Redbridge Safeguarding Adults Board

Redbridge Safeguarding Adult Board (RSAB) Annual Report 2022 - 2023

Safeguarding Adults – Working to Keep People Safe

Contents

1. Foreword from the Chair

A Message from Eileen Mills who has been the Independent Chair from March 2022

This annual report celebrates our achievements, as well as highlighting challenges, and provides updates on progress made and against our priorities: Transitional Safeguarding, Making Safeguarding personal, Quality Assurance and Modern-Day Slavery.

I am grateful for the engagement of all our partners and the amount of work that has taken place over the last year, not only to safeguard people from abuse and neglect but also to support the activity of the RSAB. Including supporting the Safeguarding Adult Review (SARs) process as it has transitioned to a new 'One Panel' approach to screening. This change enables learning and improvement in safeguarding practice across the wider system in Redbridge.

At the start of the year the RSAB did not have a Strategic Plan this has now been developed and can be found on the RSAB website, this is a positive step forward in being clear on the intentions of the RSAB and what underpins our work.

It is essential that as the RSAB moves forward, that it can assure itself that it is meeting the statutory requirements under the Care Act 2014. The Care Act 2014 statutory guidance paragraph 14.139 sets out a list of supplementary duties, in addition to the three main duties.

- Publish a strategic plan for each financial year that sets out its objectives and what members will do to achieve this;
- publish an annual report detailing what the SAB has done in the year and what each member has done to implement the strategy; and
- conduct any Safeguarding Annual Review in accordance with section 44 of the Act

The priorities for the up-and-coming year are aimed to seek assurance and support the delivery of the supplementary duties.

One of the key purposes of the annual report is to promote the profile of the RSAB with the public and other local multi-agency partnerships as well as the profile of safeguarding adults in Redbridge, with this in mind this Annual Report will be sent to:

- Safeguarding partners;
- Healthwatch Redbridge;
- Redbridge Health and Wellbeing Board; and
- made publicly available on the SAB's and members' websites.

In conclusion, I would like to take this opportunity to acknowledge that these are challenging time for all, but through our shared commitment we can continue to strive to achieve our shared vision:

People in Redbridge 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*

Warmest regards

Eileen Mills

Independent Chair

2. What is the Redbridge Safeguarding Adults Board?

The Redbridge Safeguarding Adult Board (RSAB) is a partnership of statutory and non-statutory organisations, representing health, care and support providers and the people who use those services across the Borough.

The three key statutory duties for Safeguarding Adults Boards in the Care Act are:

- publish a strategic plan for each financial year that sets out its objectives and what members will do to achieve this;
- publish an annual report detailing what the SAB has done in the year and what each member has done to implement the strategy; and
- conduct any Safeguarding Adult Reviews in accordance with section 44 of the Act.

Membership comprises of the senior leaders across organisations, who under the leadership of the Independent Chair, work collaboratively to develop and improve safeguarding across the Borough. The partnership includes:

- London Borough of Redbridge (adult health and social care, children's services, community safety, housing, public health, and commissioning)
- Metropolitan Police Service (MPS) East Area (EA) Basic Command Unit (BCU)
- Barking, Havering, and Redbridge University Hospital Trust (BHRUT)
- Bart's Health NHS Trust
- Partnership East London Cooperatives (PELC)
- Department for Work & Pensions (DWP)
- Healthwatch Redbridge
- London Fire Brigade (LFB)
- National Probation Service (NPS)
- NELFT NHS Foundation Trust
- North East London (NEL) NHS Integrated Care System (ICS)
- Age UK Redbridge, Barking & Havering (RBH)
- Voiceability
- One Place East
- Redbridge Carers Support Service (RCSS)
- Refuge
- Sanctuary Housing
- Jewish Care
- Redbridge CVS
- Cabinet Member for Adult Social Care & Health, LB Redbridge
- Lay Members
- Care Quality Commission (CQC) - Observer

The work of the RSAB is supported by the following Subgroups and linked forums:

- **Policy and Practice Subgroup** promotes multiagency good practice in relation to safeguarding adults.
- **Redbridge 'One Panel'** a forum to bring together referrals for cases to be considered for review. These include Safeguarding Adult Reviews (SARs), Domestic Homicide Reviews (DHRs), and Child Safeguarding Practice Reviews (CSPRs). The Panel will also undertake the important role of monitoring recommendations of completed reviews and ensuring that learning is shared across Redbridge.
- **Safeguarding Adults Network Forum** - enables the contribution of a user perspective to the development of safeguarding adults work across Redbridge and influence change in policies, procedures, and practice through the Safeguarding Adults Board.
- **Redbridge Bogus Caller Partnership (BCP)** - a multi-agency group that has a key role in facilitating crime reduction. Members can achieve more by working together to meet the common goals. It is accountable to the Redbridge Safer Communities Partnership Board. It has a role in prevention of safeguarding by financial abuse by facilitating crime reduction, and safeguarding residents who may already have care and support needs.

The work programme for the Board, Subgroups and that of the Independent Chair are funded through SAB contributions. A well-resourced Board is essential to enable it to deliver its statutory duties and supports the Board to fund Safeguarding Adult Reviews (SARs) and learning events and other Board activities. The current and previous Independent Chairs have raised that the RSAB is unable to effectively deliver some of its statutory duties because of lack of resources, particularly in relation to use of data, quality assurance and delivery of multi-agency training.

3. Purpose of the Annual Report

Chapter 14 of the **Care and Support Statutory Guidance** sets out what is required in an annual report for Safeguarding Adult Boards (SAB). After the end of each financial year, the SAB must publish an annual report that must clearly state what both the SAB and its members have done to carry out and deliver the objectives and other content of its strategic plan. The reports should have prominence on each core member's website and be made available to other agencies.

Specifically, the annual report must provide information about any Safeguarding Adults Reviews (SARs) that the SAB has arranged which are ongoing or have reported in the year (regardless of whether they commenced in that year). The report must state what the SAB has done to act on the findings of completed SARs or, where it has decided not to act on a finding, why not.

To examine how the board is meeting its duties the following keylines of enquiry have been examined.

Key Lines of Enquiry for Safeguarding Adult Boards

1. Is there evidence of community awareness of adult abuse and neglect and how to respond?
2. Does the RSAB analysis of safeguarding data to better understand the reasons that lie behind local data returns and use the information to improve the strategic plan and operational arrangements? Does there need to be better reporting of abuse and neglect data
3. What do adults who have experienced the safeguarding process say and the extent to which the outcomes they wanted (their wishes) have been realised?
4. What do front line practitioners say about outcomes for adults and about their ability to work in a personalised way with those adults?
5. What evidence is there of success of strategies to prevent abuse or neglect?
6. How is feedback from local Healthwatch, adults who use care and support services and carers, community groups, advocates, service providers and other partners provided?
7. How successful is adult safeguarding is at linking with other parts of the system, for example children's safeguarding, domestic violence, community safety?
8. Evidence of the impact of training carried out and future training needs identified.
9. How well agencies are co-operating and collaborating?

Findings in response to Key Lines of Enquiry

1. *Is there evidence of community awareness of adult abuse and neglect and how to respond?*

All agencies in their single agency returns (Appendix 1) identify how they train and support professionals to recognise and respond to safeguarding concerns in the communities they work in. For example, the Redbridge Carers Support Service have been raising awareness at peer support groups and events during the year, providing information to carers on the types of Safeguarding and the process for reporting concerns. As part of this year's priorities on Making Safeguarding personal in response to the Healthwatch report completed in 2021 -2022 Hearing the Voice of the Service User Project by Healthwatch Redbridge. The report highlighted the following areas:

- Service users had a lack of awareness of safeguarding systems.
- A general mistrust of professionals who were sometimes seen as unhelpful.
- Advocacy appeared to assist participants to better access the help they needed in a timely manner.
- Satisfaction with the process was inconsistent and mainly due to a lack of consistency with a follow-up review process, or the feeling of not being able to influence the outcome.

In response to the findings, a review was undertaken of information provided for professionals, volunteers, and the community on how to report a safeguarding concern. Information has been updated on the local authority website, RSAB website and MyLife (now Support and Help for Adults) website. The group also undertook a review, with service users and professionals, of current general safeguarding adults RSAB leaflets to see whether the content is sufficient on making a referral. Following consultation, new versions of the leaflet were published on the RSAB website. The multi-agency RSAB Introduction to Safeguarding Adults Briefings which include information on making a referral, for awareness raising and improving confidence amongst professionals and volunteers have been reinstated following the recovery from the pandemic. Data continues to identify that there is an underrepresentation of safeguarding adult referrals from racialised communities in Redbridge in comparison to census data. Most notably the Indian community. This is recognised in the priorities for the upcoming year, now some of the underpinning work described above has been completed.

2. *Does the RSAB analysis of safeguarding data help to better understand the reasons behind local data returns and enable utilisation of the information to improve the strategic plan and operational arrangements? Does there need to be better reporting of abuse and neglect data?*

As highlighted above the RSAB does reflect on the data and uses it to support the development of priorities, however at the present time the only data is the nationally

required annual return. Therefore, there are limitations in proactively supporting the monitoring of trends and themes to support timely responses. A priority for the 2022 - 2023 period was to develop a quarterly multiagency data set to promote better understanding of themes and trends and reflective of current priorities. A set of data requirements have been developed but at the time of writing the report there is not the capacity or resources to develop this work further. This does and will continue to be a risk for RSAB. Until it can be established the ways in which data can be analysed and interrogated to increase the SAB's understanding of the prevalence of abuse and neglect locally the board will continue to not meet the supplementary requirements of the Care Act 2014.

As the Local Authority develops its data following the implementation of a new case management system and in readiness for inspection carried out against the new CQC assessment framework for local authority assurance, it is hoped this can be shared at the RSAB as a starting point over the next year, for how the RSAB can extend to gathering data from across the partnership.

3. *What do adults who have experienced the safeguarding process say and the extent to which the outcomes they wanted (their wishes) have been realised?*

The Annual Safeguarding Adult Data return in 2022-23 identified in 58% of cases were safeguarding investigations had concluded the relevant person or their representative stated their desired outcome had been met. In 2022-23 this has increased to 69%, which demonstrates positive progress for the service.

4. *What do front line practitioners say about outcomes for adults and about their ability to work in a personalised way with those adults?*

The Safeguarding adult network and the partnership single agency returns (**Appendix 1**) highlight that communication remains an issue for professionals in knowing the outcome of referrals and safeguarding investigations, which can impact on future working and support to the service user.

The single agency returns highlight good practice across some agencies in having policy and guidance that support practitioners and monitored by single agency audits (see **Appendix 1**).

The RSAB has a well-established Policy and Practice Subgroup, which brings practitioners together to discuss cases reflect and develop practice. A key piece of work that remains ongoing for the subgroup is develop a recording system for capturing Making Safeguarding Personal (MSP). Case discussions reflect awareness and responsiveness to working in a personalised way, but it is clear how to capture and evidence this is providing a challenge.

The overriding challenge services reported related to staff recruitment and retention and increase demand on services and in turn the impact that has on services users, where dignity and making safeguarding personal may be compromised.

The data provided in the annual return to NHS digital for the period 1 April 2022 - 31 March 2023 shows an increase in the number of safeguarding adult notification received by the local authority from 1442 in 2021-2022 to 1548 for this period.

A series of 'Meet the Chair' events over the start of the year confirmed the demand on their services did impact on communication. The priorities for next year reflect the need to get back to basics to look at how partners come together when working to safeguarding service users, exploring how different levels of risk are managed in a multiagency way.

5. *What evidence is there of success of strategies to prevent abuse or neglect?*

Over the last year the priority area of work on Transitional Safeguarding has led to the implementation of the Transitional Safeguarding panel although still too early to measure success, it is anticipated that young people who are better supported post 18 will experience less harm.

The Modern-Day Slavery task and finish group has done considerable work to support the workforce to recognise this form of exploitation at the earliest opportunity to prevent ongoing harm.

Following the announcement of the Homes for Ukraine scheme the risk of safeguarding harm was recognised and plans put in place to mitigate the risk as much as possible.

The RSAB has developed guidance on People in Positions of Trust (PiPoT) to provide a framework for managing cases where allegations have been made against a person in a position of trust (PiPoT) i.e. anyone who works (either paid or unpaid) with adults with care and support needs. It is focused on the management of risk based on an assessment of abuse or harm against an adult with care and support needs. It provides a framework to ensure appropriate actions are taken to manage allegations, regardless of whether they are made in connection with the PiPoT's employment, in their private life, or any other capacity. The number of referrals increased from 5 in 2021-22 to 10 in this reporting period as a result of increasing awareness.

6. *How is feedback from local Healthwatch, adults who use care and support services and carers, community groups, advocates, service providers and other partners provided?*

The membership of the RSAB includes Healthwatch Redbridge, Lay Members and community and voluntary services. Healthwatch were instrumental raising concerns over the living conditions and experience of asylum seeks living in hotels in

Redbridge. This led to the identifications of safeguarding referral not always being made which is now being addressed through partnership working and scrutiny activity of the partners in relation safeguarding of this vulnerable group of residents.

The Safeguarding Adult Network Forum has lost some of the service user element over recent years but continues to collate issues and themes from across the partnership to raise with the RSAB. As part of the priorities for 2023 - 2024 this will be reviewed to enhance the voice of service users.

Other activity of the RSAB includes the RSAB board manager delivering a briefing on the role of the Board to the Care Providers Voice Forum.

The chair and board manager are members of the National and London Business Managers Networks and Chairs Network and the NEL SAB Chairs and Managers group, which provides a broader remit of feedback on issues affecting services users.

The RSAB supported the London SAB awareness raising campaign on social media and shared training opportunities during National Safeguarding Adults Week 2022.

7. *How successful is adult safeguarding is at linking with other parts of the system, for example children's safeguarding, domestic violence, community safety?*

Increasing the links across system has been a significant improvement over the last year.

A joint safeguarding Executive meeting has been established to bring the RSAB and RSCP agendas together on cross cutting themes.

The One Panel is bringing together children, adults, and community safety to screen serious incidents and identify learning that is shared across the whole system.

The Transitional safeguarding priority work crosses both adults and children.
The Independent Chair of the RSAB is now a member of the Community Safety Partnership Board to ensure alignment of the agendas where safeguarding issues for example exploitation and domestic abuse cut across them all.

8. *Evidence of the impact of training carried out and future train need identified.*

The offer of multiagency training is an area for improvement due to the limit capacity to support its development. However, the single agency returns (**Appendix 1**) demonstrate that agencies have a training offer for their organisation. There have been two half day multiagency sessions on protection of Vulnerable adults on behalf

of the Redbridge Learning Collaborative. As mentioned previously the awareness raising of adult safeguarding briefings have been reinstated.

As part of the 2023-24 priorities plan the RSAB will look at how it improves the development and offer of multiagency training and its oversight of the wider offer of training across agencies.

9. *How well agencies are co-operating and collaborating?*

One of the biggest changes in the board has been the transition of the former CCG to NHS North East London (NEL) Integrated Care Board (ICB). I am pleased to say that safeguarding adults and the contribution to the RSAB has remained strong. As a chair I have been connected to the Systems Quality Group along with my counterparts across North East London to ensure that quality and safeguarding are aligned as the organisation matures.

There is strong multiagency commitment to the priority workstreams and RSAB Subgroups, including the Safeguarding Adult Review activity.

The single agency returns identify how agencies participate in the many partnership forums to keep people safe for example Multi agency Public Protection Arrangements (MAPPA) and Multi agency Risk Assessment Conferences MARAC).

The Chair has initiated a piece of scrutiny work around the Safeguarding of Asylum seekers placed in Hotels in Redbridge, this will be reported at a later date, but the partners are very actively involved in coming together to review current challenges and identify solutions and escalation routes.

4. What it has the RSAB done during the year to achieve its objectives?

The priorities agreed for the period 2022 – 2023 were as follows-

Transitional Safeguarding

- Working jointly with the Redbridge Safeguarding Children Partnership (RSCP), to develop and deliver an effective response to the transitional safeguarding of young adults at continuing risk of exploitation.

Making Safeguarding Personal (MSP)

- Responding to the findings from the Hearing Your Voice Report and increasing awareness and uptake of advocacy in adult safeguarding practice.

Quality Assurance

- Holding partner agencies to account through presentation of quality assurance activities, including audit, in relation to safeguarding adults.
- Partners working together in demonstrating readiness for and effective implementation of Liberty Protection Safeguards (LPS).
- Development of a multi-agency safeguarding adults data set aligned to the priorities of the Board.

Modern Slavery

- Increasing the awareness and understanding of modern slavery, roles and responsibilities and response.

Response to priorities:

Transitional safeguarding

- Guidance, referral forms published on RSAB and RSCP websites
- A panel is now operational
- Planned feedback on the impact
- Awareness raising of transitional safeguarding issues through the RSCP Training Programme

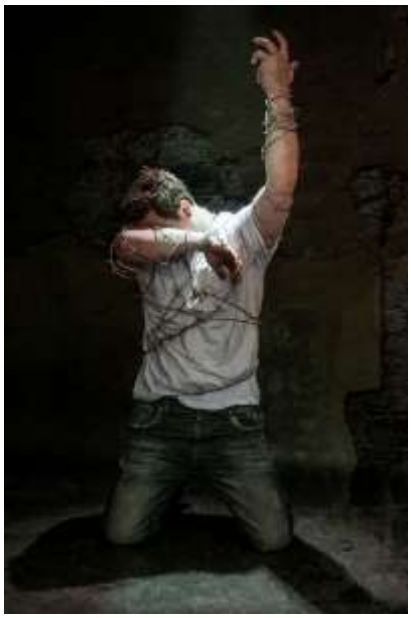
Making Safeguarding Personal (MSP)

- Review of website information for public
- New RSAB Safeguarding Adult information leaflets
- RSAB Introduction to Safeguarding Briefings delivered
- Improving communication - Glossary of terms used in Adult Safeguarding developed and published
- Review of introductory letters to service uses following referral to Adult Safeguarding

Quality Assurance

- Completion of the London Safeguarding Adults Partners Audit Tool (SAPAT)
- Oversight of the multiagency preparations for Liberty Protection Safeguards (LPS) (now delayed for the foreseeable future)

Modern Day Slavery (MDS)



- Redbridge now has additional presence on the London MDS Leads Group with a representative from the Local Authority
- Publicity materials shared with professionals and volunteers
- Briefing paper provided to the Bogus Callers Partnership and the Safeguarding Adults Network Forum
- Modern Day Slavery page on the RSAB website
- Establishment of the Modern Day Slavery Board in the Local Authority to utilise the Local Government Association (LGA) Council Guide to Modern Slavery (2022) and undertake the maturity matrix 'self-assessment'

5. Response to Findings of Safeguarding Adult Reviews (SARs)

During the year, the RSAB has commissioned two SARs, one discretionary and one mandatory as per the RSAB Safeguarding Adult Review (SAR) Protocol.

The discretionary SAR is due to be presented to the RSAB meeting in July 2023 by the Independent Reviewer, full learning will be shared in the annual report for 2023 - 2024.

The case was referred for consideration by BHRUT due to concerns that prolonged hospital admission due to the lack of suitable discharge accommodation of a patient with a learning disability and complex needs potentially contributed to their death from a hospital acquired infection. Whilst the Referral Panel felt that the case did not meet the criteria for a mandatory SAR under the Care Act 2014, the panel identified that learning from further examination of the multi-agency approach to the case could inform future management of similar cases. The SAR has taken some time to complete due to the number of agencies spanning several areas of the country.

The mandatory SAR is also due to be presented at the July RSAB 2023 and as such the learning and actions will be reported in the 2023 – 2024 RSAB annual report. The case was referred for consideration by the Redbridge Community Safety Partnership following the murder of a resident in October 2022. The circumstances around this event related to financial abuse and management of contextual safeguarding concerns. The case met the criteria for a SAR and an independent author is completing the review.

In February 2023, the first Redbridge 'One Panel' took place providing a forum to bring together reviews of serious incidents, consideration of case reviews, and learning from across the local system as well as responding to national findings, this is a big step forward for Redbridge to think of system solutions and responses to finding and prevent silo working and duplication of effort.

6. Strategic Priorities – Looking ahead to 2023 - 2024

The priorities for 2023 – 2024, are developed from the RSAB Strategic Plan 2022 – 2025 and the five areas that work needed to align to which are safe services; transitions; informing; listening and engaging; and partnership. Consideration was given to the progress of the current priorities and potential next steps, findings of the SAPAT and early learning from Safeguarding Adult Reviews (SARs).

The following area were identified for 2023 – 2024:

Priority	Description	Reason
To address the issues identified in the data provided to the RSAB that the number of safeguarding referrals is not representative of the local population.	To develop and deliver a multi-agency action plan to improve the understanding of safeguarding and how to make referrals in racialised communities by establishing trust in public bodies, addresses barriers to engagement	An outstanding area of progress for the MSP priority of 2022 – 2023 Response to data to understand the reasons why and actions required to make changes Linked to strategic priority - listening and engaging
To improve multi-agency oversight and management of high-risk safeguarding cases.	To develop a multi-agency approach for the understanding of what constitutes a high-risk, tiered approach to management. Establish a panel for multiagency oversight and management of high-risk safeguarding cases.	Findings from SARs Feedback from SAPAT Linked to Strategic priorities- safe servicers and partnership and transition
To ensure that the RSAB has assurance that local safeguarding arrangements are in place as defined in the Care Act.	Review current structure of the RSAB to: • Enhance multi-agency learning and development from themes and reviews both locally and nationally; • Provide quality assurance to the RSAB (including transition of into adulthood, voice of the service user); and • Provide data and intelligence to inform future planning.	Linked to Strategic priorities- safe servicers and partnership Preparation for CQC and demonstrating compliance with the Care Act Embedding learning from SARs

Appendix 1

Redbridge Safeguarding Adults Board Partner Contribution Statements

2022-2023

All Board members were requested to submit a completed template answering a series of questions to demonstrate how their organisations are committed to safeguarding and the contribution they have made towards the RSABs priorities over the reporting period, including key achievements and challenges.

The return rate has been 100% with variable quality of information provided. The returns do however give insight into how the work of the RSAB is further enhanced through member organisation and challenges they face.

The information provided is self-reported and capacity of the RSAB Independent Chair and Board Manager is limited to undertake additional scrutiny of the information provided.

The following section are a summary of responses and example of ways in which members are delivering their safeguarding duties and providing services that can prevent, recognise, and respond to safeguarding concerns

1. Introductory statement of commitment

All partners were asked to include internal governance arrangements, and details of new appointments related to safeguarding adults.

Summary of responses:

All returns no matter the size of the organisation could demonstrate how safeguarding is overseen in their organisations. Some organisations had made increases to establishment of teams in recognition of demand or response to service reviews

2. Key Safeguarding achievements for 2022-2023

Alongside general safeguarding adults' achievements, partners were asked to include areas of practice that aligned to the SG priorities for 2022-23. The purpose of this is to see how the RSAB priory areas of work are threaded through member organisations

Communications and Engagement

Summary of responses:

Nearly all agencies had forum networks or a method of disseminating safeguarding information; this included raising awareness of services that can support adults. Several services used national adult safeguarding week as target approach to raise awareness of safeguarding.

Some examples on how agencies responded to specific finding are below.

The Redbridge Community Health and Social Care Services (HASS) developing a specific community nursing and social worker forum to explore cases where safeguarding concerns may be present.

All Police officers have undertaken Domestic Abuse training to ensure a better understanding of victim care and behaviours.

As a new organisation replacing the former Clinical Commission Groups (CCGs), North East London Integrated Care Board (NHS NEL ICB) developed a forum to promote and assure quality so that North East London (NEL) services users have effective, safe care and a positive experience of services commissioned by them.

The Designated Nurse for NHS NEL is a member of the Safeguarding Adults National Network Transitions subgroup and was able to share the resources developed by that group with the RSAB members to support the work of the Board.

Person Centred Approach

Summary of responses:

All response state that offering person centred services are central to their practice and form part of their business as usual.

Several Board members have been key to developing the work of the RSAB.

A strong example of how assurance is taking place was given by BHRUT who have developed a Ward Accreditation Framework (WAF) which contains questions relating to "Making Safeguarding Personal"; during Q4 of 2022 there were approx. a high percentage of ward areas that had a good understanding of what this means. They have enhanced safeguarding training around person centred care. The team regularly visit the wards to provide training for those areas who score under the expected assessment need for making safeguarding personal in the WAF.

The LBR HASS teams have in place a new Quality Assurance Audit Framework. This is designed to improve person-centred focus. There is the intention to have a mechanism for tracking 'Make Safeguarding Personal', in the new case management system, Liquid Logic from May 2023.

The Police have engaged in a police-academic collaborative programme to develop a new National Operating Model for the investigation of rape and other sexual offences.

Several organisations report they have a strategy and MSP form part of their policy and procedures.

The Westminster Drug Project (to be known as VIA from June 2023) have developed Peer to Peer Naloxone scheme, which aims is to reduce the number of opiate related deaths by overdose in the community, to increase the provision of Naloxone kits in the community, to increase the provision of training for administering Naloxone to a wider range of the 'at-risk' community as well as the wider community in general. 182 additional Naloxone have been distributed since the commencement of the programme in November 2022.

Sanctuary Care have appointed a Resident to be an ambassador for all Residents, she will bring concerns or worries to the Manager, as Residents will often find it easier to talk to another Resident rather than a staff member.

Redbridge Carers Support Service has a Carers Providers Network which uses its scope to be a gauge for areas of concern to feed back to the RSAB.

Modern day slavery (MDS)

Summary of responses:

Most agencies reported that Modern Day Slavery form part of their Safeguarding Training programmes to promote recognition and response and several members have been key in the development of the RSAB task and finish group on MDS, gathering resources and sharing information from wider networks.

BHRUT have a team member whose remit is to focus on harmful practice including MDS.

The Local Authority also have also recruited a MDS lead, to support recognition in referrals and open cases.

The Local Authority have established a MDS Board in response to the work of the RSAB MDS task and finish group.

Refuge has and delivers specific services to support women and children who are impacted by modern day slavery.

Transitions

Summary of responses:

Transition activity takes place in many services as part of normal business and returns demonstrated how safeguarding is included in transition or contributes to safeguarding through transition of children to adults. Barts NHS Trust are supported by a Transition Team who work with paediatric and adult services. As part of this work Barts Health have a Youth Empowerment forum, a group of motivated young people who work collaboratively to tackle issues that are important to them and improving patient experience for all young people who engage with Barts. The diabetes team has recently appointed a Young Adult Clinical Nurse Specialist to help young people navigate their transition.

The BHRUT annual workplan for the safeguarding team for 2022/23 identified an objective of "Within the Young Person Forum for 15–18-year-olds, look at improving the experience of teenage patients at BHRUT in relation to transition to adult services." This work is ongoing, led by the Trust Women's and Child Health Division and supported by the Named Nurse for Safeguarding Children in BHRUT.

The HASS teams have regular panels to work with those young people with Special Education Needs and Disabilities (SEND).

The Adult Safeguarding Team have supported Children's services to increase their knowledge of Mental Capacity and Deprivation of Liberty in the 16- 18-year age group.

Again, several members have been instrumental in the development of the Redbridge Transitional Safeguarding panel and are active members going forward.

Prevention

Summary of responses:

All returns identified that use of training as being the keyway the prevent safeguarding harms to those they work with by early recognition of concerns and timely responses. The majority reporting that safeguarding is mandatory, with larger organisations having a method of oversight and assurance of compliance

A specific example of preventive safeguarding was the preparation for the "Homes for Ukraine" scheme lead by the Family Togethers hub ensuring Safeguarding checks with those offering accommodation were undertaken including enhanced DBS checks for all adults in household who will be receiving children or vulnerable adults. Offering a one stop shop drop-in sessions for support completing application.

A proactive response was given by the NELFT Safeguarding team on identification that concerns regarding Domestic Abuse were one of the top enquiries by staff to the safeguarding duty desk. The safeguarding team delivered several ad-hoc training sessions during 2022 - 2023 in relation to domestic abuse to raise awareness and train staff to support practice in recognising, referring, and signposting to specialist agencies when domestic abuse has been disclosed.

3. Partnership

Partners were asked about any multi-agency work to develop/improve safeguarding

Summary of responses:

All response demonstrated their active participation in partnership working.

4. What difference has it made? What is the impact? What is the evidence?

Partners were asked to evidence the impact of their work

Summary of responses:

Overall responses identified that training support recognition and response to safeguarding concerns. The following agencies gave examples of direct impact.

- Jewish Care linked CQC rating to their safeguarding offer.
- Barts -IDVA have been very active in teaching and training both formally at Level 3 training as well as offering ad hoc sessions. As a result, referrals to Victim Support increased.
- BHRUT – Dash Ric Assessments have been introduced as part of the DV training, to encourage referrals to MARAC, for high risk DV cases. Quality of MARAC referrals have been noted and positively commented on by the MARAC Panels.
- NHS NEL ICB Local Quality Surveillance Group forum identified a potential system issue relating to insulin administration by non-registered staff in nursing homes. Following collaborative working NHS NEL ICB will be in a better position to ensure that health care staff adhere to the procedures governing insulin administration in nursing homes across NEL.
- NHS NEL ICB is influencing change in matters relating to Tissue Viability following a review of Multiple Incident Pressure Ulcer (MIPU's) incidents in a provider organisation. As a result of MIPU's reported to the ICB and following discussion with the provider organisation an NHS NEL ICB Pressure Ulcer Strategic Group was established in Q4 2022 - 2023. The aim of the quality improvement project is to raise pressure care awareness across NEL and promote collaborative working across the system. This will also provide

direction and standardise practice for staff on the prevention and management of pressure ulcers in secondary care settings. The group aims to develop a project that addresses risk assessment, prevention, and treatment in children, and adults who are at risk of or have pressure area damage ulcer.

- The unique partnership arrangement between NELFT and LBR has enabled better communication and escalation of issues.
- WDP - The rough sleeper panel has also been key in providing a forum for a multi-agency approach when working with rough sleepers and those accessing hostel support and feedback from local hostels have been positive as the outreach team have been able to meet with service users at the hostels and provide substance use interventions and provide advice to hostel staff
- PELC's work with Mothers and children needs within hotels in Redbridge has triggered conversations whereby proposals have been forwarded to ensure joined up working is undertaken with health visitors, school nurses and midwives, so health concerns are addressed, and any potential mental health concerns and risks identified in a timely manner.
- Voiceability- increased numbers of safeguarding concerns reported because of training

5. Key Challenges in 2022 - 2023

Summary of responses:

The overriding challenge identified related to staff recruitment and retention and increase demand on services and in turn the impact that has on services users including:

- Dignity and respect, MSP
- Provision for support for people experiencing mental health and social concerns in the acute hospital settings
- Delayed discharges
- Provider Failure

Several agencies identified not receiving feedback following making safeguarding referrals.

Delays in completion of safeguarding investigations if the Local Authority are not the lead agency.

Asylum contingency hotels - the rapid increase in number of accommodations being used in Redbridge and the ability to respond to the needs of those seeking asylum.

Self-Neglect / Hoarding and Complexity – Increasing volume of cases identified by frontline practitioners, requiring guidance and support and awareness of RSAB Self Neglect and Hoarding Protocol and London Borough Redbridge Complex Case Management Pathway.

Poor understanding of Deprivation of Liberty Safeguards (DoLS): This has remained a fundamental issue throughout its years in legislation. This, together with the delays and uncertainty over the progress of Liberty Protection Safeguards (LPS), means that there is an increasing risk of people being deprived of their liberty without the proper authorisation.

6. Good practice case studies

All organisations were asked to provide example of where good safeguarding practice.

These included:

- Age UK demonstrating the use of advocacy for a family when they experienced challenges when not getting a response to a safeguarding concerns and what actions had been taken to protect their family member.
- Barts- preparing for transition of a child with complex needs to adulthood addressing MCA and DOLs.
- BHRUT supporting a patient affected by Domestic Abuse to achieve a safety plan.
- Homes from Ukraine Project - The innovative project was delivered in partnership with the Work Redbridge Team, Citizens Advice Redbridge, and BEAM (social enterprise), who supported 47 new Ukrainian refugees to prepare for work in the UK, including access to training, benefits, and housing advice. The team won an award at the Recognising Redbridge ceremony for their joint approach, which has successfully supported Ukrainian guests to settle and build their lives in Redbridge.
- The Borough's HASS teams gave examples of managing hoarding cases.
- The Designated professionals at the ICB supporting primary care to support an adult victim of domestic abuse and exploitation.
- WDP were able to coordinate a safety plan, which included a referral to MARAC, to provide a safe space for a victim of domestic abuse to explore her options and help her report it to the police. Which lead to her feeling safer in her home.
- PELC – advocacy, challenge and support with a family seeking asylum.
- Voicability -use of advocate in preventing homelessness.
- Sanctuary Care- recognising financial abuse and taking immediate action to safeguard a resident.

7. Priorities in relation to safeguarding adults for your organisation in 2023 - 2024

Each agency identified they had specific areas they wished to focus on in the coming year, this list is not inclusive of all the activity taking place but demonstrates either repeated themes or examples of the breath of activity that contributes to safeguarding adults in Redbridge.

- Ensuring review and delivery of robust training programmes and competency framework, including learning from reviews.
- Improving awareness and response to specific themes including Domestic Abuse - Working couples living in abusive relationships, perpetrator programmes, self-neglect, adult exploitation, Mental Capacity and Deprivations of Liberty.
- WDP development of the female only detox facility in the UK.
- WDP The development of sex-workers support group to supporting individuals with addiction issues who are at risk of exploitation due to involvement in sex work.
- Redbridge Carers Support Service Investing in more intensive support services for carers to help them build resilience and reduce the risk of crisis breakdown. Investing in Mental Health support for carers including coaching and counselling – again as a preventative measure.
- Local authority implementing the findings of a service review for adult safeguarding.
- BHRUT provision for support for people experiencing Mental Health and Social concerns in the Acute hospital settings. Importance of robust discharge planning meetings.