Kingston Hospital NHS
NHS Foundation Trust

Safeguarding Adults Annual Report 2015-16

Trust Board	**Item: 14a**
27th July 2016	**Enclosure:J1**
Purpose of the Report: The purpose of this annual report is to inform members of the Trust Board of the Safeguarding Adults activities within Kingston Hospital during the year 1st April 2015 to 31st March 2016, and priority areas for 2016/17.	
For: Information ☒ Assurance ☐ Discussion and input ☐ Decision/approval ☐	
Sponsor (Executive Lead):	Duncan Burton, Director of Nursing and Patient Experience
Author:	Sarah Gigg, Deputy Director of Nursing Sarah Loades, Safeguarding Adults Lead Nurse Richard Evans, Operations Manager Anne Marie McEntee, Specialist Nurse Practitioner Richmond Specialist Health Care Team
Author Contact Details:	Sarah.gigg@kingstonhospital.nhs.uk Extn; 3066
Risk Implications – Link to Assurance Framework or Corporate Risk Register:	Compliance with statutory requirements for safeguarding adults Fundamental standard (5) – safeguarding from abuse. Regulation 12; Safe care and treatment. Regulation 13; Safeguarding service users from abuse and improper treatment.
Legal / Regulatory / Reputation Implications:	Reputational, Regulatory - CQC Risk Profile Compliance with Care Act 2014.
Link to Relevant CQC Domain: **Safe ☒ Effective ☐ Caring ☐ Responsive ☒ Well Led ☒**	
Link to Relevant Corporate Objective:	To comply with Care Quality commission requirements to maintain license to practice
Document Previously Considered By:	Executive Management Committee 20th July 2016
Recommendations: Trust Board members are requested to **note** the report, the improvements made during 2015/16 and the priority areas for implementation during 2016/17	

1. Summary

The purpose of this annual report is to inform members of the Trust Board of the Safeguarding Adult activities in Kingston Hospital during 1st April 2015 to 31st March 2016. It aims to provide assurance of compliance with the local multi-agency guidelines for safeguarding adults, compliance with the Care Quality Commission Registration standards; Regulation 13 (safeguarding service users from abuse and improper treatment), fundamental standard 5 (safeguarding from abuse) and Safe Domain (safeguarding arrangements).

1.1. Key Issues

1.2. There are a number of local factors in addition to the national context which continue to increase and affect the focus of safeguarding adults including:

- Growth in demand (with an increasing aged population/ greater awareness/ higher levels of scrutiny)
- A shift in the approach to adult safeguarding so that decisions are personalised, ensure safeguarding practice preserves the individual's wellbeing and is underpinned by six principles; empowerment, prevention, proportionate, protection, partnerships and accountable. In essence safeguarding was once done to people, it is now a process that enables a person to reduce their risk of harm.
- An extension of the categories of risk to include self-neglect and hoarding.
- A drive nationally to standardise information sharing practices.
- A requirement for staff to be alert to signs of and risks of radicalisation.

1.3. In 2015/ 2016 the Trust has continued to manage the implications of the Supreme Court judgement in relation to Deprivation of Liberty, including the way in which the Trust deals with the risk and resource implications.

2. Recommendations & Action required by the Trust Board:

Trust Board members are requested to **note** the report, the improvements made during 2015/16 and the priority areas for implementation during 2016/17.

Safeguarding Adults Annual Report: April 2015 - March 2016

Kingston Hospital Foundation Trust.

Report prepared by:

Sarah Gigg, Deputy Director of Nursing

Sarah Loades, Safeguarding Adults Lead Nurse

3. Introduction

The purpose of this annual report is to inform members of the Trust Board how Kingston Hospital meets its duties to safeguard adults by preventing and responding to concerns of abuse, harm or neglect of adults during 1st April 2015 to 31st March 2016.

The policy and strategic context guiding safeguarding practice continues to evolve therefore this report outlines how the Trust remains responsive to national evidence and local need. It aims to provide assurance that the trust is compliant with; the local multi-agency guidelines for safeguarding adults, the Care Quality Commission Registration standards and the Care Act 2014.

This report highlights how the Trust manages allegations of abuse and neglect and how we ensure that safeguarding is integral to everyday practice. It also demonstrates how the trust performs in context with the borough of Kingston.

4. Background

The Care Act 2014 puts adult safeguarding on a statutory footing and in the statutory guidance states safeguarding ‘’is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult’s wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action. This must recognise that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear or unrealistic about their personal circumstances’’.

Safeguarding practice that preserves the individual’s wellbeing at its core should be underpinned by six principles; empowerment, prevention, proportionate, protection, partnerships and accountable; the outcome being that patients are:

- Safe and able to protect themselves from abuse and neglect
- Treated fairly and with dignity and respect
- Protected when they need to be
- Able to easily get the support, protection and services that they need.

The NHS England Accountability and Assurance Framework clearly sets out the safeguarding roles, duties and responsibilities of all organisations commissioning and providing NHS healthcare, including the duty to ensure;

- staff are suitably skilled and supported
- there is safeguarding leadership and commitment at all levels of their organisation
- they are fully engaged and in support of local accountability and assurance structures, in particular via the SABs and their commissioners.
- they have effective arrangements in place to safeguard vulnerable adults and to assure themselves, regulators and their commissioners that these are working.
- there is a named lead for adult safeguarding.

Adult Safeguarding must be seen as “everyone’s responsibility” across the whole of the organisation. Not only is there a commitment and a duty to safeguard adults at risk as stipulated in the Care Quality Commission Regulations but there is the overriding view that living a life free from harm and abuse is a fundamental right of every person.

In the context of the legislation, specific adult safeguarding duties apply to *any* adult who:

- Has care and support needs, and
- Is experiencing, or is at risk of, abuse or neglect, and
- Is unable to protect themselves from either the risk of, or the experience of abuse or neglect, because of those needs.

Safeguarding requires robust risk management processes in tandem with the serious incident framework and the Never Events Framework to identify and report adults at risk of abuse or neglect and take immediate appropriate action. Depending on the case, this may mean a submitting safeguarding referral alone or a safeguarding referral *and* the declaration of a serious incident. In addition, there may be cases reported on the Strategic Executive Information System (STEIS) may not require a safeguarding referral.

Multi-agency information sharing is pivotal to successful risk management and safeguarding process. The types of abuse that must be reported to the Local Authority have been extended to total 18 types of abuse (for further information, see appendix 1).

In addition, the Trust is required to consider the following when assessing and reporting risk and abuse;

- Radicalisation such as grooming is a growing concern. Prevent, as part of CONTEST; the Governments counter-terrorist strategy seeks to identify those at risk of being groomed into terrorist activity before crimes are committed.
- Cases of self-neglect and compulsive hoarding may require decisions based on the responses of a number of agencies. As detailed in the London Multiagency Safeguarding policy and procedures 2015 document ''it is important to recognise that assessments of self-neglect and hoarding are grounded in and influenced by, personal, social and cultural values''. The document calls for staff to be aware of how their own values can influence assessments.
- Any pressure ulcers of stage 2, 3 and 4 where harm and neglect is recognised (hospital or community acquired).

Applications requesting authorisation under the Depravation of Liberty Standards as an indicator of the organisations practice in line with the Mental Capacity Act and best interest practice.

5. Revised Safeguarding Adults Policy and strategy.

5.1. National and regional policy.

Following the significant shift over recent years to bring safeguarding into the fore of NHS, social care, local authority and public health policy, there have been notable changes to key policies underpinning safeguarding practice during 2015/16. Key changes are;

- 'No Secrets' has been replaced by the Care Act 2014 on 1 April 2015 and details mandatory requirements around adult safeguarding.
- All London multiagency partners are asked to adopt a Multi-Agency Adult Safeguarding Policy and procedure, released in December 2015, to ensure there is consistency in practice across London. This policy brings all terminology in line with that used within the Care Act 2014 to which the Trust has agreed to adopt.

- The Counter-Terrorism and Security Act 2015 (CT Act) requires specified authorities, in the exercise of their functions to have due regard to the need to prevent people being drawn into terrorism. CONTEST, the UK's Counter-terrorism strategy, aims to reduce the risk to the United Kingdom and its interests overseas from terrorism and radicalisation, so that people can go about their lives freely and with confidence. The CT Act was passed into legislation in early 2015, with different elements of the Act becoming statutory duties at slightly differing times. The CT Act covers all aspects of the CONTEST strategy including Prevent, Prepare, Protect and Pursue. The new duties are explained in the following sections.
- A NHS England report; 'Safeguarding Adults at risk – A stock take' 2016 provides an account of key issues in the capital with evidence and learning drawn from across multi-agencies in London's 33 boroughs.
- Making Safeguarding Personal (MSP) is a sector led initiative that provides an outcomes focus to safeguarding work so that practice and outcomes are person centered. The initiative represents a cultural shift in the approach into safeguarding adults.

5.2. Trust Policy

The Trusts "Safeguarding Adults Policy and Procedure" was ratified in February 2015 and due for review December 2017. Following the release of the London Multiagency Adult Safeguarding Policy, the Trust has opted to adopt this policy in full. A trust standard operating procedures document is in development in place of the Trust policy to localise guidance in context with those processes and terminology now standardised across London.

The following trust Safeguarding Policies and Guidelines relevant to adult safeguarding have been subject review as detailed below:

Policy	Date reviewed	New review date	Comments
Safeguarding Adults Policy & Procedure	27/05/14	27/03/17	To be replaced by the Multiagency policy and procedures Dec 2015 and Trust standard operating procedures
The Mental Capacity Act (2005) Policy & Procedure Incorporating the Deprivation of Liberty Safeguards	09/07/2015	09/06/17	
Domestic Violence and Abuse Policy	09/07/2015	09/16/18	
Domestic Abuse Guidelines - Accident & Emergency		NA	These guidelines are now an appendices in the above Domestic Violence and Abuse Policy

Domestic Abuse Guidelines - Maternity	09/07/2015	09/16/18	now included in the above policy
Safeguarding Girls at Risk of Female Genital Mutilation Guidance	27/05/2014	27/03/17	
Care of Women with Female Genital Mutilation (FGM) (Maternity	28/04/2016	28/03/19	
Policy on Control and Restraint for Adult Patient	12/01/2016	18/12/18	

6. Safeguarding Adults Structure and Governance:

6.1. Clinical Commissioning Groups (CCG)

The trust is accountable to clinical commissioners and principally Kingston CCG as lead commissioner for the Trust. The Trust reports Safeguarding activity and performance to the Clinical Quality Review Group (CQRG) on a quarterly and annual basis.

6.2 Safeguarding Adult Boards (SAB)

Locality SABs include membership core from the local authority, Police and the NHS (CCG), and includes; providers, Safeguarding Adult leads, Healthwatch and London Ambulance Service.

As detailed in the London Multiagency safeguarding policy, ‘’all Local Authorities must establish a SAB as set out in the Care Act. The Act (Schedule 2) gives the local SAB three specific duties it must do:

- Publish a strategic plan for each financial year that sets out how it will meet its main objective and what each member is to do to implement that strategy. In developing the plan it must consult the Local Healthwatch organisation and involve the community.
- Publish an annual report detailing what the SAB has done during the year to achieve its objective and what it and each member has done to implement its strategy as well as reporting the findings of any safeguarding adult reviews (SAR)s including any ongoing reviews
- Decide when a SAR is necessary, arrange for its conduct and if it so decides, to implement the findings. ‘’

6.2. The Trust Board

The Trust Board has a responsibility to ensure that there is an overall policy, procedure that details the processes, systems and workforce to protect adults at risk.

6.3. Clinical Quality Improvement Committee (CQIC)

CQIC receives highlight reports detailing recent activity, risks and associated mitigation on a quarterly basis from which members are assured of the measures in pace to safeguard adults.

6.4. Safeguarding Adults and Learning Disabilities Steering Group

The purpose of the Safeguarding Adults and Learning Disabilities Steering Group is to provide the leadership and direction that ensures safe and effective safeguarding practice within the trust. In 2015/ 2016 the Steering Group has included a standing agenda item for DoL's and MCA (Mental Capacity Act) updates and issues. Dr Duncan Gerry, Consultant Geriatrician, is a member of this group as the Trust's MCA lead.

The terms of reference for the group were reviewed and approved in July 2015. The group's main function is to provide the leadership and direction that ensures safeguarding and learning disabilities issues are managed effectively. Membership includes that from Kingston Borough Safeguarding Team and Your Healthcare learning disability team.

The group meets bi-monthly and is accountable to the Clinical Quality Improvement Committee and the Clinical Quality Review Group (partnership with local commissioners). The steering group reports quarterly and the most recent report was submitted in April 2016.

The group met on 6 occasions and attendance was in accordance with the terms of reference of the group. The group increases the frequency of the meeting to monthly as required, to ensure that it responds to the changing commissioning and provider environment and the increased awareness of adult safeguarding matters in Kingston. Medical representation has been consistent with a Medical Consultant member (with an interest in the Mental Capacity Act/ Deprivation of Liberty).

6.5. Executive Leadership

The Director of Nursing and Patient Experience as Trust Lead for Safeguarding is responsible for reporting to the Board on matters relating to leadership across the organisation, strategic safeguarding objectives and outcomes, and ensuring partnership working with other agencies. The Deputy Director of Nursing, as Safeguarding Adults Lead, is responsible for;

- Ensuring dissemination and implementation of the policy and procedure, thus ensuring that there is an effective safeguarding adult's process in the Trust.
- Ensuring that there are systems in place to monitor the process.
- Supporting staff involved in safeguarding adults.
- Giving advice and support and ensuring that the correct procedure for investigation is followed.
- Attends each of the quarterly Safeguarding Adults Partnership Board for both Kingston and Richmond.

6.6. Safeguarding Adults Lead Nurse

The Safeguarding Adults Lead Nurse is responsible for:

- Managing Safeguarding Adults issues/ incidents and assisting in investigations and is the lead for communicating with the appropriate Multi-agencies connected to Kingston Hospital NHS Trust
- Representing the Trust at Safeguarding Adult reviews (SAR), relevant sub groups of the SAB high risk case meetings as indicated on a case by case basis and Case Conferences.
- Providing training, expert advice and support to staff on safeguarding adults and reporting cases where abuse is suspected to the Safeguarding Adults Lead.
- Attending Service Line Meetings to ensure that learning from events and incidents is embedded in the organisation.
- Audit and accurate record keeping in order to monitor safeguarding practices.

6.7. Partnership Working:

The Clinical Quality Review Group (with local commissioners) receives regular reports from the Trust regarding safeguarding adults. The Kingston Learning Disability Parliament Partnership Board is also attended by members of the steering group and the Safeguarding Lead meets quarterly with the Learning Disability Parliament Health Group.

7. Scrutiny

The Trust safeguarding practices have been scrutinised by externally and internally commissioned agencies throughout the year. In the main, the trusts policies and procedures are reported as robust however notable improvement themes are drawn from the results, which the trust fully embraces as key strategic objectives for the year ahead (see section 11). The following presents a summary of findings leading from 3 key events;

7.1. Safeguarding Review (Care Quality Commission)

The trust safeguarding practice was inspected by the Care Quality Commission in January 2016. The CQC summary of safeguarding practice included;

''There were robust policies and procedures in place to ensure staff were supported to recognise, report and action concerns associated with the protection of vulnerable adults and children.''

''Staff throughout the trust were aware of their responsibilities to protect vulnerable adults and children; the majority of staff were conversant in being able to describe and identify the various forms of abuse, as well the process for raising concerns.''

''Staff generally had an understanding and awareness of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberties Safeguards (DoLS), but some staff reported not having formal training in either subject.''

Mental capacity assessments were not always carried out when patients required specific forms of mechanical restraint such as the use of hand mittens.''

Therefore the areas of action centred on; improving practice for patients who are restrained using mittens, improving the completion and documentation of mental capacity assessments and best interest decisions and improving staff training in the Mental Capacity

Act 2005 (MCA) and Deprivation of Liberties Safeguards (DoLS). These high priority actions will be met within the 2016/17 (see adult safeguarding action plan 2016/17, appendix 2).

7.2. Safeguarding self-assurance audit:

Kingston hospital took part in two self-assurance audits with Kingston CCG and Richmond CCGs as part of NHS England Safeguarding audit in March 2016.

The process included the completion of a self-assurance questionnaire produced by NHS England and London Council SAB independent Chairs, and supported by other London stakeholders, followed by attendance at 'challenge events' along with all SAB member organisations/functions.

The results following the Richmond challenge event, having been independently analysed, found KHFT demonstrated good internal governance and strong inter-agency working. The audit recommended the trust should;

- make improvements to MCA and DoLs training provision including that for volunteers,
- update polices in line with the London Multi-agency Safeguarding Policy
- Improve data collection processes and procedures, both electronic and manual.
- Provide administrative support to DoLS

The audit also revealed how NHS Trusts as in the case of KHFT, often need to undertake similar but subtly different processes across several SABs. As a result, Richmond SAB have escalated to NHS England (NHSe) the need for a Pan-London reporting framework.

The report form Kingston CCG is pending.

7.3. KPMG LLP (UK)

The trust commissioned an internal audit by KPMG to assess the Trust's compliance with the requirements of the Care Act 2014 and the Department of Health Safeguarding Adults Framework (the 'Framework'), and the consistency of safeguarding arrangements for adults within the trust. The outcome of which presented the trust's adult safeguarding arrangements favourably; applying an overall report rating of; **'significant assurance with minor improvement opportunities'.**

See appendix 4 for executive summary and;

7.3.1. Areas of good practice

For all formal safeguarding cases sampled, a Safeguarding Alert Form or email referral was completed and forwarded on to the Local Authority and / or police, where applicable; and

The Trust has complied with all standards in NHS England's 'Accountability and Assurance Framework for Safeguarding Vulnerable People in the NHS'.

7.3.2. Areas for development

Given the likelihood of increased DoLs referrals in the future as the knowledge and understanding of the requirements becomes more embedded, the Trust needs to assess the capacity of the current team to manage an increased workload. (Recommendation 1).

There is a lack of awareness amongst new or junior ward staff with respect to Deprivation of Liberty Safeguards (DoLs). The Trust should introduce a regime of spot checks to identify potential DoLs issues whilst the knowledge of DoLs becomes embedded across the Trust (Recommendation 2).

Both recommendations are included in the safeguarding action plan for 2016.

8. Safeguarding Practice

8.1. Safeguarding adult reviews (SAR)

The term Safeguarding Adult Reviews (SAR) replaces Serious Case Reviews. SABs arrange a SAR when an adult in its area with care and support needs dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.

SABs must also arrange a SAR if an adult with care and support needs, in its area has not died, but the SAB knows or suspects that the adult has experienced serious abuse or neglect.

There have been no serious case reviews in the last year involving the Trust.

8.2. High risk management meetings:

A number of models whereby relevant agencies collaborate to build a joint risk management plan exist in practice. This includes;

8.2.1. Multi Agency Safeguarding Hubs (MASH)

The MASH is one model where concerns may be risk assessed and decisions made about how concerns are taken forward. The MASH is a partnership of agencies that have a duty to safeguard and have agreed to share information they hold on adults at risk. Their shared vision for safeguarding is to work in an integrated way to improve the outcomes for adults at risk.

8.2.2. Multi-Agency Risk Assessment Conference (MARAC)

The MARAC is the multi-agency forum of organisations that manage high-risk cases of domestic abuse, stalking and 'honour'- based violence.

The safeguarding team regularly consult with lead agencies in support of the above.

8.3. Internal Triage

On a day to day basis a great deal of informal assessments takes place to triage the patient and filter potential concerns form actual concerns. This level of activity is not currently captured or demonstrated in activity data. It is the intended to improve data collection so this level of activity will be visible within the trust and therefore evidence the capacity needed to manage safeguarding adult practice.

8.4. Female Genital Mutilation (FGM)

In March 2014 the Department of Health issued new guidance for Trusts when recording FGM in patient's records. As of 31st October 2015, FGM must be formally reportable to the FGM Prevalence Dataset and subsequently returned to the Department of Health on a monthly basis.

FGM prevalence is discussed at both adult and children's safeguarding steering groups in the Trust. The trusts data is shown in the activity section of this report.

8.5. Mental Capacity Act (MCA) 2007.

Mental Capacity is the ability to make a decision. Capacity can vary over time and by the decision to be made. The inability to make a decision could be caused by a variety of permanent or temporary conditions, for example, a stroke or brain injury, dementia, a mental health problem, a learning disability, confusion, drowsiness or unconsciousness because of an illness or the treatment for it; or due to alcohol or drug use/ misuse.

The MCA introduced statutory responsibilities and applies to everyone who works in health and social care and is involved in the care, treatment or support of people over the age of 16 years, living in England or Wales, who are unable to make all or some decisions for themselves.

The MCA is underpinned by fundamental 5 principles:

- Assume Capacity; Every adult has the right to make their own decisions if they have capacity to do so. A person must therefore always be assumed to have capacity unless it is established otherwise.
- Practical steps to maximise decision making capacity; A person is not to be treated as unable to make a decision unless all practicable steps to help him\her to do so have been taken without success.
- Unwise decisions; A person is not to be treated as unable to make a decision because he or she makes what others may consider to be an eccentric or unwise decision.
- Best Interest; Any act done, or decision made, under the Mental Capacity Act for or on behalf of a person who lacks capacity must be done or made in his\her best interests.
- Least Restrictive; Alternative Before an act is done, or a decision is made, regard must be had to whether the purpose for which it is needed can be effectively achieved in a way that is less restrictive for the persons rights and freedom of action.

8.6. Deprivation of Liberty:

The Trust continues to drive improvements in meeting changes in national law and the threshold for referrals for Deprivation of Liberty Safeguards (DOLS). In April 2014, the new Cheshire West guidelines identified the "acid test" for making an application to deprive a patient of their liberty:

- Where a resident is in care and is deemed to lack capacity to make decisions about their care
- Where that person is not free to leave the care home, nursing home or hospital, (unsupervised)
- Where that person is under continuous supervision and control (to such an extent that they would be prevented from leaving if they attempted to).

The DoLS process requires increased scrutiny and understanding of the MCA framework (the understanding of how to formally complete a MCA assessment has to be present when making a DoLS application and this must be formally documented).

For example, the application of DoLs should be considered for; all patients actively asking, and trying, to leave the hospital where they do not have capacity, all patients who require 1:1 care, all patients who require mittens for prevention of pulling out NG tubes, any patient

requiring chemical restraint and any patients on other restrictions such as low beds, falls alarms or padded cot sides.

If a patient dies under a DoLS authorisation, this is deemed as being “death in custody”. Therefore the case has to formally be discussed with the Coroner and an inquest considered. Guidelines and forms for doing this have been made available. The Safeguarding Adults Lead Nurse has provided training to the Mortuary staff and liaises with them regarding any deaths. There were 2 such cases in 2015/16.

On July 7th 2015 the Law Commission opened a consultation on the law of mental capacity and deprivation of liberty. In the project status report, the Deprivation of Liberty safeguards ‘’have been critised since they were introduced for being overly complex and excessively bureaucratic’’. Dr Duncan Gerry, Dr Lulu Kreegar and Sarah Loades represented the Trust at one of the consultations in 2015. A final report from the Law Commission should be published in December 2016.

8.7. Dementia:

There are many reasons why people with dementia can be at risk of abuse. They might be abused by strangers or by people they know. Sometimes family or friends who are providing care to a person with dementia may also act abusively. This can be related to high levels of carer stress. It is important to acknowledge that a person with dementia can be vulnerable to abuse and staff are encouraged to be alert for signs of abuse. The three year Dementia Strategy 2014 - 17 was launched with progress being made through year two of the strategy including radical changes to the care environment, bed time routines and therapeutic activities. Measures designed to ensure patients with dementia are safeguarded include;

- Recruitment of a Dementia service improvement lead in December 2015
- A dementia scorecard is under development to monitor outcomes for patients with dementia, focusing on patient safety incidents, specifically falls and subsequent harm from falls. The dementia strategy group will review the scorecard monthly and initiate action to improve outcomes.

8.8. Pressure Ulcers:

Pressure ulcers should be monitored, assessed and screened for cases where abuse or neglect through poor care are indicated. While all category/grade 3 and 4 pressure ulcers are reportable to NHS London as a Serious Incident (SI) only those considered to be caused by abuse or neglect are reported as a safeguarding concern to the borough SAB. There must, therefore, be sound decision making processes to support staff who are concerned that a pressure ulcer may have arisen as a result of poor practice or neglect/abuse before a safeguarding concern is raised.

To support staff in screening all pressure ulcers for cases of abuse and neglect the safeguarding lead nurse has worked closely with the pressure ulcer improvement works as part of a three-year strategy to reduce pressure ulcers at Kingston Hospital. Improvements made in 2015/16 include;

- Improved assessment, reporting data tracking and investigation process.
- Improved incident and escalation process through trust incident reporting to CCG
- Enhanced and timely shared learning and feedback to staff
- Close working between Tissue Viability Nurse and Adult safeguarding leads

- Improved communication with community providers and GPs particularly at discharge
- Close working and data sharing with trust and provider safeguarding leads.

8.9. People with Learning disabilities in hospital

Going into hospital can be frightening, confusing and stressful experience. People are often unsure what to expect or how they will cope, and the language used by hospital staff can be hard to understand. It is a time when everyone will feel vulnerable.

For people with learning disabilities it is likely to be even more complicated. They are likely to find it more difficult than most people to communicate natural anxieties, or explain any pain or discomfort they may be in. They may have difficulty in adjusting to the hospital environment and routines. They may also have had poor experiences of healthcare in the past. Hospital staff may not know or understand the cognitive, health and personal care needs of individuals with learning disabilities. Vulnerability is likely to be further increased by other factors such as epilepsy, mental illness, sensory impairment or risk of choking - all of which are more common amongst people with learning disabilities.

These problems have been known about for some time and were highlighted in a series of critical reports from MENCAP, the Disability Rights Commission and the Health Service Ombudsman. The independent inquiry into access to healthcare for people with learning disabilities made ten recommendations on reasonable adjustments needed to make healthcare services as accessible to people with learning disabilities as they are to others. The government accepted these recommendations, which are reflected in Monitor's compliance framework for foundation trusts, The Human Rights Act 1998 and the Equality Act 2010 place clear duties on trusts to protect all patients' human rights and to promote equal access to treatment and care. The *NHS Constitution*, NHS outcomes framework and the '6 Cs' initiative provide further relevant detail on requirements.

Despite this background and the body of advice based on research, in 2013 the confidential inquiry into premature deaths of people with learning disabilities (CIPOLD) found that men and women with learning disabilities died sooner than those without learning disabilities (an average of 13 and 20 years respectively). CIPOLD also found that avoidable deaths from causes related to poor quality healthcare were higher than for those with no learning disabilities. In 29% of these cases there had been significant delay or difficulty in diagnosis and for 30% there had been problems with treatment.

Contributory factors included: a lack of reasonable adjustments (particularly at clinic appointments and investigations); GP referrals not mentioning individuals' learning disabilities, and limited use of hospital 'flagging' systems to identify people with learning disabilities. Information sharing and coherent, appropriate decision-making was hindered by a lack of co-ordination of care provision across different disease pathways and service providers, alongside poor adherence to, and understanding of, the Mental Capacity Act 2005. Families of those with learning disabilities frequently felt that professionals did not listen to them, although the ten year national carers' strategy stipulated that carers should be treated as partners in diagnosis, care and discharge planning.

Research into the safety of patients with learning disabilities in NHS hospitals also cited delays and omissions in treatment and basic care. The main barriers to better and safer hospital care for people with learning disabilities were found to be: the invisibility of such patients within hospitals; poor staff understanding of their specific vulnerabilities; a lack of consistent and

effective carer involvement and misunderstanding by staff of the carer role, plus a lack of clear lines of responsibility and accountability for the care of each patient with learning disabilities

The trust must meet the following 6 requirements as set out in 'Healthcare for all' (DH, 2008):

- Does the NHS foundation trust have a mechanism in place to identify and flag patients with learning disabilities and protocols that ensure that pathways of care are reasonably adjusted to meet the health needs of these patients?
- Does the NHS foundation trust provide readily available and comprehensible information to patients with learning disabilities about the following criteria:
    - treatment options
    - complaints procedures
    - appointments?
- Does the NHS foundation trust have protocols in place to provide suitable support for family carers who support patients with learning disabilities?
- Does the NHS foundation trust have protocols in place to routinely include training on providing healthcare to patients with learning disabilities for all staff?
- Does the NHS foundation trust have protocols in place to encourage representation of people with learning disabilities and their family carers?
- Does the NHS foundation trust have protocols in place to regularly audit its practices for patients with learning disabilities and to demonstrate the findings in routine public reports?

As part of a national review undertaken by Monitor during 2015/16, the Trust discussed the compliance and evidence to support each of the six elements with Monitor and provided assurance that these are in place. During 2016/17 the Safeguarding and learning disability steering group will review current practices against the above criteria.

8.9.1. Learning disability Nurse Liaison Team:

Learning disability nurses from Your Healthcare Neurodevelopmental Services Specialist Healthcare Teams for Kingston and Richmond provide acute liaison and support for patients with a learning disability from 9 – 5pm, Monday to Friday excluding public holidays. Hospital staff informs the LD Nurse who then completes a triage assessment, provides advice, support and signposts to appropriate services as required.

8.10. Prevent Duty

The Prevent Duty is effective as of 1st July 2015. The Prevent Duty provides definitions and context regarding Prevent, details regarding monitoring and enforcement and sector specific guidance. One of the specified authorities mentioned under these guidelines are NHS Foundation Trusts.

The key responsibilities applicable to all specified authorities are:

- Leadership: develop mechanisms to understand the risk, ensure staff understand the risk and have capacity to deal with it, promote the duty and ensure staff implement the duty.
- Partnership: demonstrate partnership working particularly with Prevent Co-ordinators, Local Authorities and Police, via multi-agency forums already in place, such as the Community Safety Partnerships.

- Capability: ensure front line staff are trained to understand radicalisation and vulnerabilities, know the supports available and how people can access these supports.

The key responsibilities specific to health are:

- Partnership: Regional Safeguarding Forums should have oversight of compliance with the duty. Issues should be reported to the National Prevent sub board and Prevent leads should have networks in place for advice and support to make referrals to Channel. Contractual requirements should be bolstered by the statutory duty.
- Risk Assessment: all Trusts should have a Prevent lead who acts as a single point of contact for Prevent co-ordinators and are responsible for implementing Prevent within their organisation. Within the Trust this post is held by the Operations Manager in Facilities. To comply with the duty staff are expected to be able to recognise and refer people who are risk.
- Staff Training: ensure staff are trained at the relevant competency for their role, the intercollegiate guidance Safeguarding Children and Young people: roles and competencies for health care staff and the NHS England Training and Competencies Framework provide guidance regarding the training requirements.
- Monitoring and enforcement: the duty stated that Monitor, TDA and CQC as the sector regulators will provide monitoring arrangements; however the robustness of these arrangements is being reviewed.

Healthcare professionals have a key role in PREVENT. PREVENT focuses on working with vulnerable individuals who may be at risk of being exploited by radicalisers and subsequently drawn into terrorist-related activity. PREVENT does not require staff to do anything in addition to their normal duties. What is important is that if they are concerned that a vulnerable individual is being exploited in this way, they can raise these concerns in accordance with the local procedures (through the Safeguarding Adults referral process).

9. Activity data:

The Care Act 2014 Section 45 'supply of information' duty covers the responsibilities of others to comply with requests for information.

As detailed in the London Multi-agency safeguarding policy, ''Partner organisations may be asked to share information through agreed information sharing protocols. Each SAB should have a protocol in place for information sharing.'' This means that data reporting differs from borough to borough; as stated above there is an appetite to develop a consistent reporting framework Pan-London in the future.

This report represents data which has been reported both externally and internally. It is intended that future reports will be informed by revised SAB information sharing framework.

9.1. Kingston SAB data

Kingston CCG and therefore Kingston Safeguarding Adult Board (KSAB) as the lead commissioner share data with KHFT regarding borough wide safeguarding. The data below details total safeguarding concerns (previously termed safeguarding alerts) reported to KSAB

from all sources. This data provides the trust with important context from which to review trust data.

Of all concerns reported to KSAB in 2014/15 the most common form of abuse was physical, however in 2015/16 neglect (N=31) was the most highly reported on with physical abuse as the second most reported (n=11). Sexual abuse figures have marginally increased but traditionally cases are believed to be under reported, however this fits the national picture. There have been slight increases in emotional and financial abuse and reported incidents of discrimination are low, however it is likely that reported cases of discrimination are likely fielded by national government offices, and so traditionally this figure is reflected as low within local government reporting.

Table 1. Concerns received by KSAB from all sources.

	2011/13	2012/13	2013/14	2014/15	2015/16
Alerts (concerns) received	724	600	555	654	691
Number of repeat referrals	22	67	38	45	91
Number progressed to investigation	238	228	250	246	268
Substantiated - Fully	79	67	72	83	59
Substantiated - Partially	39	20	27	21	20
Inconclusive	50	39	43	20	17
Not Substantiated	57	63	45	58	25
Investigation Ceased at Individuals Request	-	1	5	1	2
Open Cases - yet to be determined	3	9	31	45	124

9.2. Concerns raised by Kingston Hospital

Of a total 121 concerns raised, 62 formal concerns were raised by the Trust to all borough SABs, during 2015/16. Formal concerns are raised by the trust to the relevant SABs.

Table 2. Formal and informal concerns raised by KHFT

Ealing	Kingston	Merton	Richmond	Surrey	Sutton	Wandsworth	West Sussex	Total
1	23	1	14	10	1	12	0	62

9.3. All safeguarding categories reported 2015/16

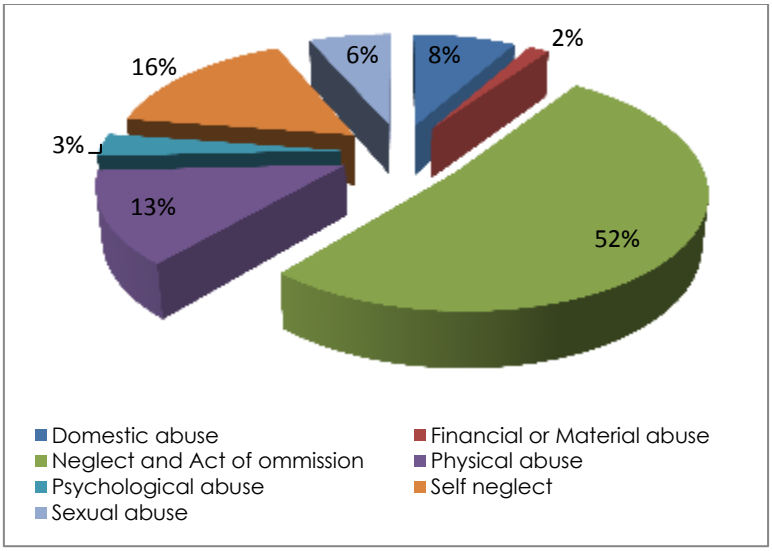
The most prominent form of abuse reported from Kingston hospital was that of ‘neglect and acts of omission’ and ‘self-neglect’.

The types of concerns reported under 'neglect and acts of omission related to community acquired pressure ulcers, packages of care not meeting requirements to support people at home and delays in progressing care plans for those living in residential nursing homes.

Examples of concerns reporting self-neglect involved individuals declining to engage in services to reduce their risk of harm and in cases of those living in isolation without family support.

A detailed breakdown of the informal and formal concerns to establish trends is not yet possible. Going forward it is intended to provide more robust data on the types of concerns raised to all boroughs.

Figure 1. Safeguarding abuse by category 2015/16



9.4. Concerns raised against the Trust

All concerns raised about the Trust are investigated by KSAB as host/lead borough. There were 20 alerts raised against the Trust in 2015-2016. This demonstrates a reduction compared to previous years.

Table 3. Concerns raised against KFT;

Month	2012/13	2013/14	2014/15	2015/16
April	3	0	3	3
May	2	3	3	1
June	0	1	1	0
July	5	3	2	5
August	0	3	1	1
September	2	2	3	1
October	3	3	4	4

November	4	5	0	1
December	0	3	1	1
January	0	1	5	2
February	2	1	3	0
March	2	2	2	1
TOTAL	**23**	**27**	**28**	**20**

Of the twenty cases raised against the Trusts, two cases were substantiated by the Kingston Safeguarding Adult Board. Details are as follows:

Case one; a patient fell and incorrect manual handling practices were employed.

Case two; incorrect medical and nursing information was included on the discharge documentation of a patient with complex end of life care needs.

Both safeguarding investigations have concluded with formal action plans in place and lead by respective service line leads.

The one partially substantiated case involved miss-communication between the hospital, community residential home staff and district nurses. The investigation has concluded for all agencies involved with formal actions plans in place. The Elderly care service line is leading the delivery of the action plan.

Table 4. Outcome of concerns against the trust.

Outcome	2012/13	2013/14	2014/15	2015/16
Substantiated	8	3	5	**2**
Partially substantiated	2	2	0	1
Unsubstantiated	3	6	2	0
Inconclusive	3	2	0	1
No further action at Alert	4	4	5	11
No further action after Strategy Meeting	1	2	6	2
Awaiting further investigation / information	0	0	5	0
Awaiting Case Conference	0	0	5	3

9.5. Female Genital Mutilation

The FGM information recorded by clinical staff is collated by the Trust in order to capture the relevant information for the FGM Prevalence Dataset. This is carried out by the Clinical Coding team at the Trust. The trust reported fourteen **adult** safeguarding cases of FGM in 2015/16 compared with Nil cases in 2014/15. The reason for this increase may be due to improved awareness since reporting was mandated on 31st October 2015; however is not fully know at this stage. Future year on year data will inform this assumption.

Figure 1. Total Number of new FGM cases reported by KHFT per CCG in 2015/16

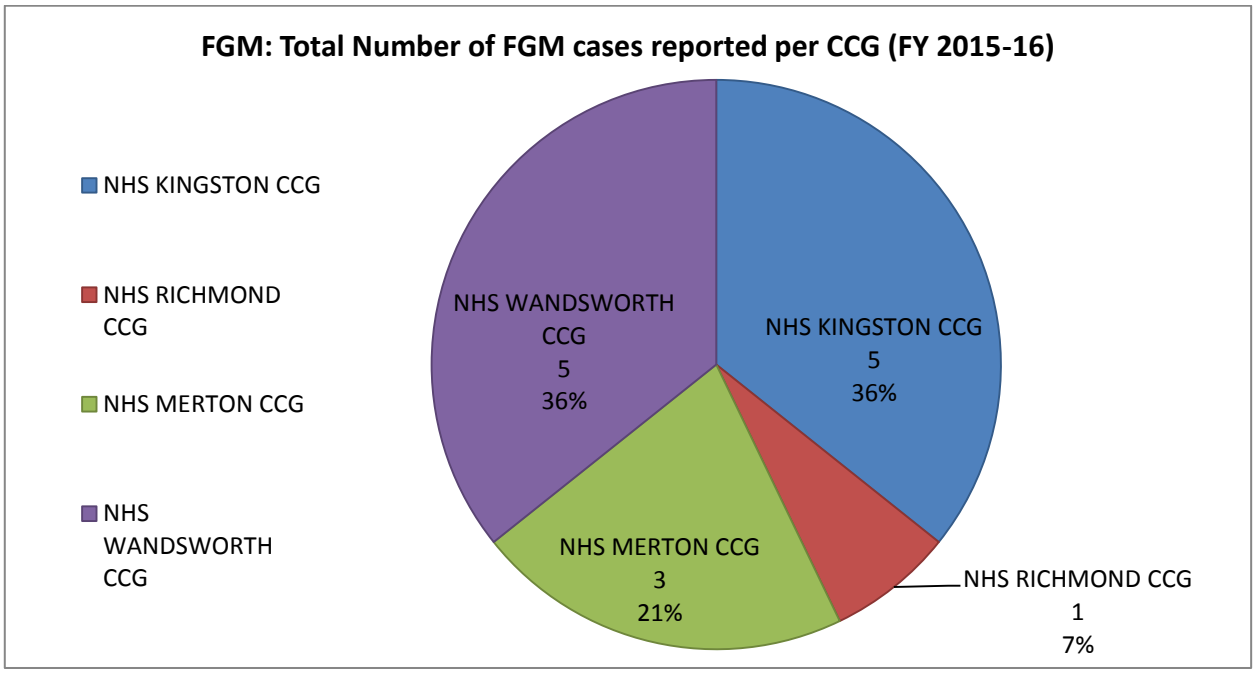
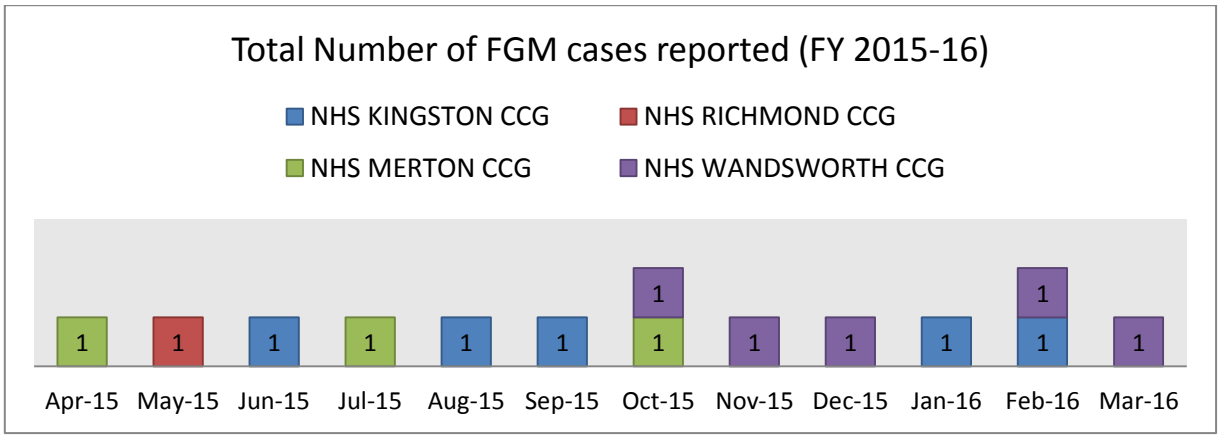


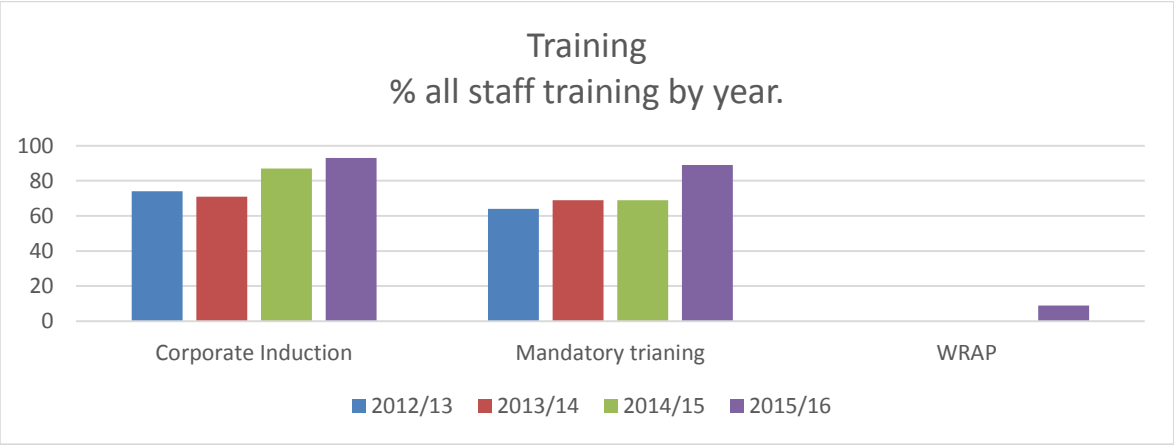
Figure 2. Total Number of new FGM cases reported by KHFT in 2015/16



9.6. Training

The table below shows the delegate attendance on all training containing Safeguarding Adults modules and WRAP training recorded on the Trust data base from April 1st 2013 to 30th March 2016 for all new staff.

Figure 3 Percentage of staff trained through induction and mandatory refresher training each year.



9.6.1. Safeguarding training

The Trust provides safeguarding adults training for every member of staff with a mandatory requirement for a three yearly update. The intention of the training is to:

- Raise awareness throughout the organisation.
- Embed the aspects of the multi-agency Safeguarding Adults Policy in the practice of staff.
- Ensure that every member of staff employed by the organisation has a basic awareness of the requirements and their responsibilities in relation to safeguarding adults at risk.
- Awareness of the Mental Capacity Act and Deprivation of Liberty.

Training is provided in a variety of formats including; corporate induction and mandatory training via an online refresher training booklet and a rolling monthly programme directed at band 2 and band 5 staff.

Training levels are monitored at the Safeguarding Adults and Learning Disability Steering Group and Executive Management Committee.

In terms of compliance, we achieved induction training for 79% (new staff) at year-end against a target of 75%. For existing staff a mandatory training level of 85% was achieved (against a required threshold of 75%). When combining both figures in year, 93% of eligible staff received safeguarding training.

In addition to mandatory training, the rolling monthly face to face programme delivered training to 88 band 2 and 134 band 5 staff.

Dr Gerry, Consultant, is leading on the programme of training for medical staff. There have been two medical Grand Round presentations.

In 2015 -2016 Dr Gerry and Sarah Loades have provided bespoke sessions on the MCA and DOL's to many departments and staff groups in the trust.

There have been sessions to the Surgical and Orthopaedic Services Lines to capture all medical and nursing staff. The Palliative Care department and the Palliative care link nurse have had bespoke presentations. The Royal Eye Unit, ITU, the Dieticians and OT's have all received separate bespoke presentations on MCA and DOL's as have the Elderly Care Service in 2015/16.

9.6.2. WRAP

A Prevent Training and Competencies Framework had been developed to support NHS providers in meeting their contractual obligations in relation to the Prevent strategy. It is the role of the Clinical Commissioning Group (CCG) to hold the providers to account on the NHS Standard Contract requirements. The Prevent Training and Competencies Framework works in conjunction with the 'Safeguarding Children and Young people: roles and competences for health care staff. Intercollegiate Document' (December 2013) in order to ensure a consistent approach within the children safeguarding agenda and develop some parity between the expectations to safeguard both children and adults at risk.

The framework aims to assist organisations in developing their training framework in relation to raising awareness of the Prevent strategy and in identifying staff groups requiring basic Prevent awareness training and Workshop to Raise Awareness of Prevent (WRAP or Health WRAP). It has been developed between October 2013 and April 2014 by NHS England Regional Prevent Coordinators and the Regional Prevent Forum Working Group in the South West, consisting of NHS Prevent Leads from both commissioning and provider organisations.

Two key staff are trained to deliver PREVENT training across the Trust, with several others identified to be trained, and is now part of the Safeguarding Adults element of on-line mandatory training in the Trust.

Delivery of the Health WRAP training has begun with several hundred (n= 250) front line and senior staff having already received the training. This equates to 9% of permanent staff against a target of 100% of all staff by end 2016. This target is unlikely to be realised and so the Trust is working closely with the CCG to ensure the challenges associated with this training are raised and addressed.

The Trust Prevent Lead will develop and implement the Trust training plan during 2016/17 with the aim of front line staff having received the training by July 2017.The Trust continues to support the quarterly data reporting to NHS England (London).

9.7. Learning Disability

The following summarises the activity supporting people with learning disabilities cared for at Kingston Hospital during 2015/16.

9.7.1. Admissions

Specialist Learning Disability nurses from Your Healthcare Neurodevelopmental Services continue to track and support inpatient admissions. In tracking admissions, the learning disability nurse liaison team are able to provide specialist support and advice and ensure any necessary reasonable adjustments are made. It also enables the team to identify any recurrent themes in terms of admissions and any issues / barriers identified and learning is used to achieve real change by embedding national and best practice guidance and local innovation into existing practice and procedures. The team are notified of admissions through a number of routes, direct contact with the local community learning disability teams, the duty learning disability social worker or from A&E, or ward staff.

There were 133 admissions during 2015/16 which shows an increase compared to 2014/15 of 102 admissions. The total figure includes patients admitted on more than one occasion. Further breakdown of data will be made available to the safeguarding adult steering group in Q2 2016 by the learning disability nurse liaison team.

Figure 4. Total hospital admissions of patients with learning disabilities.

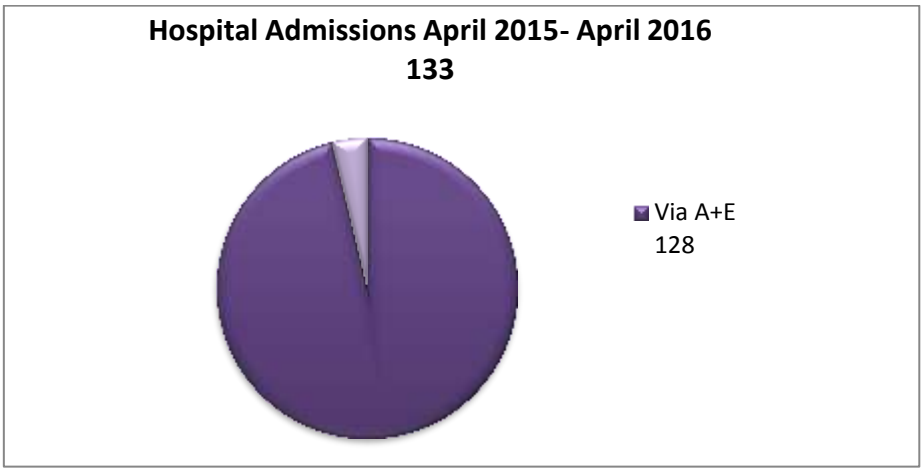
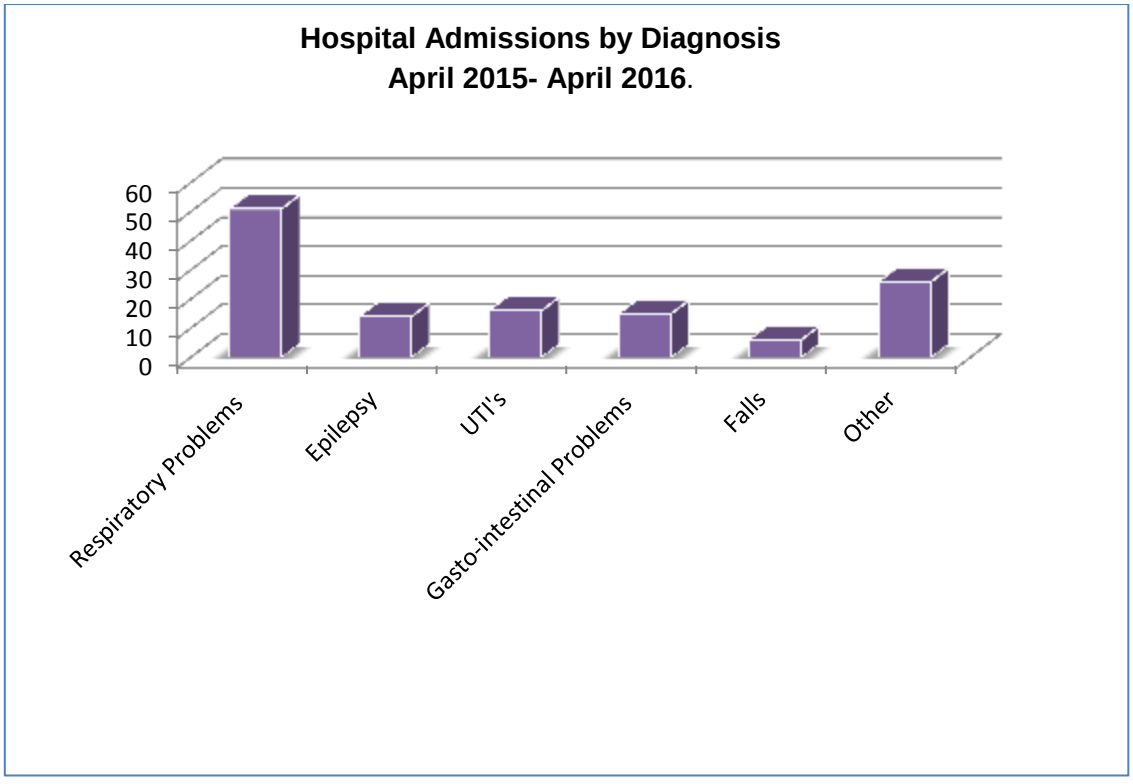


Figure 5. Hospital Admissions of patients with learning disabilities by Diagnosis



In the last year the learning disability nurse liaison team have provided:

- Pre-attendance planning, admission, consultation, investigation and treatment
- Produced personalised / accessible information on investigations and treatments
- Direct support during investigations
- Advice and support to acute care staff
- Risk management
- Advocacy
- Consent – maximising residual capacity
- Supporting mental capacity assessments
- Liaison with primary care, family carers
- Discharge planning
- Follow up from attendance at A&E
- Education sessions to staff

The team are notified of admissions through a number of routes, direct contact with the team, the duty learning disability social worker or from A&E, or ward staff.

9.7.2. Achievements 2015 /16

- Joint hospital protocol reviewed and updated
- A learning disability resource page has been developed on the Trust intranet and internet.
- A learning disability nurse triage checklist for acute admissions has been developed to ensure any complex or specific needs of patients with learning disabilities are met and the necessary reasonable adjustments are made. A risk and support needs assessment has also been developed to help ward staff and carers identify if additional one to one support is required to ensure safe care.
- Bespoke emergency and inpatient care pathways are now offered to all learning disability patients with complex needs who have very specific support and care requirements that mean they are at greater risk in an acute setting. These pathways are person centred, developed collaboratively between the relevant hospital and community clinicians and signed by both parties

The learning disability nurses continue to provide learning disability awareness sessions on the corporate induction and CMT training programme. From January 2016 they also have a dedicated slot on the Band 2 and Band 5 induction programme.

9.7.3. Plans for 2016 /17

- The development of a learning disability steering group consisting of clinicians from the hospital and other key community stakeholders
- The development of a joint work plan between the hospital and Your Healthcare Neurodevelopmental Services
- A “Getting to know your Hospital” Event to be arranged, this will include an opportunity to visit wards and departments

9.8. Deprivation of Liberty:

Following work in 2014/15 that identified that approximately 50% of patients could be appropriate for a DoLs application, the Trust has seen a significant increase in applications however fewer in 2015/16 have been formally processed. This is often because on

assessment patients may have regained capacity, been discharged, died or been transferred to other care providers. There is further work to do to demonstrate and monitor the level of decision making and assessment prior to and following submission of a DoLs application.

Two people have died in care at KHFT while under a Deprivation of Liberty Safeguard.

Table 8. DoLs applications approved by borough

Borough	2013/2014	2014/2015	2015/16
Kingston	4	26	16
Richmond	2	18	15
Wandsworth	0	4	7
Surrey	1	4	3
Merton	0	2	3
Sutton	0	1	0
Total	**7**	**55**	**44**

9.9. Lampard Review:

Following the Saville review, Kingston Hospital NHS Foundation Trust has completed the majority of actions in relation to the recommendations (summarised from all of the investigations undertaken in the Lampard Review) having assessed current processes for adequacy during 2015/16. A final policy change is due to be approved in July 2016.

See appendix 3 for the action plan.

10. Strategic Objectives for 2016/ 2017:

The year ahead looks set to be equally as challenging as the trust strives to maintain and improve the current level of performance in response to the changing landscape and the needs of the community. The action plan in appendix 2 details the planned activity going forward.

The following strategic priorities form the bedrock of the action plan:

Table 9. Strategic priorities

Strategic objective	Lead	Measures of Success	Timescale for completion
To improve awareness of MCA and DoLS policy and procedure including the safe and appropriate application of mechanical restraints through improved access to MCA and DOLS training for all staff	Safeguarding adult lead nurse	Training schedule, evaluation and attendance data.	Q3
To improve the appropriate delivery of the MCA and DoLS policies and procedures, including accurate documentation, across the organisation	Safeguarding adult lead nurse	The number of DOLS applications and authorisations. Audit of MCA assessments in all aspects of treatment and care. Collect data from CRS to robustly report % of Safeguarding triage cases and formal Section 42 enquiries to all Boroughs	Q3
To Increase the resilience and capacity within the team to lead a robust assured process for adult safeguarding, DOLS and MCA processes.	Deputy Director of Nursing (Safeguarding adult lead)	Recruitment to new post holder. Revised and agreed data capture and reporting process	Q2
To align children's and adult safeguarding teams (policy application and shared learning)	Deputy Director of Nursing (Safeguarding adult lead)	Meeting restructure Number of transitional/shared concern case studies discussed	Q2
Increase delivery of Prevent training across the organisation to target	Prevent Lead	Training schedule.	Q4

11. Conclusion:

This annual report for 2015/16 details a year of significant activity and scrutiny. The trust has demonstrated that there are robust mechanisms in place to safeguard adults at risk and to investigate and learn from concerns raised about the Trust through safeguarding processes. As the approach to safeguarding evolves and the complexity of decision making increases in context of newly recognised forms of harm and abuse, the current structures and process must continue to develop in response.

Key areas for improvement drawn from audit, assessments and review, are the need for enhanced training to support MCA and DoLS application, increased staffing capacity to manage the DoLS process and improved data sharing across all boroughs. The planned programme of activity for 2016/17 will see these improvements met.

Appendix 1: Types of abuse and abusive behaviours

The list below, taken from the London Multi-Agency Policy and Procedures (Dec 2015) document, illustrates types of abuse and abusive behaviours provides some detail on the 18 recognised types of abuse and abusive behaviours.

TYPE OF ABUSE	DESCRIPTION OR SUPPORTING GUIDANCE
Disability Hate Crime	The Criminal Justice System defines a disability hate crime as any criminal offence, which is perceived, by the victim or any other person, to be motivated by hostility or prejudice based on a person's disability or perceived disability. The Police monitor five strands of hate crime, Disability; Race; Religion; Sexual orientation; Transgender.
Discriminatory abuse	Discrimination on the grounds of race, faith or religion, age, disability, gender, sexual orientation and political views, along with racist, sexist, homophobic or ageist comments or jokes, or comments and jokes based on a person's disability or any other form of harassment, slur or similar treatment. Excluding a person from activities on the basis they are 'not liked' is also discriminatory abuse
Domestic abuse	The Home Office (March 2013) defines domestic abuse as: Any incident or pattern of incidents of controlling, coercive or 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. This can encompass but is not limited to the following types of abuse: Psychological; Physical; Sexual; Financial; Emotional. Domestic Abuse includes controlling and coercive behaviour.
Female genital mutilation (FGM)	Involves procedures that intentionally alter or injure female genital organs for non-medical reasons. The procedure has no health benefits for girls and women. The Female Genital Mutilation Act (2003) makes it illegal to practise FGM in the UK or to take girls who are British nationals or permanent residents of the UK abroad for FGM whether or not it is lawful in another country.
Financial or material abuse	Theft, fraud, internet scamming, coercion in relation to an adult's financial affairs or arrangements, including in connection with wills, property, inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits.

Forced marriage	Is a term used to describe a marriage in which one or both of the parties are married without their consent or against their will. A forced marriage differs from an arranged marriage, in which both parties consent to the assistance of a third party in identifying a spouse. In a situation where there is concern that an adult is being forced into a marriage they do not or cannot consent to, there will be an overlap between action taken under the forced marriage provisions and the adult safeguarding process. In this case action will be co-ordinated with the police and other relevant organisations. The police must always be contacted in such cases as urgent action may need to be taken. The Anti-social Behaviour, Crime and Policing Act 2014 make it a criminal offence to force someone to marry. In addition, Part 4A of the Family Law Act 1996 may be used to obtain a Forced Marriage Protection Order as a civil remedy. Registrars and registry staff need to be supported through relevant training to know the signs of possible forced marriage.
Hate Crime	The police define Hate Crime as 'any incident that is perceived by the victim, or any other person, to be racist, homophobic, transphobic or due to a person's religion, belief, gender identity or disability'. It should be noted that this definition is based on the perception of the victim or anyone else and is not reliant on evidence. In addition it includes incidents that do not constitute a criminal offence.
Honour-based violence	Will usually be a criminal offence, and referring to the police must always be considered. It has or may have been committed when families feel that dishonour has been brought to them. Women are predominantly (but not exclusively) the victims and the violence is often committed with a degree of collusion from family members and/or the community. Some of these victims will contact the police or other organisations. However, many others are so isolated and controlled that they are unable to seek help. Adult safeguarding concerns that may indicate honour-based violence include domestic violence, concerns about forced marriage, enforced house arrest and missing person's reports. If an adult safeguarding concern is raised, and there is a suspicion that the adult is the victim of honour-based violence, referring to the police must always be considered as they have the necessary expertise to manage the risk.
Human trafficking	Is actively being used by Serious and Organised Crime Groups to make considerable amounts of money. This problem has a global reach covering a wide number of countries. It is run like a business with the supply of people and services to a customer, all for the purpose of making a profit. Traffickers exploit the social, cultural or financial vulnerability of the victim and place huge financial and ethical obligations on them. They control almost every aspect of the victim's life, with little regard for the victim's welfare and health. The Organised Crime Groups will continue to be involved in the trafficking of people, whilst there is still a supply of victims, a demand for the services they provide and a lack of information and intelligence on the groups and their activities.

Mate Crime	A ‘mate crime’ as defined by the Safety Net Projectxl is ‘when vulnerable people are befriended by members of the community who go on to exploit and take advantage of them. It may not be an illegal act but still has a negative effect on the individual.’ Mate crime is often difficult for police to investigate, due to its sometimes ambiguous nature, but should be reported to the police who will make a decision about whether or not a criminal offence has been committed. Mate Crime is carried out by someone the adult knows and often happens in private. In recent years there have been a number of Serious Case Reviews relating to people with a learning disability who were murdered or seriously harmed by people who purported to be their friend.
Modern slavery	Slavery, servitude and forced or compulsory labour. A person commits an offence if: The person holds another person in slavery or servitude and the circumstances are such that the person knows or ought to know that the other person is held in slavery or servitude, or The person requires another person to perform forced or compulsory labour and the circumstances are such that the person knows or ought to know that the other person is being required to perform forced or compulsory labour. There are many different characteristics that distinguish slavery from other human rights violations, however only one needs to be present for slavery to exist. Someone is in slavery if they are: Forced to work - through mental or physical threat; Owned or controlled by an 'employer', usually through mental or physical abuse or the threat of abuse; Dehumanised, treated as a commodity or bought and sold as 'property'; Physically constrained or has restrictions placed on his/her freedom of movement. Contemporary slavery takes various forms and affects people of all ages, gender and races. Adults who are enslaved are not always subject to human trafficking. Recent court cases have found homeless adults, promised paid work opportunities enslaved and forced to work and live in dehumanised conditions, and adults with a learning difficulty restricted in their movements and threatened to hand over their finances and work for no gains. From 1 November 2015, specified public authorities have a duty to notify the Secretary of State of any individual identified in England and Wales as a suspected victim of slavery or human trafficking, under Section 52 of the Modern Slavery Act 2015.
Neglect and acts of omission	Ignoring medical, emotional or physical care needs, failure to provide access to appropriate health, social care or educational services, and the withholding of the necessities of life such as medication, adequate nutrition and heating. Neglect also includes a failure to intervene in situations that are dangerous to the person concerned or to others, particularly when the person lacks the mental capacity to assess risk for themselves.
Organisational abuse	Is the mistreatment, abuse or neglect of an adult by a regime or individuals in a setting or service where the adult lives or that they use. Such abuse violates the person’s dignity and represents a lack of respect for their human rights.
Physical abuse	Assault, hitting, slapping, pushing, misuse of medication, restraint or inappropriate physical sanctions.

Psychological abuse	Emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, cyber bullying, isolation or unreasonable and unjustified withdrawal of services or supportive networks.
Restraint	Unlawful or inappropriate use of restraint or physical interventions. In extreme circumstances unlawful or inappropriate use of restraint may constitute a criminal offence. Someone is using restraint if they use force, or threaten to use force, to make someone do something they are resisting, or where an adult's freedom of movement is restricted, whether they are resisting or not. Restraint covers a wide range of actions. It includes the use of active or passive means to ensure that the person concerned does something, or does not do something they want to do, for example, the use of key pads to prevent people from going where they want from a closed environment.
Sexual abuse	Rape, indecent exposure, sexual harassment, inappropriate looking or touching, sexual teasing or innuendo, sexual photography, subjection to pornography or witnessing sexual acts, indecent exposure and sexual assault or sexual acts to which the adult has not consented or was pressured into consenting.
Sexual exploitation	Involves exploitative situations, contexts and relationships where adults at risk (or a third person or persons) receive 'something' (e.g. food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of them performing, and/or another or others performing on them, sexual activities. It affects men as well as women. People who are sexually exploited do not always perceive that they are being exploited. In all cases those exploiting the adult have power over them by virtue of their age, gender, intellect, physical strength, and/or economic or other resources. There is a distinct inequality in the relationship. Signs to look out for are not being able to speak to the adult alone, observation of the adult seeking approval from the exploiter to respond and the person exploiting the adult answering for them and making decisions without consulting them.

Appendix 2: Safeguarding and Learning Disability Action plan

Issue	Action Required	Measure of success	SRO	Date raised	Due Date	Progress/Comments	Status
Policy							
Internal policy must be consistent with national and regional policy	Replace Trust policy with Multi-agency Safeguarding Adult policy (M-ASAP) through correct routes.	Policy reviewed through CQIC	SG	01/03/2016	01.09.16		
SOPS required to localise the London M-ASAP policy	Develop SOPS supporting all due process aligned to M-ASAP	Signed off SOPS through SASG	SG	01/03/2016	01.09.16		
Data							
Data capture process is reliant on manual feeds and subject to reduced efficiency and data error.	Revise CRS data feeds and potential to automate activity reports, triage reports and data assessment completion	Data report	SL	01.04.16	01.07.16		
The trust will be required to meet Borough data reporting framework in 2016	Revise and refresh data collection in line with data reporting frameworks as they emerge.	Data report	SL/SG	01.06.16	31.03.17		
Audit							
Assurance is required that practice follows DoLS policy. (CQC action)	Complete an Audit of DoLS practice including the use of Mittens including referral and documentation compliance	Audit results	SL	20.06.16	31.12.16		
Assurance is required that practice follows MCA policy (CQC action)	Complete an Audit of MCA practice including referral and documentation compliance using the NHS improvement tool; http://londonadass.org.uk/wp-content/uploads/2014/12/MCA-and-Dols-improvement-tool.pdf	Audit results	SL	20.06.16	31.12.16		
Safeguarding reporting through the incident route do not match anecdotal experience s of activity	Conduct a data audit of electronic data systems (CRS) compared with safeguarding incidents reported on Ulysses.	Audit results	SL	01.04.16	01.07.16		
Practice supporting those with learning disabilities must conform to the 6 requirements set out in Health care for all	Audit LD practice	Audit results and recommendations	AM	01.05.16	01.12.16		
Education							
Current trust practice is informed by out of date terminology.	Provide refresher training to all staff regarding the practice, procedures and terminology cited in the new Multi-agency policy.	Training schedule	SL	01.04.16	01.08.16		
MCA training should be reviewed annually	Revise training practices in line with MCA assessment tool;	training assessment and completion of recommendations	SL	01.06.16	31.10.16		
CQC inspection highlights a requirement to improve training supporting MCA and DoLS practice. (CQC action)	Deliver a revised training programme across the trust. Enhancing the training imparting MCA regulation, practice and process	Training schedule	SL	20.06.16	01.08.16		
The prevent training target of 100% all staff trained by 2016 will not be realised.	Increase training capacity within the trust.	Training schedule	RE	01.04.16	01.09.16		
The CCG Assurance Audit 2016 recommends that volunteer training and monitoring is reviewed and reported through Trust governance.	Revise training and evaluate understanding of principles of safeguarding policy for all trust volunteers.	Training schedule	SL	01.04.16	01.09.16		
Other							
Capacity to deliver adult safeguarding and particularly to administer DoLS applications is challenged.	Increase team capacity	Recruitment of 2nd post holder.	SG	01/09/2015	01.06.16	Post offered. Awaiting references.	
Where safeguarding issues demanding both adult and children's safeguarding structures work collaboratively, there is a need to review governance to ensure such issues do not fall between both structure.	Move towards aligned or collaborative structure to ensure shared issues benefit form expertise of both groups.	revised and agreed terms of reference. Meeting attendance	SG/K	01.04.16	01.10.16		
Bank Staff providing 121 care for patient with complex learning disabilities have not often had enhanced training.	Provide training to interested staff	Training programme and Bank staff booking records.	AM	01.05.16	31.03.17		

Appendix 3. Action plan in response to the Lampard report.

Report on actions in response to Kate Lampard's report into Themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile				
NAME OF TRUST:	**Kingston Hospital NHS Foundation Trust**			
Recommendation	**Issue Identified**	**Planned Action**	**Progress to date**	**Due for Completion**
R1 All NHS hospital trusts should develop a policy for agreeing to and managing visits by celebrities, VIPs and other official visitors. The policy should apply to all such visits without exception.	VIP, VVIP and 'Persons of Interest' (Patients) Plan did not include a section on "planned" attendances. Media Policy does not specifically refer to VIP/ VVIP visits (and management process)	Revision of relevant section Revision of relevant section	Complete Complete	Completed Completed
R2 All NHS trusts should review their voluntary services arrangements and ensure that: • they are fit for purpose; • volunteers are properly recruited, selected and trained and are subject to appropriate management and supervision; and • all voluntary services managers have development opportunities and are properly supported.	Compliant Robust, documented processes for volunteers Volunteer service manager (substantive) has fortnightly 121 with Deputy Director of Nursing Voluntary service manage appraisal completed in April 2015 with agreed development plan for the member of staff Annual review of Volunteering Strategy (overseen by Board member)	No further action required		
R4 All NHS trusts should ensure that their staff and volunteers undergo formal refresher training in safeguarding at the appropriate level at least every three years.	Compliant Safeguarding training provided for all volunteers Supervision process for volunteers in place	No further action required		
R5 All NHS hospital	Compliant	Internal Audit of	Timeline agreed	Completed

trusts should undertake regular reviews of: • their safeguarding resources, structures and processes (including their training programmes); and • the behaviours and responsiveness of management and staff in relation to safeguarding issues to ensure that their arrangements are robust and operate as effectively as possible.	Annual report to Trust Board (with quarterly reports to Clinical Quality Review Group, which involves commissioners) Last three SAAF assessments have been peer reviewed and presented to two largest SAPB meetings Child/ Adult/ Maternity Safeguarding posts in place Annual reports regarding safeguarding presented to Trust Board	Adult Safeguarding to take place during Q2 of 15/16	with KPMG (Internal Auditors)	September 2015
R7 All NHS hospital trusts should undertake DBS checks (including, where applicable, enhanced DBS and barring list checks) on their staff and volunteers every three years. The implementation of this recommendation should be supported by NHS Employers.	Currently every 5 years NON Compliant for every 3 years Exercise to review all existing staff and volunteers concluded Inactive volunteers who did not return required paperwork removed from volunteer register	TBC	Conduct annual review to provide assurance that existing systems are effective DBS policy ratified March 2016 and includes the addition of a commitment; ‘’To undertake a rolling programme of re-checking existing staff every three years‘’ Compliance /data required to demonstrate activity. Three yearly rolling programme implemented June 2016	Completed. Completed Completed

				Completed
R9 All NHS hospital trusts should devise a robust trust-wide policy setting out how access by patients and visitors to the internet, to social networks and other social media activities such as blogs and Twitter is managed and where necessary restricted. Such policy should be widely publicised to staff, patients and visitors and should be regularly reviewed and updated as necessary.	Compliant Media Policy to be updated to include the relevant wording and publication cascade to be implemented	Update media Policy	Completed	Completed
R10 All NHS hospital trusts should ensure that arrangements and processes for the recruitment, checking, general employment and training of contract and agency staff are consistent with their own internal HR processes and standards and are subject to monitoring and oversight by their own HR managers.	DBS are currently rechecked on staff every 5 years. This needs to move to 3 yearly on basis of new requirement. Use of Non - Framework Agency workers	Review of Workforce to identify numbers for rechecks required greater than 3 years & complete checks - prioritised by high risk area Baseline cost and resource required to carry out checks Identify the Non-Framework agencies used in the last 12 months. Audit agency files for those workers that have been supplied into clinical areas to ensure correct governance checks Rollout a Trust PSL (Preferred	Identification process completed Completed Completed Ongoing process	Completed Completed Completed New Process commenced. Completed Completed

		Supplier List) of agencies that can be used at the Trust with all subject to audit checks for NHS Standards Compliance.	PSL reviewed. Neutral vendor for medical staff reviewed. System software solution identified.	
R11 NHS hospital trusts should review their recruitment, checking, training and general employment processes to ensure they operate in a consistent and robust manner across all departments and functions and that overall responsibility for these matters rests with a single executive director.	Revise process to ensure conflicts of interests during the recruitment process are fully highlighted Executive declarations of (actual/perceived) conflicts of interest in place & director with responsibility in place	Update Recruitment Policy to reflect changes Communicate (internal comms) the changes to the policy	Addendum to the Recruitment and Selection policy drafted and for approval at Executive Management Committee on **20th July 2016**	In progress
R12 NHS hospital trusts and their associated NHS charities should consider the adequacy of their policies and procedures in relation to the assessment and management of the risks to their brand and reputation, including as a result of their associations with celebrities and major donors, and whether their risk registers adequately reflect such risks.	Compliant Amendment to Media Policy	Nil further action required		
R13 Monitor, the Trust Development Authority, the Care Quality Commission and NHS England should exercise their powers to ensure that NHS hospital trusts,(and	NA	NA	NA	NA

where applicable, independent hospital and care organisations), comply with recommendations 1, 2, 4, 5, 7, 9, 10 and 11.				
R14 Monitor and the Trust Development Authority should exercise their powers to ensure that NHS hospital trusts comply with recommendation 12	NA	NA	NA	NA

Appendix 4 KPMG Exec summary

The Trust's policy for safeguarding adults at risk is comprehensive and is supplemented by a full suite of process flow charts, procedure notes and associated policies, including the Mental Capacity Act Policy. We assessed compliance with the requirements of NHS England's 'Accountability and Assurance Framework for Safeguarding Vulnerable People in the NHS' ('the Framework') and did not identify any exceptions. There is no formal requirement for Acute providers in the Care Act 2014 to comply with its guidance, although we note that the Trust has upheld the collaborative working underpinning the principles of the Act through its attendance at Local Authority Safeguarding Adults Boards. The impact of the Act was presented to the Trust Board in July 2015.

The control framework in relation to safeguarding adults is adequate in design, although management needs to assess the capacity of the current structure to deal with any future increase in the level of referrals. The system is reliant on the Safeguarding Adults Coordinator which exposes the Trust to a business continuity risk.

We assessed the consistency of adult safeguarding arrangements across a sample of wards and found that all internal alerts tested were identified on the date of admittance, which indicates these were detected in a timely manner. Externally raised alerts sampled were also subject to prompt investigation.

Training levels are monitored centrally by the Education Centre and on a service line and ward basis in performance review meetings. This allows senior ward staff to understand who has adhered to training deadlines at any point in time. Ward managers are proactive in ensuring team members have met their training requirements and remain accountable for any instances of non-compliance.

Monitoring and reporting arrangements for safeguarding adults involve reporting to the Safeguarding Adults and Learning Disability Steering Group, and the Clinical Quality and Improvement Committee as an extra layer of scrutiny. Safeguarding activity is presented in detail annually to the Trust Board and is supplemented by ad hoc reports as and when required.

Interviews with staff across a sample of wards found that there is further work to be done to raise awareness of the Mental Capacity Act 2005 and the implications of the Deprivation of Liberty Safeguards (DoLs), particularly amongst new or junior ward staff. Testing performed over a sample of confirmed DoLs cases determined that evidence of potential safeguarding concerns was considered and these were appropriately escalated to the relevant Local Authority for authorisation.