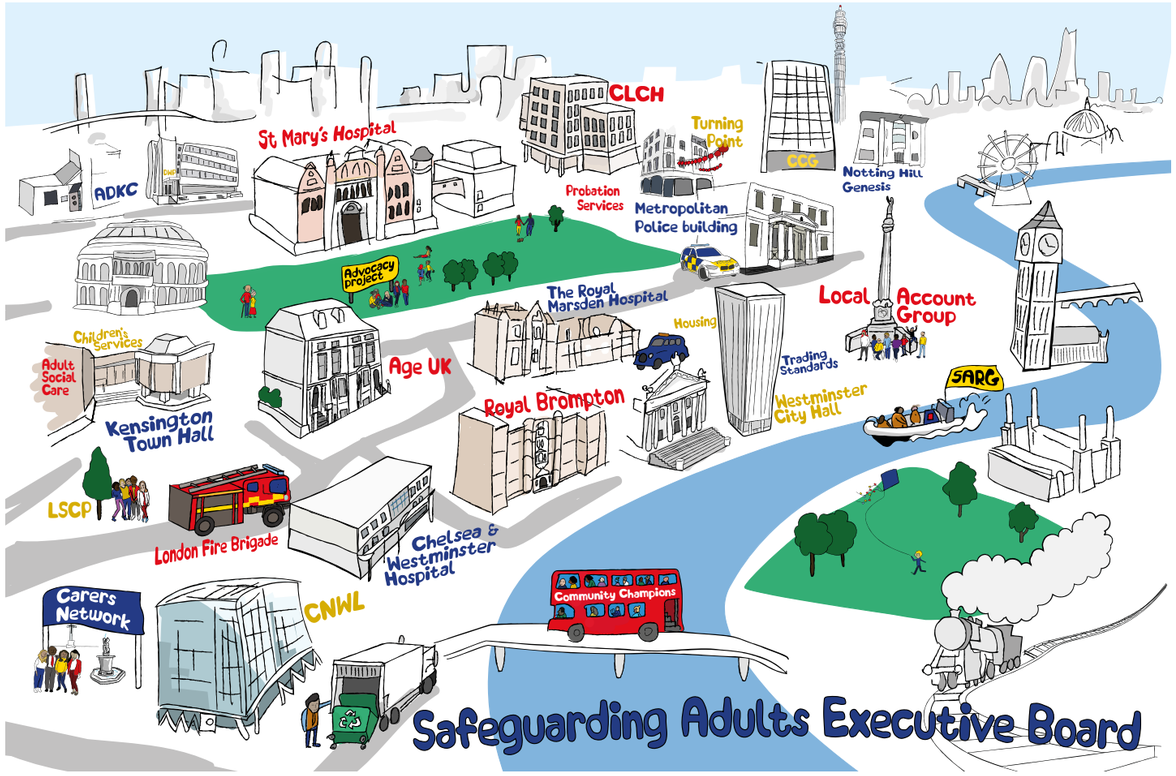
The statutory members of the Safeguarding Adults Executive Board:

- The Bi Borough Executive Director of Adult Social Care and Health
- The Deputy Director of Quality, Nursing and Safeguarding, Central Westminster Hammersmith Hillingdon and Ealing Clinical Commissioning Groups Commissioning Collaborative
- BCU Commander of Central West, Chief Superintendent, Metropolitan Police

The Care Act 2014 states that the Board can appoint other members it considers appropriate with the right skills and experience.

There are senior representatives on the Board, from the following organisations:

- 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)
- Local Councillors
- Housing (Local Authority)
- Mind
- Genesis Notting Hill Housing
- Trading Standards (Local Authority)
- Public Health Community Champions Programme
- Royal Brompton and Harefield HNS Foundation Trust Healthwatch



Adult Social Care (Local Authority)Board members are the senior 'go to' person in each of these organisations or services with lead responsibility for adult safeguarding.

They bring their organisations' adult safeguarding issues to the attention of the Board, promote the Board's priorities, and disseminate lessons learned throughout their organisation.

The Board can use its statutory authority also to assist members in addressing barriers to effective safeguarding that may exist in their organisation, and between organisations.

An even wider group of people, including voluntary sector organisations; housing and homelessness agencies; advocacy and carers' groups; and members of the public all contribute to the Boards various work-streams.

Adult Safeguarding now includes such areas as

- People Trafficking
- Modern Day Slavery
- Self- Neglect
- Domestic Violence

This Agenda is much wider than when Safeguarding Boards were first introduced.

Sub-groups of the Board are chaired by officers from the following organisations:

- Central North West London NHS Foundation Trust
- Imperial College Healthcare NHS Trust
- Central London Community Healthcare Trust
- The Royal Marsden NHS Foundation Trust
- London Fire Brigade
- Metropolitan Police
- Notting Hill Genesis Housing
- The North West London Collaboration of Clinical Commissioning Groups (NWL CCGs)

The North West London Collaboration of Clinical Commissioning Groups (NWL CCGs) is committed to safeguarding the wellbeing of vulnerable adults who access services that are commissioned by the NWL CCGs. The NWL CCG ensures that staff have appropriate policies, procedures, training and access to expert advice to ensure that adults at risk are identified and, where appropriate, a referral is made to adult social care.

"The Care Act 2014 states that local authorities, Clinical Commissioning Groups (CCGs) and the chief officer of the local police must be members of the Safeguarding Adults Board. The CCG is an active member of the Safeguarding Adults Executive Board. Safeguarding is about making sure everyone is treated with dignity and respect and does not suffer abuse. This is particularly important for those who are unable to protect themselves from harm or abuse, possibly because of their age, a disability or because they are unwell. To ensure this, care must be of a high quality in order to prevent abuse happening. It also means there is an effective response if there is evidence or suspicion of abuse."

"Safeguarding is always our top priority. There is a requirement to ensure that safeguarding is embedded throughout the commissioning process. Safeguarding is central to the commissioning strategy in North West London."

"To keep our communities safe from abuse and neglect, it is not enough to simply react when a safeguarding concern arises. Safeguarding principles need to be embedded across organisations' cultures at all levels, and people's safety needs to be considered all the time, whenever a decision is made."

We are committed to embed learning from Serious Case Reviews at a strategic level so that learning is shared across the system. We anticipate that this will improve the experience of patients using the services that we commission and makes our safeguarding processes more robust."

Chief Nurse & Director of Quality
North West London Collaboration of Clinical Commissioning Groups

The Care Act 2014 says members may make payments for purposes connected with the Board. Most of the funding for the Board comes from the Local Authorities. The North West London Collaboration of Clinical Commissioning Groups (NWL CCGs) contribute £20,00.00 per borough.

Mayor's Office for Policing and Crime provides an annual contribution of £5,000 to local safeguarding adult boards.

Also, for the third year running, The London Fire Brigade has contributed £1,000 per borough, to be shared between the Safeguarding Adults Board and the Local Safeguarding Children Board.

The Care Act 2014 guidance states that all members of the Board should have the right skills and experience necessary for the Board to act effectively and efficiently to safeguard adults in its area.

We acknowledge the value of the work of the subgroups in supporting the Board. Attendance is good and members are committed and work hard to progress the Board's priorities and safeguard adults at risk of abuse and neglect.

Putting our "house" in order

Our "House" model has set the scene for our safeguarding adults' journey: it is valued by our service users and experts by experience and is recognised at a national level as a framework built on the wellbeing principle.

Residents across the Bi-Borough told us how important it is to be in control of the decisions they make about their life, even when they have experienced abuse or neglect. Throughout this report you will find examples of what people told us under the headings "you said" and "we did"

"The House strategy has supported the SAEB to ensure that all its safeguarding adults work is focused on making safeguarding personal, prioritising the safety and well-being of all our residents and to ensure they are fully listened to by incorporating the voice of residents in everything we do "

The Safeguarding Adults Reference Group

Putting our “house” in order

However, we are motivated to continue to learn from others how to make safeguarding adults better for residents.

In March 2019 London Adult Directors of Adult Social Services (ADASS) were invited to complete a review of our safeguarding adults’ arrangements within the Bi-Borough.

Local Government Association

“Peer challenge is a proven tool for improvement. It is a process commissioned by a council and involves a small team of local government officers and councillors spending time at the council as peers to provide challenge and share learning”

The outcome of the peer review provided key messages on what is working well and some areas for consideration, which will be taken forward to inform the Board strategy for the next 3 years.

What is working well: Leadership

Strong leadership and the positive changes over the previous 18 months demonstrated that, despite differences in the two boroughs, there were also many similarities in ensuring safeguarding outcomes of residents are met. The Peer Review team feedback was that staff from both boroughs were supported in safeguarding activity. It was acknowledged that service user engagement across the Bi-Borough was very good, and the Peer Review team were impressed with the ambitions of the Local Account Group in supporting the Councils.

Members of the London ADASS Peer review team and the Local Account Group

What is working well: Partnership

There was clear evidence of: a focus on high risk groups, through approaches to hoarding, homelessness, rough sleepers and modern slavery; and a good level of partnership response across council departments and with statutory partners in working with both individuals and at a strategic level. The Quality Assurance Team were noted to be making a positive difference, enhancing market oversight and improvement work.

Areas for consideration

It was noted that it would be helpful to review the governance arrangements of the Board.

Next Steps

The Board held a Development Day with members and the Local Account Group to set the Board agenda for the next 3 years

Information used to inform the development day came from various sources including:

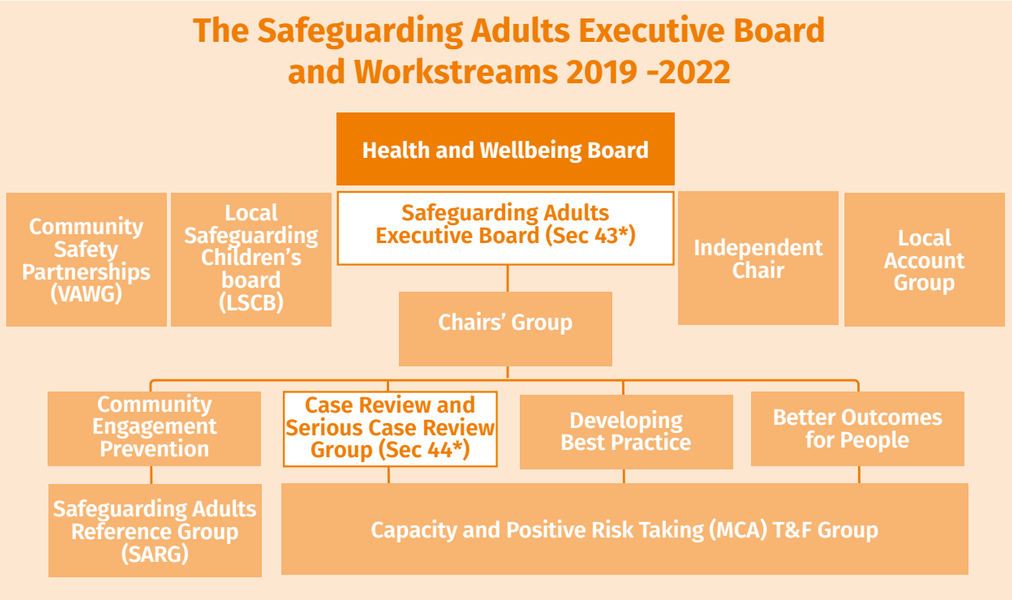
London ADASS Peer Review of Bi-Borough Safeguarding arrangements recommendation: To review the governance arrangements and align the vision and values for safeguarding across the Councils;

The Safeguarding Adults at Risk Audit tool (SARAT) 2018-19, which was completed by all partners, to provide assurance to the Safeguarding Adults Executive Board (SAEB) that all partners are compliant with safeguarding, following the introduction of the Care Act 2014;

Local and National Safeguarding Adult Reviews: The Board commissioned a Safeguarding Adult Review (SAR) in 2018/19. The findings from the SAR gave us the opportunity to explore more closely the areas shared with the Local Children’s Safeguarding Board (LSCB), such as ‘Think Family’, Transitions and Liberty Protection Safeguards.

The outcome of the development day was two-fold

1. A new governance structure with greater emphasis placed on service user engagement in the workings of the Board: **The Safeguarding Adults Executive Board and Workstreams.**



2. The new strategic plan or statement of intent: **Statement of Intent 2019 – 2022**

Statement of Intent 2019 – 2022

Working Together across agencies & between Adults and Children's Services	Capacity and Positive Risk Taking	Awareness and Support	Governance
Think Family: To jointly raise awareness and develop guidance and tools **Transition Group:** Joint workshop with operational staff to develop sound pathways for young adults into adult services which are relevant to need this may mean statutory or voluntary organisations. **SAEB and LSCB:** Joint Board Event to review work and share experiences **Lead group or agency** • Local Safeguarding Children's Partnership (LSCP) • Safeguarding Adults Executive Board (SAEB)	**Liberty Protection Safeguards:** Help prepare the Safeguarding Adults Executive Board Partnership for LPS **Multi-agency Quality Assurance:** Partnership Audit of Mental Capacity Audit practice **Rough-sleeping and Safeguarding** **Partnership awareness of Legal Literacy:** Development of Interagency protocols related to Court of Protection **Developing good partnership practice around managing risk and defensible decision making** **Lead group or agency** • Capacity and Positive Risk-Taking Sub-group	**Prevention "Raising Awareness of Safeguarding":** Increase service users by experience involvement in SAEB activity • Co-designed events for seldom heard service user groups • Multi-agency leaflets -Review • Train the Trainer-Refresh Learning from SAR's and DHR's Raising awareness of usefulness of High-Risk Panels **Lead group or agency** • Community Engagement group • Safeguarding Adults Reference Group • Local Account Group	**Governance review:** • Legal Indemnity Insurance • Membership review • Finance review • Service User Engagement • Review Our Values • Cycle of Quality Assurance function **Lead group or agency** • Safeguarding Adults Executive Board (SAEB)
IT systems and Information Sharing • Statement from the SAEB to reinforce obligations • Focus on best practice in recording **Lead group or agency** • Developing Best Practice Group		**Advocacy** • Re-commissioning • Workforce development • Public Awareness **Lead group or agency** • Adult Social Care Commissioning • Developing Best Practice Group	**Variability in referral rates across partnership:** Consistency in responses Bi-Borough Board to align local practice and pathways **Workstreams:** • Better Outcomes for People

CREATING A SAFE AND HEALTHY COMMUNITY

Service User Involvement

"I am able to make choices about my wellbeing"

We have had an ambitious year in which we have combined our approaches to working with service users by having a service user by experience group and the Local Account Group. This ensures that there is service user involvement in all areas of the Board's work.

Service users by experience

The Safeguarding Adults Reference Group was re-launched with the support of our community engagement subgroup. The group is now focussed on co-producing safeguarding training and delivering events to raise awareness of safeguarding adults.

This is the groups explanation of how stages of co-production work in practice using the analogy of a cake.

Coercion is telling someone that they will have cake.

Educating or informing is telling someone about the look and flavour of the cake that they will be given, but there is no choice.

Consultation or engagement is about asking people what type of cake they would like and why - but this might be ignored.

Co-design is like people deciding what flavour the cake should be and how it should be decorated... but that is it.

"our views are important, and our voices heard"

Co-production is:

1. deciding whether cake is needed (or would something else be better)
2. deciding on the flavour of the cake and the decoration,
3. working out how to make the cake,
4. baking it,
5. trying it to find out how it is
6. working out what could be done better in the future.

"We are often approached by organisations who say they want to co-produce with us and then they allow us to 'decorate the cake'! This year the Safeguarding Adults Executive Board have worked with members and instilled confidence about what co-production really is...that our views are important and our voices heard"

Chief Executive, Action Disability Kensington & Chelsea

In March 2019 members from the Safeguarding Adults Reference Group delivered a short presentation to the Board on their ideas on what service user events in the community should look like. Their proposals were supported, and these events are now being co-produced with the community engagement group.

The Local Account Group

In July 2018 the Bi-Borough Local Account Group launched their Ambition Plan. Within this plan it was agreed that the Local Account Group will input and support the priorities of the Safeguarding Adults Executive Board. This has meant that feedback from service users and carers groups is heard at every Board meeting and through the subgroups. In 2019/20 the Local Account Group will co-produce a Service User Feedback Form for adults involved in the safeguarding adults process. 12 months after the form has been launched and in line with the Local Account Group Ambition Plan, we will support the Local Account Group to analyse the feedback and present the findings to the Board, with identified learning from a service user perspective.

"The contribution and support from both the Local Account group and The Safeguarding Adults Reference Group has been invaluable. It is inspirational to work such a highly motivated and enthusiastic group"

Head of Service, Safeguarding and Workforce Development Team, Bi-Borough Adult Social Care

Community Engagement

You said:
I want to know how to stay safe in my own home

We did:
This year the Community Engagement Group have commenced a Safe at Home Programme which will include a national universal video accessible to all home care and health agencies. It will be a helpful guide on scams and security and safety issues in the home.

"This year the Community Engagement Group have commenced a Safe at Home Programme which will include a national universal video accessible to all home care and health agencies. It will be a helpful guide on scams and security and safety issues in the home"

Chairs of the Community Engagement Group

As well as putting on awareness-raising events to help people spot scams and creating links with local organisations and community groups to spread the message about how to stay safe, here is the Community Engagements Group message to residents:

Everyone has the right to live in safety, free from abuse and neglect.

Abuse and neglect can occur anywhere: in your own home or a public place, while you are in hospital or attending a day centre, or in a college or care home.

You may be living alone or with others. The person causing the harm may be a stranger but, more often than not, you'll know and feel safe with them. They're usually in a position of trust and power, such as a health or care professional, relative or neighbour.

Far too often this could be someone stealing money or other valuables. Or it might be that someone appointed to look after your money on your behalf is using it inappropriately or coercing you to spend it in a way you're not happy with. Internet scams and doorstep crime are also common forms of financial abuse.

People and organisations worked together to deliver the Community Engagement Group event in February 2019 raising awareness of how residents can stay 'Safe at Home'. The focus of this event was to raise awareness and provide information on:

- Home fire safety
- Home Improvement Agency Services available in Westminster
- Trading standards and scam information

The next page includes example of the information that was provided at the 'Safe at Home' event.

You said:
You are willing to work with me

We did:
In 2018/19 the London Fire carried out 3,334 Home Fire Safety Visits across the Bi-Borough in 2018/19

We were told what happens during a home fire safety visit by a member of the London Fire Brigade

Firefighters or trained staff will visit the home and offer advice based on individual needs, this includes information on how to prevent fires, the importance of smoke alarms to detect a fire and having escape plans in the event of a fire. They will also fit smoke alarms if required.

Prevention:

- Understand the main causes of fire in the home and how to prevent them.
- Identify fire hazards in the home and know how to reduce the risk of a fire happening.
- Reduce the risk of a fire happening at night by having an appropriate bedtime routine.

Detection:

- Identify the function and importance of a smoke alarm in home fire safety, as smoke generated by fire can kill people and is just as dangerous as fire.
- Every home should have at least one smoke alarm fitted on each floor level, and ideally one in every room a fire could start.
- Smoke alarms should be tested once a week
- LFB can provide specialist smoke alarms for people with hearing or visual impairments.
- Understand that the Fire Brigade carry out Home Fire Safety Visits and that they can be requested via the Brigade website

Escape:

- Know that fire should only be tackled by firefighters as they use special equipment and protective clothing.
- Prepare and practice a fire escape plan, making sure everyone in the home knows what to do if there is a fire.
- Understand how to call 999 and when it is appropriate to do so.

Our Trading Standards Lead Officer told us about Door step scams

Doorstep scams take place when someone comes to your door and tries to scam you out of your money or tries to gain access to your home. Doorstep scammers aren't always pushy and persuasive, they may seem polite or friendly. So, if you're not expecting someone it's important to be vigilant when you answer the door, especially if you live on your own.

A victim of Doorstep Crime:

Alfred's Story

Earlier this year Alfred received an unexpected knock at the door from a roofer claiming to be doing some work for a neighbour nearby and who noticed they have some loose tiles on the roof. The roofer claimed that they have some left-over materials and he could do the work quickly and for a discount. He offered to fix the tiles for £50-100 cash. Alfred agreed but once the work started more problems are found with the roof and the bill keeps on increasing. Alfred felt very intimidated and pressurised by the roofer and agreed to them doing more work and the increased costs. Alfred told his Daughter who called the police who opened an investigation into the matter.

The Outcome:

The roofer is now being prosecuted for 3 cases of doorstep crime in the same street.

Financial Abuse, Better Outcomes for People

Financial Abuse is another name for stealing or defrauding someone of goods and/or property. It is always a crime but is not always prosecuted. Sometimes the issue is straightforward, for example a care-worker stealing from an older person's purse, but at other times it is more difficult to address. This is because very often the person alleged to have caused harm can be someone's son or daughter. A common issue that comes to the Boards attention through safeguarding are relatives attempting to justify their actions on the basis that they are simply obtaining their inheritance in advance by the misuse of Lasting Powers of Attorney.

Financial abuse/harm can happen because the older person can be seen as an easy way of getting money, particularly if they are dependent or confused. Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services have recently published a report advising that the police and the Crown Prosecution Service (CPS) need to prepare for the growing challenges of helping and keeping safe an ageing population. Many older people lead active and safe lives. Not all older people are vulnerable, but they are more likely than other groups to be living with some form of physical or mental ill health. Too many older people are socially isolated and lonely and may leave their homes only rarely.

"It's important to remember that these criminals are incredibly sophisticated and prepared to put a huge amount of effort into conning people out of their money. Scams make victims part with their money and personal details by intimidating them or promising cash, prizes, services and fictitious high returns on investment. It's important to remember that no matter what type of scam, all scams are crimes.

- Approximately 3.2 million people (1 in every 15) fall victim to scams each year.
- The average age of a scam victim is 75.
- Scams cost the UK economy between 5 and 10 billion pounds each year.
- Only 5% of these crimes are ever reported.

Trading Standards

Trading Standards Top Tips on how to Stay Safe at Home

- Don't buy at the door
- If you think work needs doing around the home get quotes from other businesses that are members of a Trading Standards trusty trader scheme or use the vetted business on the free online directory from Which? magazine, or from Age UK.
- Use a security chain/ spy hole at the front door when you receive any unexpected calls – many Councils have a Home Improvement Agency Service and for those on certain benefits or pensioners they may be able to have these installed for free
- If the caller claims to be from a utility company to read the meter, ensure you have set up an agreed password in advance and the callers has given this
- Never let anyone into your home unless you are satisfied who they are
- Ask them to show you identification and independently verify they are calling from Company they claim to be
- Never leave valuables, money or bank cards lying around
- Do not donate to alleged charities at the door
- Contact the Citizens Advice Consumer Service if you would like help.

Assisting residents to stay 'Safe at Home'

Age UK Kensington & Chelsea assists residents who are aged 55 and over to maintain their independence, making the tasks of daily living a bit easier. The aim of the 'Safe at Home' service is to reduce the risk of falls in the home, reduce the risk of harm from other hazards in the home, improve health, wellbeing and peace of mind by ensuring that the home environment is safe for the resident.

Our DIY service provides support to clients helping them with those little tasks around the house that can make a huge difference to their quality of life. Those tasks go from changing a lightbulb to assemble a flat-pack so corridors are clear of clutter helping to avoid falls. We also fit spyholes and door chains to help people stay safer at home.

Community Engagement Manager, Age UK Kensington & Chelsea

Better outcomes for People

The main purpose of the Better Outcomes for People (BOP) sub-group is to provide evidence that gives the Safeguarding Adults Executive Board (SAEB) assurance that it is delivering its prime responsibility of preventing abuse and increasing the safety and well-being of adults who have experienced harm across the Bi-Borough.

The BOP identifies outcome measures for the SAEB's strategic priorities; identifies sources of information; collects and analyses relevant information; and reports to the Board and member agencies, as required.

In 2018/19 the Board tasked the BOP Better to complete a local analysis of safeguarding and crime.

We wanted to know, under our restorative justice agenda:

- What percentage of safeguarding concerns were crimes?
- How many were reported to the police?
- How many resulted in prosecutions?

The group established that:

- About 1 in 3 Safeguarding concerns were classified as crimes / potential crimes;
- These concerns differed from others, not so much in terms of the personal characteristics of the adult at risk, as in the type of harm or abuse alleged as in the type of harm or abuse alleged. Financial abuse featured more highly and the source of risk was more likely to be from non-professionals;
- The majority (74%) of these concerns were raised with the police (some later in the pathway);
- The majority of safeguarding enquiries were completed in under 90 days but those raised with the police were slightly less likely to have been completed in this time (70%:79%)

- There was little difference between the groups in terms of the identification of risk and the impact of the enquiry on risk, but those raised with the police were slightly more likely to have ended at the individual's request and slightly more likely to have ended with the risk remaining;
- We were unable to identify the number resulting in prosecutions.

CHART DEMONSTRATES ABUSE TYPE

	Crime / Potential crime	Other (Not crime / Don't know)	Total
% financial abuse*	60%	18%	33%
% physical abuse*	42%	20%	28%
% sexual abuse*	10%	2%	5%
% domestic abuse / violence*	10%	5%	7%
% neglect / omission*	7%	58%	40%
% source of risk: ASC / NHS provider	22%	42%	35%
% source of risk: family/stranger/not known	69%	42%	52%
% met s42 enquiry criteria	52%	43%	46%
Number of concerns	136	245	381

*On own or in combination with other(s). Differences between groups more marked in terms of type and source of risk, rather than personal characteristics

Financial abuse occurred in 60% of cases in a number of ways, including:

- Taking cash / bank card / belongings directly;
- Taking money from cashpoint;
- Taking money via bank transactions / bank transfers (including scam calls);
- Taking money from post-office account;
- Blackmail;
- Burglary;
- Being asked for money by care worker (and paying); and
- Overcharging (at local restaurant).

"The abuse that vulnerable adults can suffer is often hidden from view. In the Bi-Borough we work closely together with our multi-agency partners and external organisations to identify and support those who may be victims. When incidents or concerns are reported to us, we endeavour to conduct a thorough investigation and where possible, bring those who abuse and mistreat vulnerable people to justice".

Safeguarding Lead
Metropolitan Police Service
Co-Chair of the Better Outcomes for People subgroup

METROPOLITAN POLICE

Working together for a safer London

MAKING SAFEGUARDING PERSONAL

Financial Abuse, Dementia Friends

You said:
I want to be able to make choices about my well-being

We did:
Here are two case examples of how the work of the Board is helping to protect residents from Financial Abuse

How we supported Elsie to maintain her financial independence

"I have lived on my own since my sister died last year. We lived together for over 60 years, we went through everything together, including the blitz. I remember those days when we ran hand in hand to the underground tunnels in Bethnal Green to stay safe in from the raids. We moved to west London after the War, we had lost our home and had relatives here.

I have carers who come to help me about 2 times a day as I have difficulties getting to the bathroom as my sight is rather poor nowadays. I have a neighbour who has been helping me to pay my bills since my sister died. My neighbour is my only friend and I trust her, so I let her take my bank card to withdraw money the pay my bills and then she pays it all through her account for me.

I told my social worker about this and she seemed concerned that my bills were high. I gave her all my paperwork to look at and she said that my neighbour withdraws more money than the bills cost.

I was very upset about this. I may have poor sight but I'm not a bad judge of character and I can't believe that my neighbour would steal from me. I always tell her to take a little extra to buy a treat for the kids as she does all my shopping as well, I never have to worry about what I need, and I depend on her.

Over the next few weeks I had many visits from my social worker who talked to me about safeguarding. I explained to her that I always tell my neighbour to keep any change from the bills and that I wanted to keep my friendship with her as she visits me regularly and makes me lovely cups of tea and we sit down and chat for hours most evenings and the children visit me too. They call me Aunty Elsie.

My social worker supported me to set up my direct debits for all my bills and set up regular online shopping which includes some treats that I like to buy for my neighbour and her children. "

The outcome:

"My social worker listened to what I wanted to happen next and helped me to sort out everything I needed"

Here is the Voice of another resident:

"My care workers were not supporting me properly and some of the residents I lived with were always borrowing money from me and causing me problems. My social worker helped me to sort out my problems in a way that suited me and helped me to maintain relationships that were important to me"

No Decision about me without me

This story demonstrates how Making Safeguarding Personal put Mohammed's best interests at the heart of discussions

"My family have always helped to manage my finances. I came from a very wealthy family, we never needed to worry about money, so I was surprised when my family kept telling me I didn't have enough money for the things that I liked. I like to have afternoon tea and my grand-daughter used to take me to the Ritz every Sunday but she says we can't always afford to go, and she is always arguing with my family about wanting to take me there. They have ramps in place for my wheelchair and they all know me there as I have been a regular there for years. I told my social worker when she visited who then had a safeguarding meeting about this and introduced me to another lady who is now my advocate. My social worker told me she completed a mental capacity assessment and said

"I lacked capacity to make informed decisions regarding my money and where I live due to my dementia"

The police came to see me to execute a warrant as part of an investigation into allegations of financial abuse made by my grand-daughter. My grandson had Lasting Power of Attorney over my finances and welfare decisions, but the investigation showed that he was spending all my money. This made me very sad at first, but I am now on holiday in a lovely care home following something called a best interests decision meeting."

The outcome:

"With the help of my social worker, the police and my advocate I am changing my will and getting everything back into order. I get confused sometimes, but they help me to understand and I don't have to worry about not having money any more. My grand-daughter now visits me regularly and takes me out shopping once a month and to the Ritz for afternoon tea."

Dementia Friends

As part of Mental Health Awareness Week, the Adult Social Care (ASC) and Public Health team staff conference: 'With Health in Mind' took place in 2019. The focus: to raise awareness of mental health issues in the workplace and community and to de-stigmatise mental health issues and encourage open discussion. Linda O'Sullivan from the Alzheimer's Society conducted a Dementia Friends training workshop.

Watch the team's video

Dementia Friends is open to anyone of any age to join. A Dementia Friend learns about how dementia affects a person and uses that understanding to make a real difference for people affected by dementia. To find out more and get involved, visit www.dementiafriends.org.uk

Dementia Friends
An Alzheimer's Society initiative

Creating a Safe and Healthy Community

Rough sleeping and Safeguarding

The last 3 years have seen a significant increase and change in profile of deaths of people across the 'rough sleeping pathway', which includes rough sleepers on the street through to those in hostels and supported accommodation. The Safeguarding Adults Team in Westminster have supported a review of all individual deaths in 2018 and agreed that, given the increase in deaths there was a need for a more comprehensive and standardised approach to reviews following deaths of rough sleepers, to keep track of trends and to look for and share lessons learned, with a multi-agency approach and within a clear governance structure.

The circumstances in which the Safeguarding Adult Board might arrange a Safeguarding Adult Review are set out in the Care Act 2014 and apply equally to someone who was sleeping rough. Safeguarding Adults Services in Westminster takes all deaths of people on the street seriously. Our responsibilities under the Care Act 2014 ensure that we will make enquires irrespective of the persons 'ordinary residence'. We agree that it is important that the risks of living on the streets are not compounded by agencies failing to provide a timely and appropriate service response in the locality where a person is sleeping rough and is at risk of harm or abuse.

Safeguarding Adults Services in Westminster have been working closely with the Rough Sleeping commissioning team to develop a new pathway to support people who are rough sleepers and those who are in hostels and supported housing who may be at high risk and eligible for safeguarding under the Care Act 2014. All deaths are reviewed within this new pathway to see if they meet the referral criteria for a safeguarding adult review under Section 44 criteria of the Care Act 2014.

The Enhanced Vulnerabilities Forum

The enhanced vulnerabilities forum in Westminster was set up in August 2018 to discuss rough sleepers and clients accessing the rough sleeping pathway, that present with high risk health and mental health concerns. The principal focus is on people who have "fallen through cracks" and/ or been very resistant to change.

These monthly meetings review actions taken by practitioners, propose and track solutions, as well as escalate cases that are deemed to require further review or that may need statutory decisions appealed. In addition, specific trends and/or risks to the wider cohort of people who are rough sleeping are reviewed and escalated, including a review of deaths across the rough sleeping pathway.

Making Every Adult Matter (MEAM)

This year Making Every Adult Matter (MEAM) was launched in Westminster

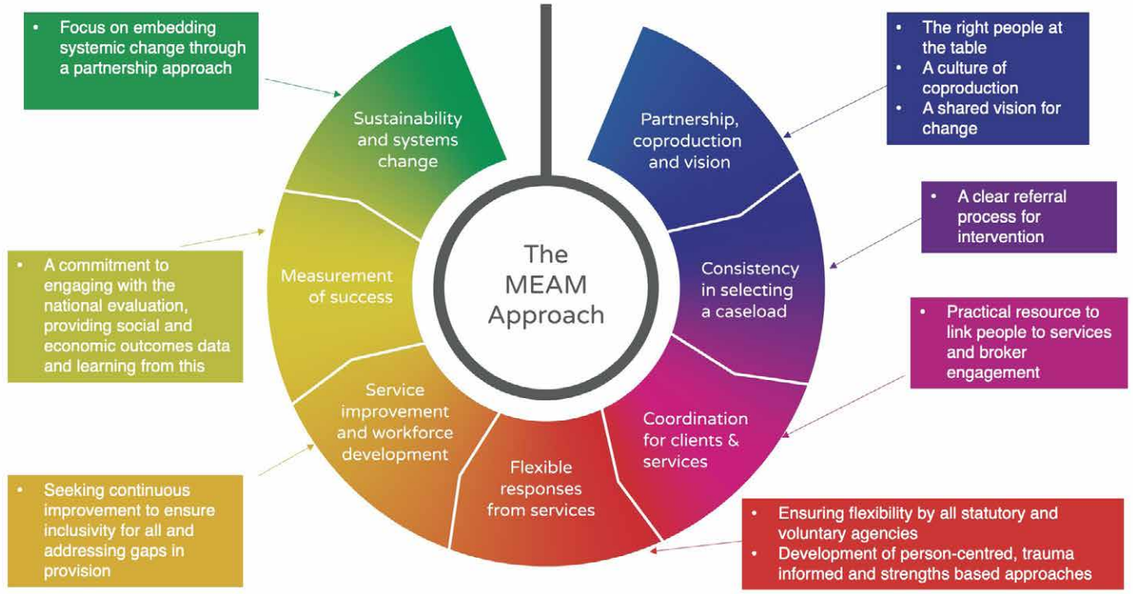
The Making Every Adult Matter (MEAM) coalition is made up of the national charities Clinks, Homeless Link and Mind. People facing multiple disadvantage face a combination of problems including homelessness, substance misuse, learning disabilities, contact with the criminal justice system and mental ill health. They can 'fall through the gaps' between services and systems, making it harder for them to address their problems and lead fulfilling lives.

The MEAM Approach is a framework to help local areas develop effective, coordinated services for people facing multiple disadvantage, and promote lasting, embedded change to local systems.

What are the benefits of being in a MEAM area:

Westminster applied to become a MEAM area and were selected in Nov 2018. Four strands of project work have been identified so far:

- Improving support for adults with autism in Westminster facing multiple disadvantage;
- Improving join up between probation and homelessness services;
- Improving join up between council and partner agencies in relation to treatment resistance alcohol users; and
- Improving psychiatric hospital discharge planning for homeless patients.



Community Safety – Violence Against Women and Girls

You said:
My recovery is important

We did:
The Angelou Partnership support women and girls affected by domestic violence and abuse

Making the transition to adulthood is difficult for everyone but can be especially challenging for young people who are vulnerable or leaving care.

Maria had a difficult transition into adulthood and found stability in a co-dependent relationship and had been the subject of physical and emotional abuse by her partner for several years. Following a safeguarding adults enquiry, which was undertaken in conjunction with a police investigation, Maria was able to remain in her own home and feel safe from abuse from her partner. The case was very complicated and overwhelming for Maria at times, as there were interviews, care and support assessments with social workers, legal advice, advocacy, court actions and several meetings with the police.

The outcome:

As a result of the above, Maria's partner was prosecuted for assaults on her and he left their home with an injunction to prevent his return. Maria was able to remain in the home she loved and, once she was convinced that her partner could not return to abuse her, she felt safe and was able to develop her own relationships and interests.

Violence against women and Girls (VAWG) is a strategic priority for the Royal Borough of Kensington and Chelsea and Westminster City Council. VAWG is a form of discrimination and a violation of human rights and links strongly to adult safeguarding.

Data shows that 17 referrals were made to the Multi-agency Risk Assessment Conference and 13 referrals from Adult Safeguarding were made to the Angelou Partnership, the main commissioned VAWG service in the Bi-Borough.

It is estimated that 1 in 4 women in the Royal Borough of Kensington and Chelsea will experience domestic abuse. 1 in 5 will experience stalking and 1 in 3 will experience sexual violence. Additional vulnerabilities mean that this number is likely to be higher for some groups, such as those with care and support needs who may require safeguarding adult services. With this in mind, work is being done to strengthen the adult safeguarding response to Violence Against Women and Girls.

Joint working protocols were reviewed this year between the Violence Against Women and Girls (VAWG) Strategic Board and the Safeguarding Adult Executive Board. The joint working agenda is driven by seven strategic priorities which include ongoing communication, prevention and awareness-raising activities, creating a menu of options for survivors and their children and continuing to strengthen the coordinated community response. Joint working is focused on ensuring there is preventative, immediate and long-term support for survivors and their children.

Modern Slavery and Exploitation is a key area for the VAWG Strategic Partnership and the Safeguarding Adult Executive Board and work in this area took place throughout 2018-19.

Modern Slavery and Exploitation

RAISING AWARENESS FOR STOP THE TRAFFIK
PEOPLE SHOULDN'T BE BOUGHT & SOLD

Modern Slavery is an umbrella term for human trafficking and servitude. It is used when somebody is forced or coerced into doing something and another person gains from this exploitation. It affects an estimated 40 million men, women and children worldwide. 136,000 individuals are estimated to be in modern slavery here in the UK.

Tackling Modern Slavery is a priority for the Bi-Borough and is a vital part of our Violence Against Women and Girls strategy, while acknowledging it affects men and boys as well.

We have a multi-agency partnership group, whose objectives are to raise awareness of modern slavery and exploitation, resulting in an increase of victim identification; to provide necessary support to enable survivors of trafficking to recover; to build communities, which are resilient to human trafficking; and to ensure perpetrators are brought to justice.

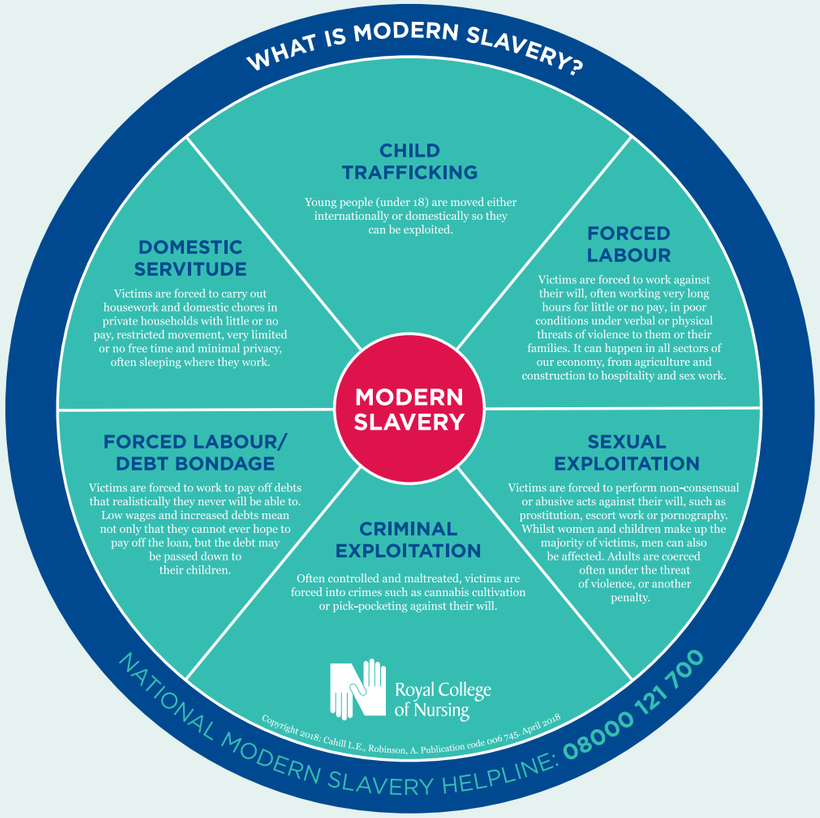
In June 2018 we partnered with the charity **STOP THE TRAFFIK** to employ a Modern Slavery and Exploitation Partnership and Community Coordinator. One of the roles of the Coordinator is to deliver training to raise awareness of modern slavery and the support available for victim/survivors. 300 multi-agency staff were trained in the period between April 2018- March 2019. Prior to the training, 47.8% of attendees agreed with the statement, "I am confident I could respond appropriately if I suspected a case of modern slavery". Following the training, 96.7% agreed with the statement. This increase of over 100% demonstrates that front-line professionals are better equipped with skills to identify and report.

In order to support staff to do this, we developed a Modern Slavery Adult Referral Pathway. The pathway sets out the roles and responsibilities of staff if a victim/survivor of modern slavery is identified, along with the **National Referral Mechanism (NRM)** process. 52 professionals across Adult Social Care and Housing were trained on how to sensitively conduct NRM interviews and complete the forms ahead of the launch of the pathway.

Since the development of the pathway, we have seen an increase in referrals to the National Referral Mechanism. By knowing the options available to victim/survivors of modern slavery and understanding the process, we can help them access the support they deserve. Data collection is in its infancy but will be provided in next years report for 2019-20

"We cannot stop what we cannot see"

Modern Slavery & Exploitation Partnerships and Community Coordinator, Community Safety Team



The vision of safeguarding

Imperial College Healthcare NHS
NHS Trust

"is to achieve the best possible outcomes for children and vulnerable adults through ensuring that their voices are heard, and that early intervention ensures their safety and wellbeing. This will be achieved through effective, united multi agency team working and engendering a culture where safeguarding is at the forefront of our care"

Modern slavery is a crime and a violation of fundamental human rights. It takes various forms, such as slavery, servitude, forced and compulsory labour and human trafficking, all of which have in common the deprivation of a person's liberty by another in order to exploit them for personal or commercial gain.

We are committed to improving our practices to combat slavery and human trafficking.

LEADING, LISTENING AND LEARNING

Safeguarding Adult Reviews (SARS)

The Care Act 2014 states that the Board must conduct a Safeguarding Adults Review in accordance with Section 44 of the Act

The Care Act 2014: SARS - what they are and what they aren't

They should not:	They should be:
• Reinvestigate or apportion blame	• About 'learning lessons'
• Only focus on finding out what happened	• Understanding why the incident happened

You said:
We want you to listen

We did:
We did: The Safeguarding Adults Case Review Group considers the recommendations and lessons learned from Enquiries and Safeguarding Adults Reviews (SARs) and where relevant, from Children's Serious Case Reviews and Domestic Homicide Reviews.

Safeguarding Adult Reviews are about learning together and improving how adults are protected from abuse of all kinds.

This year we have been working on:

1. Local Improvements for referral with a focus on fatal fires, deaths of people who are rough sleeping or homelessness, to ensure that:

- there is a clear process for referral;
- Triaging of cases for potential referral takes place at organisational level; and
- Partnership support is available to organisations in the referral process with clear rationale if the referral is not accepted.

2. Embedding Learning from SAR's into practice: A series of workshops were launched aiming to:

- Raise awareness of the Safeguarding Adults Review process;
- identify opportunities to draw on what works and promote good practice;
- sustain and embed learning into ongoing service improvements such, as the 7 mins briefing model.

7-minute briefings are based on a technique borrowed from the FBI. This is based on research, which suggests that seven minutes is an ideal time span to concentrate and learn. Learning for seven minutes is manageable in most services, and learning is more memorable as it is simple and not clouded by other issues and pressures.

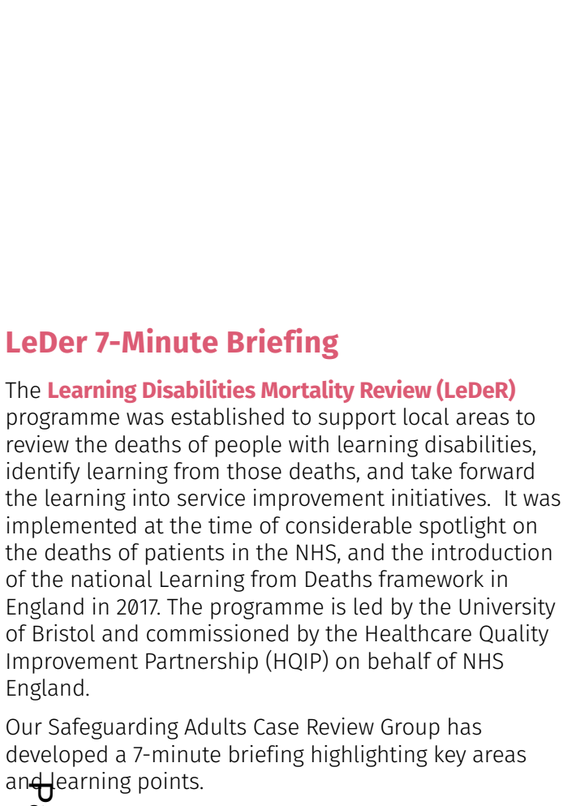
7-minute briefings have been created as a learning aid for use in supervision, team meetings, or just as a reminder of the key issues around a theme or current issue.

The following page describes 2 examples of how the 7 -minute learning is being used to aid learning .

LeDer 7-Minute Briefing

The **Learning Disabilities Mortality Review (LeDeR)** programme was established to support local areas to review the deaths of people with learning disabilities, identify learning from those deaths, and take forward the learning into service improvement initiatives. It was implemented at the time of considerable spotlight on the deaths of patients in the NHS, and the introduction of the national Learning from Deaths framework in England in 2017. The programme is led by the University of Bristol and commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England.

Our Safeguarding Adults Case Review Group has developed a 7-minute briefing highlighting key areas and learning points.



Safeguarding Adults Case Review Group

LeDeR: 7 minute review February 2019

LeDeR

Learning from deaths programme now completed it's second year and as more deaths are reported and reviewed more learning outcomes can be shared.

Learning into Action network (LiAN) will be hosting resources and information connected to learning from mortality reviews.

- End November 2017, 1311 deaths reported
- 14%: 178 deaths in London.
- <8% reviews completed.
- Females dying 29.3 years earlier and males 22.8 years earlier than the general population.

Learning point 1. Inter-agency collaboration and communication

Carers' Competencies: eg: discharging patients with catheters without confirmation that carers have the skill set to manage these patients.

Place of discharge noted as 'nursing home' instead of supported living accommodation.

More use of Hospital Passports – patients to arrive with copy or send electronically so that information available.

LeDeR Steering Group

Local area Contact (LAC) Peter Beard allocates the LeDeR reviews and chairs this group.

Group considers the learning points and sets actions for follow up in the community or hospitals.

Learning Point 2. Awareness of the needs of people with learning disabilities.

Call for mandatory training: Government has announced its consultation on learning disability training for all health and care staff. Responses due by 12 April 2019

Causes of death (Learning into Action Bulletins)

Pneumonia + Aspiration pneumonia: 17% (Issue 1, July 2018)

Sepsis: 11% (Issue 2, September 2018)

Dementia

Epilepsy

Constipation (Issue 4, Jan 2019: Dying for a poo)

Learning point 3. Understanding and application of the Mental Capacity Act 2005

Capacity for decision making not correctly recorded.
Best interest decisions not always followed correctly:

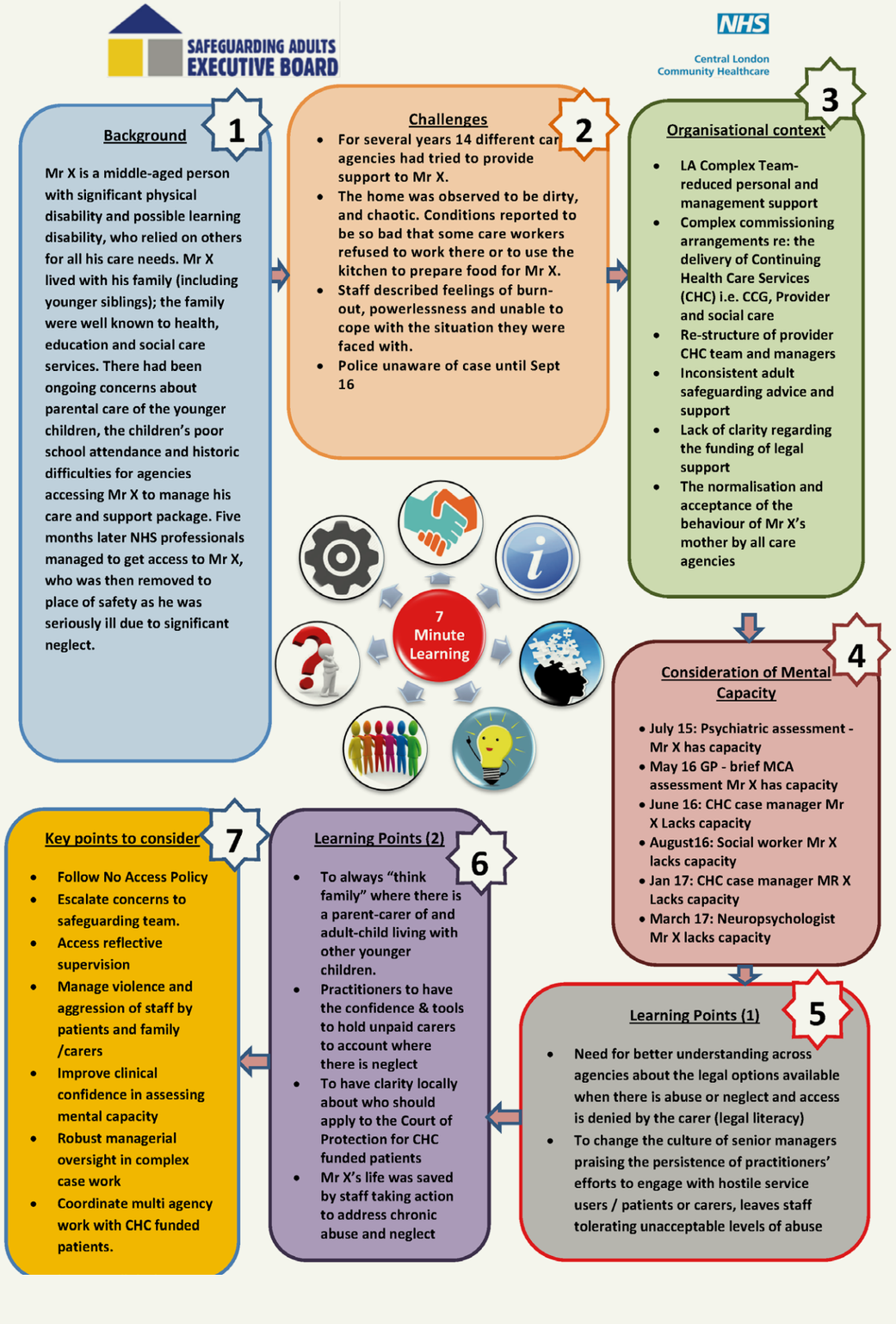
- may miss speaking to all who know the patients
- may miss involving IMCAs if the person is unbefriended

DNAR's not completed / recorded correctly.

In 2018-19 2 cases were accepted by the Group as meeting the Section 44 Safeguarding Adults Review criteria.

An Appendix of the cases presented and reviewed by the group is found at the back of this report in APPENDIX 1.

We used the 7-minute learning model to share learning from a recently commissioned Safeguarding Adults Review for the case of Mr X.

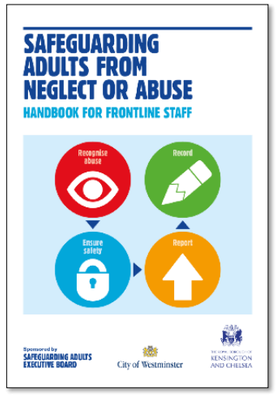


WHAT HAS THE BOARD BEEN DOING?

Adult Safeguarding in Action 2018/19

The Board has been working this year to ensure that we can demonstrate Adult Safeguarding in Action and the impact this has on our partnership.

- The following section provides examples of specific work our partners have been engaged with to include: Think Family within a community health setting
- Person centred care for learning disabilities patients in a hospital setting
- Dignity Champion project work in which the experiences of patients , staff are collected to provide insights to help improve quality of care being delivered



Developing Best Practice

The Developing Best Practice subgroup has produced a guidance booklet to help people working directly with adults at risk of abuse or neglect to understand how to raise concerns. This booklet supplements the London Multi-agency Safeguarding Adults Policy and Procedures.

It is the responsibility of everyone to recognise suspected or actual abuse and to take appropriate action in line with the procedures in this document.

"Staff have found this handbook to be both an essential and effective aid to all safeguarding work"

Deputy Director Patient Experience Imperial College Healthcare NHS Trust

Think Family

The Central London Community Healthcare NHS Trust Safeguarding Team supports the Trust in fulfilling its statutory duty to safeguard children, young people and adults at risk from experiencing harm or abuse. We encourage our staff to take a personalised and 'think family' approach when assessing risk, planning safe care and acting on or escalating concerns.

In August 2018 we introduced a single point of contact (SPOC) with 'duty' safeguarding staff available to ensure frontline staff and managers have access to timely advice and support in managing urgent or complex safeguarding cases.

Associate Director of Safeguarding, Central London Community Healthcare NHS Trust

Person Centred Care

The Royal Marsden NHS Foundation Trust *works hard to ensure that all adults are cared for in a safe, secure and caring environment; that all services have safeguarding at their core, and that staff are supported and trained appropriately to manage safeguarding issues where they arise.*

During the last year, we have launched our new Learning Disabilities policy and pathways, which supports to identify and flag patients with learning disabilities coming into the Trust and the pathways of care to ensure reasonable adjustments can be made to meet their health and support needs.

Head of Adult Safeguarding
The Royal Marsden NHS Foundation Trust

The ROYAL MARSDEN
NHS Foundation Trust

Making Safeguarding Personal

To safeguard individuals in a way that supports them in making choices and having control in how they choose to live their lives is a core objective and key priority for all members of staff who work with adults within the Trust. All staff are given training to help them to identify adults who may require safeguarding and work with other highly experienced colleagues to share information as needed and make referrals to other agencies – such as Social Services – to ensure those adults are protected. As a Trust we are committed to ensuring that all patients, are cared for in a safe and secure environment.

We do this by having named professionals in post who lead on issues relating to safeguarding and ensuring staff are trained in safeguarding – including at director level – and this is annually refreshed.

Director of Nursing, West Middlesex Hospital

NHS
Chelsea and Westminster Hospital
NHS Foundation Trust

Healthwatch Central West London's Dignity Champion project *continues to be an essential part of our local engagement with health and care services in the boroughs of Kensington and Chelsea, and Westminster City Council. Using our statutory power as a local Healthwatch, we collect the experiences of patients, staff, carers and relatives in publicly funded health or care services. These insights help us to develop recommendations that improve the quality of care being delivered.*

Chief Executive Officer, Healthwatch Central West London

healthwatch
Central West London

London Ambulance Service (LAS)

In 2018/2019 the London Ambulance Service NHS Trust (LAS) has continued to ensure the safeguarding of children and "adults at risk" remains a focal point within the organisation and the Trust is committed to ensuring all persons within London are protected at all times.

The Safeguarding Team have worked hard to support staff, monitor and review safeguarding practice and raise the profile of safeguarding during 2018/19 and have undertaken a number of audits and established several review groups to assure practice. The Trust serves a population of 8.78 million, covering 8,382 square miles and is made up of 32 boroughs. The Trust responds to over 5000, 999 calls every day and in 2018/19 we raised safeguarding concerns for an average of 2.1% of incidents received. The Trusts 111/ Integrated Urgent Care services in SE and NE London also raised safeguarding referrals and concerns via the Trusts reporting process

All staff have a duty to be alert to potential safeguarding concerns and are expected to be aware of and implement the Trust's safeguarding policies and procedures and work in partnership with other agencies to help safeguard those at risk.

Associate Director of Quality, Safeguarding & Safety and Security

COMPASSION RESPECT EMPOWERMENT PARTNERSHIP

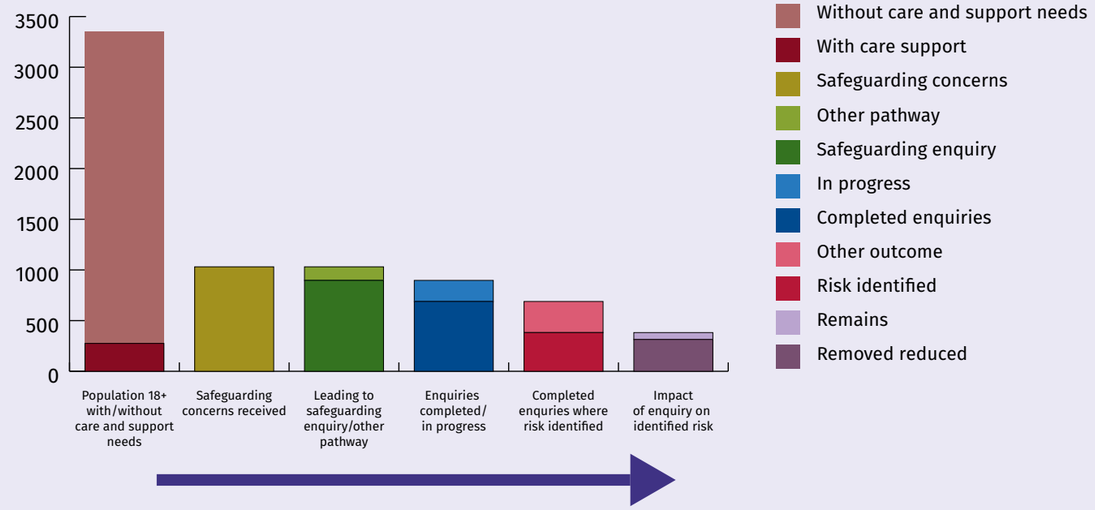
NHS London Ambulance Service NHS Trust

Central North West London NHS Foundation Trust *is committed to making sure that safeguarding and promoting the welfare of adults at risk is embedded across every directorate and in every aspect of the Trust's work*

WHAT ARE THE NUMBERS TELLING US?

This section brings together information on the safeguarding concerns that were received by the two boroughs in the period 1 April 2018 to 31 March 2019. The table and charts below highlight key statistics and show what happened to the concerns after they had been received, from the follow-up enquiry, where appropriate, to outcome

The Safeguarding Journey – from raising of safeguarding concern to outcome of safe guarding enquiry



The safeguarding journey

Raising of safeguarding concern

- In 2018-19 we received across RBKC and WCC a total of 1,031 concerns about cases of potential or actual harm or abuse. This is equivalent to three concerns for every 1,000 adults in the general population, or, we estimate, 38 for every 1,000 adults with care and support needs
- The great majority of concerns (897) met the threshold for a safeguarding enquiry. They involved 789 adults at risk; 69% were aged 65+ and 62% were women. Those concerns that did not meet the threshold were followed up in other ways for example by referral to the social care management team, the customer services team, trading standards offices, domestic abuse support agencies, or the police

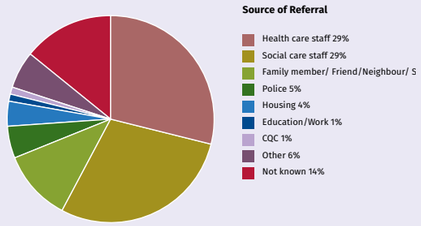
Resulting safeguarding process

- Of the concerns that met the threshold for a safeguarding enquiry over half (518, or 58%) were classified as s42 enquiries in that the person was experiencing or at risk of harm or abuse and had care and support needs which prevented them from protecting themselves
- The focus of all safeguarding enquiries is to establish what the adult at risk would like to happen in relation to the risk and what needs to be done to achieve this

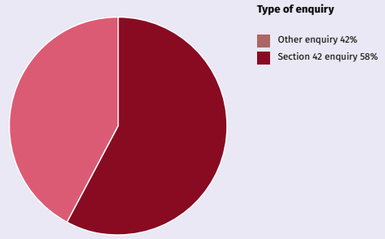
The outcome of the safeguarding process

- In over half (382, or 55%) of the enquiries which were completed in 2018-19, a clear risk of harm or abuse was identified. In the great majority of these cases (82%) the risk of harm was assessed by the social worker as having been removed or reduced by the end of the enquiry. This may have involved actions such as increased monitoring of the adult at risk or disciplinary action
- In the remaining cases the risk was judged to have remained. Commonly this was when the inquiry involved a family member and the adult was accepting of the risk and did not wish any specific action to be taken.

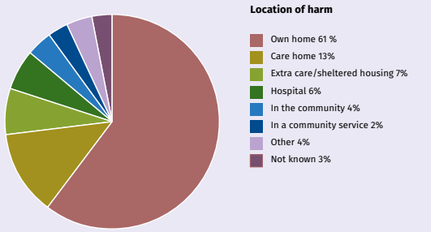
Data set for 2018-19 looking at who makes a referral ,threshold, location of harm and outcomes for the adult at risk



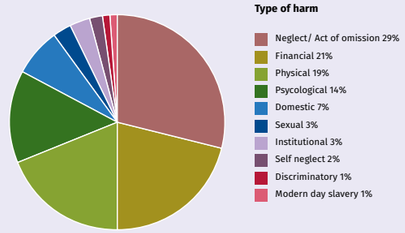
The majority of incidents (61%) occurred in the adult at risk's own home. About a quarter occurred in care settings



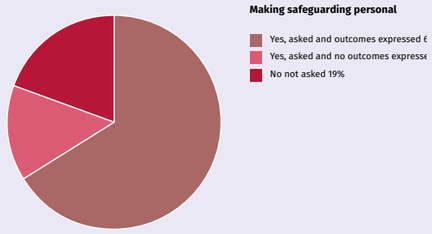
Just over 40% of concerns were followed up under safeguarding even though they did not meet the threshold for a s42 enquiry



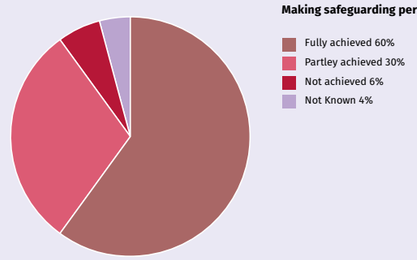
The majority of incidents (61%) occurred in the adult at risk's own home. About a quarter occurred in care settings



Self-neglect is under-represented among the allegations of abuse raised as this is followed-up under a separate pathway



In about 80% of completed enquiries the adult at risk, or their representative, was asked about the outcomes they wanted to achieves but in 14% of cases no desired outcomes were expressed



Where the adult at risk, or their representative, expressed a desired outcome, in nine out of ten cases the outcome desired was assessed as having been fully or partially achieved

APPENDIX

The Safeguarding Adults Board must arrange a Safeguarding Adults Review when an adult in its area dies or there is a near miss as a result of abuse or neglect and there is concern that partner agencies could have worked more effectively to protect the adult .

The Safeguarding Case Review Group reviewed the 2 cases below and determined that they met the statutory criteria for a SAR.

	Date case to SACRG	Emerging themes from Safeguarding Adults Reviews
1	**27 July 2018**	This is a 'near miss' case involving a person (Mr O) who was discharged from hospital. This review highlighted that Mr O presented well in terms of his functioning. While there were underlying tendencies to self-neglect, these were not always apparent, and it would have been helpful if services that supported Mr O had a greater awareness of his vulnerabilities and tendency to self-neglect. The safeguarding investigation identified the need for greater communication between agencies. The learning for organisations included the importance of creating robust handover and information on specific cases prior to staff changing or leaving their role. Early learning from this case has helped to develop clearer lines of communication between adult social care and housing. This review also highlighted the need for closer working between agencies and people, who may not require formal care services, but would benefit from some monitoring in the community to safely support their choices, rights and freedoms. **Outcome:** It was agreed a Learning Lessons Review (LLR) was the most appropriate methodology review to promote effective learning and improvement action to explore the way organisations are working together. The review will be completed in 2019 and the learning will be disseminated to all members of the SAEB. This Safeguarding Adults Case Review Group will ensure that a seven-minute learning briefing is disseminated, and practice changes are embedded by the relevant agencies.

	Date case to SACRG	Emerging themes from Safeguarding Adults Reviews
2	**21 November 2018** **Mr P**	This case concerned a man (Mr P) who had complex care and support needs, complex physical co-morbidities. Mr P exhibited challenging behaviour and had fluctuating mental capacity. Challenging behaviours impacted upon carers ability to support Mr P . He would self -neglect, increased is alcohol intake making him susceptible to falls and started to self medicate and overuse pain killers .This led to an increase in hospital admissions on at least 6 occasions in 1 year. **Outcome:** A Learning Lessons Review was undertaken to consider how agencies worked together to safeguard a man with complex care and support needs. The key focus of the review was to consider if there were 'checks and balances' in the planning and delivery of care to assure safe systems are in place and if not to explore risk to address systems issues or unsafe practice. Professionals worked closely to produce an Action Plan. The action plan includes new guidance and escalation policies for local nursing homes, promotion of joint working and changes to bariatric pathways in community care settings.

JARGON BUSTER

This is Our Safeguarding Jargon Buster using plain English definitions of the most commonly used words and phrases in this annual report.

Abuse

Harm that is caused by anyone who has power over another person, which may include family members, friends, unpaid carers and health or social care workers. It can take various forms, including physical harm or neglect, and verbal, emotional or sexual abuse. Adults at risk can also be the victim of financial abuse from people they trust. Abuse may be carried out by individuals or by the organisation that employs them.

Accountability

When a person or organisation is responsible for ensuring that things happen, and is expected to explain what happened and why.

Adult at risk

An adult who is in need of extra support because of their age, disability, or physical or mental ill-health, and who may be unable to protect themselves from harm, neglect or exploitation.

Advocacy

Help to enable you to get the care and support you need that is independent of your local council. An advocate can help you express your needs and wishes, and weigh up and take decisions about the options available to you. They can help you find services, make sure correct procedures are followed and challenge decisions made by councils or other organisations.

Autonomy

Having control and choice over your life and the freedom to decide what happens to you. Even when you need a lot of care and support, you should still be able to make your own choices and should be treated with dignity.

Best interests decision

Other people should act in your 'best interests' if you are unable to make a particular decision for yourself (for example, about your health or your finances). The law does not define what 'best interests' might be, but gives a list of things that the people around you must consider when they are deciding what is best for you. These include your wishes, feelings and beliefs, the views of your close family and friends on what you would want, and all your personal circumstances.

Carer

A person who provides unpaid support to a partner, family member, friend or neighbour who is ill, struggling or disabled and could not manage without this help. This is distinct from a care worker, who is paid to support people.

Challenging behaviour

Challenging behaviour may cause harm to the person or to those around them, and may make it difficult for them to go out and about. It may include aggression, self-injury or disruptive or destructive behaviour. It is often caused by a person's difficulty in communicating what they need - perhaps because of a learning disability, autism, dementia or a mental health problem. People whose behaviour is a threat to their own wellbeing or to others need the right support. They may be referred by their GP to a specialist behavioural team. The specialist team will work on understanding the causes of the behaviour and finding solutions. This is sometimes known as positive behaviour support.

Deprivation of liberty safeguards

Legal protection for people in hospitals or care homes who are unable to make decisions about their own care and support, property or finances. People with mental health conditions, including dementia, may not be allowed to make decisions for themselves, if this is deemed to be in their best interests. The safeguards exist to make sure that people do not lose the right to make their own decisions for the wrong reasons.

Dignity

Being worthy of respect as a human being and being treated as if you matter. You should be treated with dignity by everyone involved in your care and support. If dignity is not part of the care and support you receive, you may feel uncomfortable, embarrassed and unable to make decisions for yourself. Dignity applies equally to everyone, regardless of whether they have capacity.

Human trafficking

When someone is dishonest to you about the job you are interested in and you travel to a place and find out that you have been lied to. But you have paid money to get there and find out you now need to pay this money back before you are allowed to leave.

Learning Lessons Review

Safeguarding Adults Boards must arrange for there to be a review of a case involving an adult in its area with needs for care and support if there is reasonable cause for concern about how the SAEB, members of it or other persons with relevant functions worked together to safeguard the adult, and the adult is still alive, and the SAEB knows or suspects that the adult has experienced serious abuse or neglect. Each member of the SAEB must co-operate in and contribute to the carrying out of a review under this section with a view to identifying the lessons to be learnt from the adult's case, and applying those lessons to future cases.

Liberty Protection Safeguards

In July 2018, the government published a Mental Capacity (Amendment) Bill, which passed into law in May 2019. It replaces the Deprivation of Liberty Safeguards (DoLS) with a scheme known as the Liberty Protection Safeguards (although the term is not used in the Bill itself).

Making Safeguarding Personal (MSP)

It means that you are asked what you want to do about the incident of abuse and how you may be supported in making yourself safe. It helps you to take control and it gives you choice.

Mental Capacity Act 2005

A law that is designed to protect people who are unable to make decisions about their own care and support, property or finances, because of a mental health condition, learning disability, brain injury or illness. 'Mental capacity' is the ability to make decisions for yourself. The law says that people may lose the right to make decisions if this is in their best interests.

Near miss

Something that is not supposed to happen and is prevented before serious harm is caused.

Outcomes

In social care, an 'outcome' refers to an aim or objective you would like to achieve or need to happen - for example, continuing to live in your own home, or being able to go out and about. You should be able to say which outcomes are the most important to you, and receive support to achieve them.

Proportionality

Doing what is needed, without intruding into people's lives any further than is necessary to meet their needs or keep them safe. It is an important principle in the Care Act 2014

Prevention

Any action that prevents or delays the need for you to receive care and support, by keeping you well and enabling you to remain independent

Think Family

A Think Family approach is the steps taken by practitioners to identify wider family needs which extend beyond the individual they are supporting.

Transitions

This Term relates to the transition between children's and adults' services. Young people, who receive social care, often still need support when they turn 18. 'Transition' is the period of time when young people are moving from childhood into adulthood.

Council services for adults are different from those for children, so it's important that young adults get the services they need to live a full life. This is a very important stage in a young person's life because they need to make plans for their future care arrangements which will help them live as independently as possible.

WHAT THE BOARD WILL BE WORKING ON IN 2019/2020

The Board will continue to be guided by what people are telling us is important to them, as contained in the “house”.

We continue to work in the coming year on the three key areas:

- **Making Safeguarding Personal**

Working alongside our service user groups to develop further ways to hear the voice of the adult at risk on the Board and at a local level:

1. Service user feedback form implementation and audit
2. Marketing of Safe at home videos at a local and national level
3. Review of Train the Trainers programme delivered by service users and Community Champions

- **Creating a safe and Healthy community**

1. Preparation for implementation of the Mental Capacity Act (Amended) 2019 Liberty Protection Safeguards across the Partnership
2. Feedback from joint working group with safeguarding and community safety partnerships on prevention of repeat victimisation of older people
3. Understanding what good Quality Assurance looks like at Board Level

- **Leading listening and Learning**

1. Programme of workshops jointly developed with the Local Safeguarding Children’s Partnership to include: Transitions & Think Family
2. Launch of learning programme from safeguarding adults review and other reviews and exploring ways to better embed learning into front line practice
3. Partnership response and evaluation of Safeguarding Adults Risk Assessment Tool

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

Kensington and Chelsea

T 020 7361 3013
E socialservices@rbkc.gov.uk

Westminster

T 020 7641 2176
E adultsocialcare@westminster.gov.uk

This page is intentionally left blank

City of Westminster

Family and People Services Policy & Scrutiny Committee

Date:	27 January 2019
Classification:	General Release
Title:	**2019/20 Work Programme and Action Tracker**
Report of:	Director of Policy, Performance & Communications
Cabinet Member Portfolio:	Cabinet Member for Family Services and Public Health
Wards Involved:	All
Policy Context:	All
Report Author and Contact Details:	**Lizzie Barrett** **ebarrett@westminster.gov.uk**

1. Executive Summary

1. This report asks the committee to agree topics for the 2019/20 work programme and note the committee's action tracker.

2. Key Matters for the Committee's Consideration

2.1 The Committee is asked to:

- Review and approve the draft list of suggested items (appendix 1) and prioritise where required.
- Note the action tracker (appendix 2).
- Note the recommendation tracker (appendix 3).

3. Work Programme

3.1 The proposed list of topics (appendix 1) takes in to account comments by the committee at its previous meeting.

4. North West London Joint Health Overview and Scrutiny Committee (JHOSC)

4.1 Since the committee's last meeting the JHOSC met on 27 January 2020. The meeting was to consider the estate strategies for the NHS, GP at Hand and receive a written update on walk-in clinics.

4.2 The next meeting of the JHOSC will take place on 9 March 2020, the agenda will cover citizens' panels and patient transport.

If you have any queries about this report or wish to inspect any of the background papers, please contact Lizzie Barrett.

ebarrett@westminster.gov.uk

APPENDICES:

Appendix 1 - Work Programme 2019/20
Appendix 2 - Action Tracker
Appendix 3 – Recommendation Tracker

WORK PROGRAMME 2019/2020

Family and People Service Policy and Scrutiny Committee

ROUND FOUR 27 January 2020		
Agenda Item	**Reasons & objective for item**	**Represented by**
Cabinet Member Q&A	To receive an update and provide "critical friend" challenge	Councillor Heather Acton, Cabinet Member for Family Services and Public Health
Support for young carers	What support does the council offer to young carers? Can we do more to help them and those they care for?	
Local Safeguarding Adults Board	Review of the annual report	Independent LSAB Chair
Local Safeguarding Children Board	Review of the annual report	Independent LSCB Chair

ROUND FIVE 5 MARCH 2020		
Agenda Item	**Reasons & objective for item**	**Represented by**
Cabinet Member Q&A	To receive an update and provide "critical friend" challenge	Councillor Heather Acton, Cabinet Member for Family Services and Public Health
Integrated Care Systems	Investigate the impact of NW London ICS work on Westminster	Mark Easton, NW London CCG
Primary Care Networks (and social prescribing)		

ROUND SIX 20 APRIL 2020		
Agenda Item	**Reasons & objective for item**	**Represented by**
Cabinet Member Q&A	To receive an update and provide "critical friend" challenge	Councillor Heather Acton, Cabinet Member for

		Family Services and Public Health
Westminster Family Hubs	Review the implementation of the family hubs model in Westminster	
NHS screening		

ROUND SEVEN TBC		
Agenda Item	**Reasons & objective for item**	**Represented by**
Cabinet Member Q&A	To receive an update and provide "critical friend" challenge	Councillor Heather Acton, Cabinet Member for Family Services and Public Health
Supported Families	Review of the troubled/supported families programme following the council securing autonomy over the scheme	
Looked after Children and Unaccompanied Asylum-Seeking Children	Review of the annual report of the independent reviewing officer	

ROUND EIGHT TBC		
Agenda Item	**Reasons & objective for item**	**Represented by**
Cabinet Member Q&A	To receive an update and provide "critical friend" challenge	Councillor Heather Acton, Cabinet Member for Family Services and Public Health
Sexual and Relationship Education	Review of the implementation of SRE across Westminster after a year of it being a statutory part of the curriculum	

UNALLOCATED ITEMS		
Agenda Item	**Reasons & objective for item**	**Represented by**

Adult Social Care Account Group		
Imperial College Healthcare NHS Trust	Review of ICHNT estates program. Especially focusing on maintenance backlog and effect on services	
Suicide	Review of approach to suicide prevention	
Public Health	Review of the annual report of the Director of Public Health	Director of Public Health
Social Prescribing	Examine the approach to social prescribing across Westminster and its outcomes	

TASK GROUPS AND STUDIES		
Subject	**Reasons & objective**	**Type**
Young People's Mental Health and Technology	Investigate the effect of technology on young people	Task Group

This page is intentionally left blank

Family and People Services Policy and Scrutiny Committee Action Tracker

ROUND THREE 25 NOVEMBER 2019		
Agenda Item	Action	Update
Item 4: Cabinet Member Update	Requested that an update on Meals on Wheels three-month review come to committee	In progress
	Requested a paper on serious case reviews	In progress
	Requested an update update on the PREP (Pre-Exposure Prophylaxis) trial.	Complete
Item 5: Westminster's Youth Justice, Strategic Partnership Plan, 2019-2022, A Pathway to Positive Choices	Requested a breakdown of the 71 drug offences referenced in the report.	Complete
	Requested an update on the establishment of a charity and/or support for Kurdish residents.	In progress
	Requested more information about the early help strategy.	Complete
Item 6: Looked After Children and Care Leavers Report: Independent Reviewing Service	Requested an example of the minutes of a review meeting.	Complete
	Requested more information about what happens at a review meeting.	Complete

ROUND TWO 17 OCTOBER 2019		
Agenda Item	Action	Update
Item 4: Cabinet Member Update	Requested that the Ofsted report be circulated.	Completed
	Requested a report on why people become homeless and the reasons why they sometimes do not ask for help.	Completed

	Requested an update on proposed changes to palliative care and how this would impact Westminster residents.	Completed
Item 5: Immunisation Programmes in Westminster	Requested MMR London recovery plan	Completed
	Requested that the committee be kept appraised of IT roll outs.	Ongoing
Item 7: Work Programme	Move Primary Care Networks from round three to a later round.	Completed
	Receive Healthwatch update electronically.	Completed

ROUND ONE 17 JUNE 2019		
Agenda Item	Action	Update
Item 4: Central London Clinical Commissioning Group Update	Circulate diabetes dashboard and update on the project	Completed
	Circulate paper on Different ICP/ ICS models of care	Completed
	Circulate detail on the models of care work streams	Completed
	Circulate the recently published end of life specialist care review	Completed
Item 5: Dementia Strategy	Circulate the number of places in memory cafe drop-in sessions	Completed
Item 6: Cabinet Member Update	Circulate an update of the TUPE of staff to Sanctuary Care	Completed
	Investigate if there is an issue in Westminster with immunisation takeup	Completed

	Investigate if there is a SEN tribunal numbers are going down?	Completed
Item 7: Work Programme	Circulate a briefing on mental health transformation	Completed
	Ask RBKC why they've gone to mandating LLW with care homes	Completed
	Investigate if the Council has any concerns with safeguarding in care homes to protect residents against abuse	Completed

ROUND FIVE 1 APRIL 2019		
Agenda Item	Action	Update
Item 4: Cabinet Member Update	Organise a visit for members to DAWS	Completed
	Supply a note on the active life meeting that took place on 20th March	In progress
	Circulate a briefing note on the use of the dark web to purchase drugs	Completed
	Circulate a note on the family hubs conference	Completed
	Speech and Language Therapy budget – what is the new budget, how has this affected services?	Completed
	What is the new budget for troubled/supported families and how is it being used?	Completed
	Circulate a note on the recent dementia strategy event	Completed
	Circulate a note on the Youth Providers roundtable	Completed

	Circulate the report on Immunisation Programmes	Completed

ROUND FOUR 4 FEBRUARY 2019		
Agenda Item	Action	Update
Item 4: Cabinet Member Update	Circulate director of public health report to the committee when it is published	Completed
	Circulate report on barriers to uptake of childhood vaccinations to the committee when it is available	In progress
Item 5: Childhood Obesity in Westminster	Circulate details of water fountains in school scheme	Completed
Item 6: Local Children's Safeguarding Board	Circulate the final version of the LSCB annual report to the committee	In progress

ROUND THREE 3 DECEMBER 2018		
Agenda Item	Action	Update
Item 4: Cabinet Member Update	Provide details of how people without internet access can get the SEND self-evaluation forms	Completed
	Include and update on youth violence public health approach in cabinet member report	In progress
	Include updates on agreements of areas of lead responsibility for Speech and Language Therapy in cabinet member report	In progress
Item 5: Safeguarding Board	Share section 42 safeguarding process map with the committee	Completed
	Circulate to all councilors the contact details they should use to raise safeguarding issues	Completed
	Provide update on deprivation of liberty safeguards work in cabinet member update	In progress

Item 6: Direct Payments/Personal Budgets	Circulate examples of payroll services to the committee	Completed

ROUND TWO 15 OCTOBER 2018		
Agenda Item	Action	Update
Item 4: Cabinet Member Update	Include updates on the e-based system for STIs in future cabinet member updates	In progress
	Contact Central London CCG about the discontinuation of the 'different voices' service.	Completed
	Provide a briefing note on new contract for passenger transport	Completed
Item 5: Westminster HealthWatch Update	Include direct payments/personal budgets on the committee's work programme	Completed
Item 6: Care Home Improvement Programme (CHIP) - Older People's Nursing and Residential Homes	Share reply about young woman at Forrester court with the committee	Completed
	Provide benchmarking briefing on care home ratings	Completed
	Organise briefing session on commissioning for the committee	In Progress
	Provide the committee with an update on the IBCF funding settlement once it's known.	In Progress

This page is intentionally left blank

RECOMMENDATION TRACKER 2019 -2020

Family and People Services Committee Policy and Scrutiny Committee

Recommendations from the meeting on 17 October 2019
NHS England
RECOMMENDATION 1
That electronic consent for immunisations be pursued.
NHS England comments: • The electronic consent for immunisations in schools is being piloted by three of our eight providers and we will be happy to update the committee on this once it has been rolled out.
RECOMMENDATION 2
That it be made clear that non-porcine options are available for some immunisations, and that the default option be the non-porcine option.
NHS England comments: • Porcine is not used in all vaccinations and where it is, it is advised that parents wishing their children to have non-porcine gelatine MMR should request Priorix vaccine from their GP. This is a question for national PHE as NHSE (London) doesn't have a role in deciding the vaccines used for the national programmes.
RECOMMENDATION 3
That a mechanism for requiring private GPs to share immunisation rates be explored.
NHS England comments: • We have looked at getting the information from private GPs to upload onto child health information services to use in our reporting, but this has proven difficult as private GPs are private enterprises and there is no legal obligation for them to share vaccination information with us. We welcome any ideas or suggestions on how we might do this.
West London CCG
RECOMMENDATION 1
That it be made clear that non-porcine options are available for some immunisations, and that the default option be the non-porcine option.
West London CCG comments: •
RECOMMENDATION 2
That Westminster become part of pilot that is being rolled out in East London.
West London CCG comments:

-

RECOMMENDATION 3

That a pilot be set up to extend school vaccinations to nursery schools.

West London CCG comments:

-

Central London CCG

RECOMMENDATION 1

That it be made clear that non-porcine options are available for some immunisations, and that the default option be the non-porcine option.

Central London CCG comments:

- Porcine is not used in all vaccinations and where it is, it is advised that parents wishing their children to have non-porcine gelatine MMR should request Priorix vaccine from their GP. In terms of any change to policy regarding the use of vaccines, this is a question for national PHE as the CCG doesn't have a role in deciding the vaccine used for the national programmes.

RECOMMENDATION 2

That Westminster become part of pilot that is being rolled out in East London.

Central London CCG comments:

- NHS England has already responded by saying that it would be happy to share and update the Committee once the data collection process starts and there is enough information to determine the success or otherwise of the pilots. In terms of extending this to Westminster, we may need to wait for the results from the early adopter sites to come through before this can be fully rolled out in the Borough. However, as the CCG does not directly the commission the school nursing provider in Westminster, CNWL, the final decision would need to be made by NHSE&I (London) as they have the contract with the provider.

RECOMMENDATION 3

That a pilot be set up to extend school vaccinations to nursery schools.

Central London CCG comments:

- This recommendation by the Committee is very interesting and may be worth further exploration. However, at the moment in Westminster, most of this work is undertaken in general practice for children aged 0-5 through their primary care contract and thus any change to this arrangement would need to have the support of GPs and would also have a cost implication. It is acknowledged that current performance within general practice for this cohort is low and thus we have identified a number of areas where we think improvements can be made including greater use of our local text messaging service directed at parents for vaccination appointments and follow up reminders. Extending the school nursing service for pre-school children attending nursery even on a pilot-type basis

would require a potential financial commitment from the CCG that at the moment we would find very difficult to achieve. Nonetheless, I will take away an action to discuss with primary care colleagues to see if we might be able to undertake something at a Primary Care Network (PCN) level especially where there are nurseries within a PCN boundary. PCNs are still in their infancy but generally meet monthly and thus I will endeavour to get a space on a forthcoming agenda to talk through the idea and will keep Committee members updated accordingly.

Local Implementation Group

RECOMMENDATION 1

That all groups involved with immunisations in Westminster be encouraged to promote immunisation uptake across the city.

Local Implementation Group comments:

- The Local implementation Group will ensure the implementation plan reflects this recommendation. Furthermore, Public Health have developed an immunisations communications plan for Westminster City Council in conjunction with corporate comms and are already delivering actions accordingly.

This page is intentionally left blank