Redbridge Safeguarding Adults

REDBRIDGE SAFEGUARDING ADULTS BOARD

Annual Report 2019 – 2020

Contents

Foreword

I am pleased to introduce the Annual Report of the Safeguarding Adults Board for 2018/19. This is the third Annual Report I have been responsible for producing since I took on the role of Independent Chair of the Board in June 2017.

Overall, I think it is fair to say that the report presents a mixed picture of adult safeguarding in Redbridge in 2019/20, and indeed of the robustness of the Safeguarding Adults Board itself. It is important to note at the outset that this report covers the twelve-month period to 31 March 2020. It barely touches therefore on the impact of the coronavirus pandemic as that accelerated during March, and what we describe later in the report as the extraordinary efforts and the extraordinary achievements of all agencies and staff, managers, and volunteers at all levels in maintaining essential and effective services for vulnerable people in Redbridge. Continuing to ensure the effective safeguarding of adults at risk of abuse or neglect during a pandemic has been and continues to be a key challenge and preoccupation for all agencies.

There is no doubt that practitioners and safeguarding specialists in all agencies are strongly committed to effective safeguarding. This is confirmed, for example, in some of the external inspection evidence cited in Section 3 of this report. Within the local authority, the priority which is rightly given to responding as effectively as possible to adult safeguarding concerns is experienced as placing significant pressure on the integrated health and adult social care service. In 2019/20, over 900 safeguarding concerns were raised with the local authority. The report notes, however, that in 2018/19 (the latest year for which comparative data is available), the number of adult safeguarding concerns raised in Redbridge was in fact the second lowest of any London borough. In that year, each of the 32 London boroughs received on average almost 1500 safeguarding concerns.

It may be that one explanation for the apparent discrepancy between a relatively low rate of concerns raised and the pressure experienced by practitioners has been the very high percentage of safeguarding concerns in Redbridge that have been judged to require a formal safeguarding enquiry under Section 42(2) of the Care Act 2014, compared to other authorities and national data. It is encouraging to report, therefore, that in 2019/20 the conversion rate in Redbridge, which has for the past few years been at 70% or over, fell in 2019/20 to 59%. In London as a whole in 2018/19 (the most recent data available) the conversion rate was 43%, and in England 39%. Practice in Redbridge may now be beginning to converge with practice elsewhere.

There are though important areas in which less progress has been made. It is disappointing that some of the concerns reported by voluntary sector partners in previous years continue to feature in their contributions to this year's report – the lack of feedback from the local authority when they raise a safeguarding concern, and the need for a clearer format in which to raise such concerns, to ensure that all necessary information is included. One of the major concerns articulated in last year's Annual Report emerged from a review of the

deaths in one year of ten people sleeping rough on the streets of Redbridge – and the number has increased since. The Board, and subsequently the Health and Wellbeing Board, called for the Rough Sleeping Strategic Board, led by the Housing Department, to lead the development of an integrated multi-agency strategy to address the health and wellbeing needs of rough sleepers, engaging with the voluntary sector, NHS partners, social care, and the police. Although there have been some developments in service provision, the development of a co-ordinated strategy has not moved forward, and the Rough Sleeping Strategic Board did not continue to meet. On the ground, however, the coronavirus pandemic rapidly generated an acceleration of multi-agency work to respond to the needs of rough sleepers. This report highlights the enormous achievements of Housing and other colleagues in the speed and flexibility with which they responded to the outbreak of the pandemic in March, bringing large numbers of rough sleepers off the streets in a matter of days.

The local authority's performance in dealing with Deprivation of Liberty Safeguards (DoLS) applications appeared to improve significantly in 2019/20. 73% of the applications received during the year were completed by 31 March, compared to 55% in 2018/19. However, this was largely due to a large increase in the number of cases in which the subject sadly died after the application had been made, heavily concentrated towards the end of the year. Closer scrutiny of the data shows that there continues to be a lack of capacity to meet demand and statutory obligations.

When I presented last year's Annual Report in a number of forums, I said that my ambition for 2019/20 was to raise the status, profile and impact of the Safeguarding Adults Board to match that of the Local Safeguarding Children's Board, now reshaped as the Redbridge Safeguarding Children Partnership. In some important respects the Board has been significantly strengthened this year, with increased senior representation. I am delighted that Adrian Loades, Corporate Director of People, and Mark Santos, Cabinet Member for Health, Social Care, Mental Health and the Ageing, have now joined the Board. I am also delighted that Detective Superintendent John Carroll, appointed in March 2020 to head up the Safeguarding strand in the MPS East Area Basic Command Unit (BCU) after a year in which there had been four different people in that role, has made a strong personal commitment to the Board. There is still however a long way to go. In particular, the Safeguarding Adults Board continues to be hamstrung by the lack of a dedicated budget funded on a multi-agency basis. Although the Clinical Commissioning Group have agreed in principle to contribute financially to the work of the Board, as they do in Barking and Dagenham and in Havering, the contribution has not been agreed or received at the time of writing. The Board is not able to fulfil the full range of expectations placed on a SAB under paragraph 14.139 of the statutory guidance on care and support under the Care Act 2014: in particular, it has not been able to identify resources for the development of a multi-agency audit programme or a broader quality assurance strategy, or to promote and deliver multi-agency training. Although increased voluntary sector participation on the Board has helped to strengthen the articulation of community perspectives in the Board's work, the Board has no direct access to hearing the voice of service users and their experience of the safeguarding system. The Board's attempts in 2019/20 to develop effective ways of

hearing, understanding and acting on the voice of individuals who experience safeguarding interventions foundered on the lack of resources to take this work forward, either in kind, within the capacity of partner agencies, or in cash – any available budget to fund a piece of work.

It remains the case that we know much less about the quality and impact of adult safeguarding work, particularly in the local authority as lead agency, than we do about children's safeguarding. There is no external inspection of adult social care services. There is limited data. Although the initiatives taken in the past year by the central Safeguarding Team to introduce reflective practice sessions and strengthen the support to locality teams have been welcomed, there is no systematic programme of quality assurance in place. In my review of the effectiveness of adult safeguarding arrangements in 2018, I recommended that urgent attention should be given to establishing the peer auditing of social work practice within the integrated service, and that safeguarding practice should be an early focus of such a programme. It has not yet been possible to develop such a programme. However, the Safeguarding and Adult Protection Team report that they are planning to begin a programme of case audits in early 2021.

John Goldup

Independent Chair, Redbridge Safeguarding Adults Board

1. What is the Redbridge Safeguarding Adults Board?

The Safeguarding Adults Board (SAB) is a multi-agency partnership board, hosted by the Council. It has existed in different guises for many years – this is its seventeenth Annual Report. However, Safeguarding Adults Boards were not placed on a statutory footing until the implementation of the Care Act 2014. Under Section 43 of that Act, a local authority must establish a Safeguarding Adults Board for its area. The objective of a SAB is defined in the Act as to help and protect vulnerable adults in its area whose circumstances fall within the criteria set out in the legislation. These are that the individual:

- has needs for care and support, whether or not the local authority is providing or commissioning services or resources to meet those needs
- is experiencing, or is at risk of, abuse or neglect, and
- as a result of those needs, is unable to protect himself or herself against the abuse or neglect or the risk of it.

The SAB is expected to fulfil its purpose by acting to co-ordinate and ensure the effectiveness of what each member agency does in working to safeguard vulnerable adults.

While the legislation itself does not go beyond this in specifying the duties of a SAB, the statutory guidance on the Care Act 2014 makes it clear that the SAB is expected to take a strategic role in overseeing and leading adult safeguarding across the locality and in all settings. It is clear also that the SAB has a key role in effective challenge and scrutiny.

> "It is important that SAB partners are able to challenge each other and other organisations where it believes that their actions or inactions are increasing the risk of abuse or neglect. This will include commissioners, as well as providers of services."

While a SAB may do anything which appears to it to be necessary or desirable in fulfil its objective, there are three specific things that it must do. It must publish an annual plan, setting out how it will meet its main objective and what member agencies will do to achieve this; it must publish an Annual Report; and it must carry out Safeguarding Adults Reviews (SARs) when required under Section 44 of the Act.

The only members of the SAB prescribed in legislation are the local authority, the Clinical Commissioning Group (CCG), and the police. Guidance, however, encourages a wider membership. The Board membership as at 31 March 2020 is detailed in the table below.

Board Members

John Carroll	Detective Superintendent Safeguarding – East Area BCU, MPS
Adrian Loades	Corporate Director of People, LBR
John Richards	Crime Partnerships Service Manager, LB Redbridge
Stephen Hynes	Named Nurse for Adult Safeguarding (Interim), BHRUT
Jenny Ellis	Chief Officer, Redbridge CVS
Glynis Donovan	Executive Director, Redbridge Carers Support Service (RCSS)
Bob Edwards	Integrated Care Director, NELFT
Compton Gustave	Housing Area Manager (Interim), LBR
Sue Elliott	Director of Quality, Governance and Nursing (Interim), PELC
Andrew Hardwick	Commissioning Manager – Public Health, LBR
Gita Hargun	Service Manager, Families Together Hub, LBR
Leila Hussain	Head of Service/Principal Social Worker (PSW), LBR
Jamie Jenkins	Borough Commander, London Fire Brigade
Mark Gilbey-Cross	Deputy Nurse Director, NHS BHR CCGs
Eve McGrath	Designated Nurse for Adult Safeguarding, NHS BHR CCGs
Annmarie Ahtuam	Service Manager, Voiceability
Anthony Pardoe-Matthews	Head of Contracts & Procurement, LBR
Denise Brown	Manager, Sanctuary Care
Samira Natafgi-Roberts	Head of Safeguarding Adults & Protection Service, LBR
Clare Hughes	Lead Named Nurse, Safeguarding, Bart's NHS Health Trust
Margaret Summers	Chief Officer, One Place East
Cathy Turland	Chief Executive Officer, Healthwatch Redbridge
Andreea Albu	Chief Executive Officer, Age UK BHR
Lesley Wines	Social Work Manager, Jewish Care
Cllr Mark Santos	Cabinet Member for Health, Social Care, Mental Health and the Ageing, LBR
Stuart Dunn	Inspection Manager, London Region, CQC (Observer)

The SAB has been independently chaired since June 2017 by John Goldup, who also chairs the Redbridge Safeguarding Children's Partnership (RSCP). He has a background in both adults' and children's social care, having been Director of Adult Social Services in Tower Hamlets from 2000 to 2009, and National Director of Social Care Inspection, and Deputy Chief Inspector, in Ofsted from 2009 to 2013.

As noted in last year's Annual Report, the Redbridge SAB is significantly under-resourced compared to both local and London-wide benchmarks. This limits the range of work that can be undertaken by the Board. There is no dedicated capacity for either quality assurance or multi-agency training. Unlike other SABs in London, the Redbridge Board is wholly funded by the local authority, with the exception of £5000 a year from the Metropolitan Police, with no contributions from other partner agencies. Following discussion at the Health and Wellbeing Board in December 2019, the CCG agreed in principle to contribute to funding SAB activity, as they do in Barking and Dagenham and in Havering, with effect from the financial year 2020/21. However, no specific amount has yet been agreed or received. Information collated by London Safeguarding Adults Boards Chairs in 2017/18 suggested that at that time the average contribution made by CCGs in London to local SABs was £23,500.

The legislation sets out two main requirements for the SAB Annual Report. It must set out the actions which the Board and individual members have taken to deliver on the objectives and actions set out in its annual plan, and the outcomes achieved; and it must provide information about any Safeguarding Adults Reviews (SARs) completed during the year, the findings and lessons learned, and what has been done to act on them. Progress against the 2018/19 Action Plan is outlined in Section 7 of this report.

There were no SARs completed by the Board in 2019/20. However, a review of one case commissioned during the year is currently nearing completion. A review of a second case is in the process of being commissioned. When completed, reports will be published on the **Board's website** and in the **SCIE SAR Library**.

This report covers the period April 2019 to March 2020. The Board is scheduled to meet four times a year. However, the last meeting scheduled for 2019/20 was cancelled in the face of the need to concentrate all efforts on responding to the dramatically changed circumstances that unfolded in the last two weeks of March. All services suddenly faced the huge challenges of responding to lockdown and the COVID pandemic, needing to organise themselves and deliver services in what felt like entirely new ways almost overnight. Because of the time frame covered, this report gives little coverage to those extraordinary efforts and the extraordinary achievements in maintaining effective services of all involved. There is no doubt that the SAB Annual Report for 2020/21 will be heavily focused on those efforts, those achievements, the challenges, and the lessons learned. Continuing to ensure the effective safeguarding of adults at risk of abuse or neglect during a pandemic has been and continues to be a key challenge and preoccupation for all agencies.

2. Safeguarding activity and outcomes 2019/20

Local authority safeguarding activity data is collated in an annual return, the Safeguarding Adults Collection, to NHS Digital. In 2019/20, 906 safeguarding concerns were reported as raised with the local authority. This compares with 881 in 2018/19, and 998 in 2017/18. However, it is difficult to ascertain any underlying trend, as the 2018/19 data was incomplete. The 2019/20 data is fuller, although a number of notifications of activity were received after the deadline for submission to NHS Digital. The compilation and collation of this data is a wholly manual and extremely labour-intensive process, and there is a recognised need to develop a system for the digital collection of data. Within the integrated health and social care service, priority is given to responding as effectively as possible to safeguarding concerns, and the volume of adult safeguarding work is experienced as a significant pressure on the service. It might be noted, however, that in 2018/19 (the latest year for which comparative data is available), the number of adult safeguarding concerns raised in Redbridge was the second lowest of any London borough. In that year, each of the 32 London boroughs received on average 1477 safeguarding concerns.

Previous Annual Reports have highlighted the very high percentage of safeguarding concerns in Redbridge that have been judged to require a formal safeguarding enquiry under Section 42(2) of the Care Act 2014, compared to other authorities and national data. They have identified a potential 'over-definition' of what is and is not a safeguarding issue as defined in the Care Act as a significant explanation for the high conversion rate of concerns to enquiries in Redbridge, and the workload pressures that follow from that. It is encouraging to report, therefore, that in 2019/20 the conversion rate in Redbridge in 2019/20 fell to 59%. This compares to 70% in 2018/19. In London as a whole in 2018/19 (the most recent data available) the conversion rate was 43%, and in England 39%. It appears therefore that practice in Redbridge is beginning to converge with practice elsewhere, although caution should be exercised in drawing conclusions from a single year's data.

This is no doubt the result of continuing attention from managers at all levels, supported by the central Safeguarding Team, supporting a shift in culture and practice. It has also been supported by a very helpful framework for decision making on whether or not to carry out a safeguarding enquiry under Section 42(2), published in 2019 by the Association of Directors of Adult Social Services (ADASS). The framework is clear that the duty to undertake a safeguarding enquiry is only triggered if the criteria in Section 42(1) are met: that the local authority has reasonable cause to suspect that the adult concerned has care and support needs (whether or not those needs are eligible to be met or are being met by the local authority; that s/he is experiencing, or is at risk of, abuse or neglect; and that s/he is unable to protect himself or herself against abuse or neglect or the risk of it as a result of those care and support needs. Further information gathering may be necessary before a decision can be made as to whether this threshold is met and whether a safeguarding enquiry should be undertaken. The unusually high historic conversion rate in Redbridge suggests that the threshold may not always have been appropriately applied. Understanding of the ADASS framework is being disseminated throughout the Integrated Health and Adult

Social Care Service (HASS), and, through extensive discussion at the Safeguarding Adults Board, through the wider partnership. It will be interesting to see, when comparative data for 2019/20 is published, whether a better understanding of the decision-making framework in other authorities has contributed to an increase in the average conversion rate, just as in Redbridge it has supported a reduction.

The statutory "safeguarding process" is triggered by the raising of an initial safeguarding concern, which may come from any statutory or voluntary agency, or directly from the public. Discussions at the Safeguarding Adults Board and elsewhere have highlighted a need for greater clarity for potential referrers on what constitutes an appropriate "safeguarding concern", in order to avoid unnecessary and inappropriate referrals while continuing to prioritise the protection of vulnerable people. Hospital colleagues, for example, have recognised that some safeguarding referrals would, in the absence of harm, be more appropriately raised through the internal discharge alert route. The Board was pleased to learn at its meeting in January 2020, when the Council's Head of Safeguarding led a discussion on the ADASS framework for decision making on Section 42 enquiries, that ADASS now plan to develop a complementary framework for determining when it is appropriate to raise a safeguarding concern. It is likely, however, that this work has been delayed by the impact of the COVID-19 pandemic.

Although the majority of safeguarding enquiries continue to concern older people, there is a continuing trend for an increased focus on the safeguarding of younger adults: 40% of all enquiries started in 2019/20 concerned people aged 18 to 64, compared to the same figure in 2018/19 and 32% in 2017/18. This may reflect an increased awareness over the last two years of safeguarding issues for individuals with a learning disability or suffering from mental ill health. 18% of safeguarding enquiries undertaken in 2019/20 related to individuals whose primary support need was recorded as 'learning disability support', compared to 12% in 2017/18. 18% concerned individuals whose primary support need related to mental health, compared to 13% in 2017/18.

In 2019/20 60% of individuals who were subject to safeguarding enquiries were white, compared to 64% in 2018/19 and 69% in 2017/18. For the borough's population as a whole, the latest estimate is that over 65% of residents are from black and minority ethnic backgrounds. However, caution should be exercised in comparing the ethnicity of people subject to safeguarding enquiries with the overall population as the ethnicity profile changes significantly with age.

Of the enquiries concluded in 2019/20, 52% related to abuse or neglect in the service user's home, compared to 66% in 2018/9 and 48% in 2017/18. However, as previously commented, it is notable that very few concerns were raised by domiciliary care services: more work is needed with domiciliary care providers to ensure that their staff are vigilant for signs of potential abuse or neglect and confident about reporting them. In 30% of enquiries in 2019/20, the location of risk was a care or nursing home, compared to 22% in 2018/19 and 30% in 2017/18. Across all settings, service providers were identified as the source of risk in 41% of reported concluded enquiries in 2019/20, compared to 38% in 2017/18 and 50% in each of the previous two years before that.

There has been a significant increase in concerns raised about self-neglect over the past few years, although it may now be levelling off. Following the implementation of the Care Act 2014 under which self-neglect was first identified as a category of safeguarding concern, self-neglect accounted for 9% of the causes for concern raised in 2015/16. This increased to 11% in 2016/17, when the Board's **Self Neglect and Hoarding Protocol** was developed and implemented, 14% in 2017/18, and 15% in 2018/19. In 2019/20 self-neglect constituted 16% of the total causes for concern raised.

In 73% of safeguarding enquiries, risks were identified and action taken. This is a slightly higher percentage than that either for England as a whole (69%) or for London (66%) – 2018/19 data. Of the cases in which risk was identified, it was removed or reduced at the conclusion of the enquiry in 86% of cases – a significant improvement on the 2018/19 figure of 71%. The equivalent figure for both England as a whole and London as a whole is 89%.

One of the key principles of adult safeguarding work under the Care Act is personalisation – Making Safeguarding Personal. Among the key measures of this defined by central government are whether at the outset of a safeguarding enquiry the individual or their representative is asked what their desired outcomes are, and whether those outcomes are achieved or not. 77% of the adults at risk involved in safeguarding enquiries in Redbridge were asked what their desired outcomes were, and desired outcomes were expressed in 66% of cases. These are very similar to the national figures, and again an improvement on 2018/19, when only 67% of subjects were asked about their desired outcomes, and 56% were able to express their desired outcomes. For those who expressed desired outcomes in Redbridge 94% of those outcomes were fully or partially achieved.

In 2019/20, across all BHRUT sites, there were 558 safeguarding adults concerns raised by staff, compared to 491 in 2018/19 and 660 in 2017/18. 454, or 81%, related to referrals raised by Trust staff concerning risks arising in the community. Of these 454, 100 related to Redbridge residents. By type of concern, self-neglect was the largest category of concern – 23% of all referrals. There was a continuing decrease in the number of safeguarding concerns raised relating to community acquired pressure ulcers – 33 in 2019/20, compared to 38 in 2018/19 and 55 in 2017/18. This appears to reflect an increased understanding amongst front line staff that not all pressure damage is due to neglect or acts of omission. 104 referrals were raised by external agencies as Section 42 enquiries relating to concerns within the Trust. Eight of these on investigation were found to be fully substantiated. As in previous years, they primarily related to poor discharge practice. In its Safeguarding Adults Annual Report, the Trust note that there is a very wide variation in the thresholds being applied by different local authorities to define what is and is not an adult safeguarding concern and as a generalisation the threshold is too low. However, the generalisation may not apply to Redbridge, as Redbridge raised only 7 of the 104 Section 42 enquiries into concerns arising within the Trust.

There were 553 adult safeguarding concerns raised by NELFT in 2019, across all services and geographical areas of operation, compared to 504 in 2018. Continuing a year on year on trend, there was an increase in enquiries to the internal adults safeguarding advice service, from 2994 to 3277. Patient on patient abuse, domestic violence, and pressure ulcers

were the three main causes of concern. A pressure ulcer decision support tool is being piloted, to support implementation of the **Department of Health and Social Care protocol** on the interface between pressure ulcer care and the interface with adult safeguarding enquiries. This protocol is clear that only in a minority of cases will concerns about skin damage arising from pressure warrant raising a safeguarding concern with the local authority. Generally, however, as in previous years, the fact that there were almost six times as many requests for advice received by the internal safeguarding advice as there were safeguarding alerts raised suggest that sound judgement is being exercised in determining what does and does not constitute a safeguarding concern to be raised with the responsible local authority under the Care Act.

Across the whole of Barts Health, of which Whipps Cross is part, adult safeguarding referrals increased by 24% in 2019/20, compared to the previous year. The majority of the concerns raised related to pressure ulcers and neglect acquired or experienced in the community. As with BHRUT, concerns relating to care within the Trust primarily related to poor discharge practice.

If a person who lacks the mental capacity to consent or otherwise to the arrangements is deprived of their liberty in a hospital or care home (i.e. they are subject to continuous control and supervision, and are not free to leave) other than under the Mental Health Act, the Deprivation of Liberty Safeguards require that this must be authorised by the local authority. In some circumstances the safeguards can also apply to care provided in a person's own home, or in a supported living situation. For these cases the final authority rests with the Court of Protection.

Having increased by 55% between 2015/16 and 2017/18 (from 541 applications to 842), there was a slight decrease in the number of Deprivation of Liberty Safeguards (DoLS) applications made to LB Redbridge in 2018/19, to 832. The number of applications received fell slightly again in 2019/20, to 815. The timeliness with which applications were dealt appeared to improve considerably in 2019/20. 73% of the applications received during the year were completed by 31 March, compared to 55% in 2018/19. However, this was largely due to a large increase in the number of cases in which the subject sadly died after the application had been made, heavily concentrated towards the end of the year. In such cases the time required to complete the DoLS process is very significantly reduced. Of those cases which did require full assessment, scrutiny and authorisation, only 58 applications were granted during the year. At 31 March, 102 were awaiting authorisation, 29 were awaiting scrutiny, 58 were awaiting allocation, and 35 had been allocated for assessment but assessments had not yet taken place. There continues to be a lack of capacity to meet demand and statutory obligations.

The number of DoLS applications made by BHRUT, across all sites, has risen exponentially over the past three years. It increased by 37% in 2019/20 - from 1338 to 1832 – having increased by 33% the previous year and by 43% the year before that. This figure includes applications to all boroughs from which patients are admitted, and is not specific to Redbridge. Conversely, the number of DoLS applications made by NELFT shows a downward trend. There were 66 DoLS applications from NELFT across the whole of their geographical area of operation, compared to 83 in 2018/19, 73 in 2017/18 and 136 in 2016/17. Across Barts Health NHS Trust as a whole, the number of DoLS applications fell by 13%.

3. Safeguarding in Redbridge 2019/20: Developments and Challenges

All partner agencies represented on the SAB continue to demonstrate a strong commitment to the safeguarding of vulnerable adults, across both statutory and voluntary sectors.

The London Fire Brigade (LFB) completed and published a full review of their 2011 policy and procedure on safeguarding adults at risk, which seeks to provide clear and concise guidance on the importance of raising referrals and on the referral pathway, and to raise awareness of vulnerability factors. Locally, given the strong association between self-neglect and fire deaths, the LFB Borough Commander has vigorously promoted the availability both of free fire safety visits to vulnerable people and of training available to other professionals. However, Redbridge only accounted for 1.6% of the safeguarding adult referrals made by the LFB to London local authorities in 2019/20 – 22 referrals out of a total of 1376. This data is however somewhat distorted by the fact that LFB and local authority borough boundaries are not wholly coterminous. The LFB completed 2568 fire safety visits in Redbridge in 2019/20, compared to 2656 in 2018/19.

The East Area BCU within the Metropolitan Police Service (MPS), covering Redbridge, Barking and Dagenham and Havering, have worked to strengthen their safeguarding work. Following a 12-month period in which there were four different Detective Superintendents leading the BCU Safeguarding Strand, a permanent appointment at the end of 2019/20 was warmly welcomed. Dedicated specialist investigative teams focusing on domestic abuse, child abuse, and sexual offences have been established, to ensure that victims are supported by officers with appropriate skills and experience. The BCU gives high priority to supporting the victims of domestic abuse. In the last quarter of 2019/20, East Area BCU had the highest rate of increase in domestic violence offences in London. However, arrest rates and "successful outcomes" (perpetrators charged or summonsed) both also rose significantly. 44% of the domestic violence protection orders issued in London in 2019/20 were issued by the East Area BCU. The BCU report that the courts have agreed to convert the vast majority of these notices, which provide emergency protection, into full domestic violence protection orders. The BCU have also prioritised an effective response to individuals suffering from mental health ill health, reporting that across the BCU they are making approximately 200 adult safeguarding referrals a month related to mental health to the relevant local authorities.

Nationally, the police engagement with adult safeguarding has been under the spotlight, following the publication in July 2019 by the Justice inspectorates of "The Poor Relation: the police and CPS response to crimes against older people". The report included an assessment of the effectiveness and consistency of police engagement with adult safeguarding arrangements, and described "a bleak picture of the state, resourcing and effectiveness of these arrangements". One of the priorities agreed by the Safeguarding Adults Board for 2020/21 is to seek assurance on the effectiveness of arrangements and practice in the East Area BCU.

In last year's **Annual Report**, we described the People Matter approach within adult social care as perhaps the most significant development which will ultimately affect safeguarding practice. It is worth reproducing the summary from last year's report of the close alignment between the principles of People Matter and the six principles of Making Safeguarding Personal embedded in the statutory guidance to the Care Act 2014:

Safeguarding Principles	People Matter Principles
1. Empowerment	
People being supported and encouraged to make their own decisions and informed consent. *"I am asked what I want as the outcomes from the safeguarding process and these directly inform what happens."*	**Listen and Connect.** **We are not the experts – people and families are.** *How can I connect you to the things that will help you to get on with your life, based on your assets, strengths and that of your family and community? What do you want to do? What can I connect you to?*
2. Protection	
Support and representation for those in greatest need. *"I get help and support to report abuse and neglect. I get help so that I am able to take part in the safeguarding process to the extent to which I want."*	**Work intensively with people in crisis.** *When people are at risk (an emergency), what needs to change make you safe and regain control? How can I help to make this happen?*
3. Proportionality	
The least intrusive response appropriate to the risk presented. *"I am sure that the professionals will work in my interest, as I see them and they will only get involved as much as needed."*	**You have a conversation rather than focussing on completing an assessment and meeting criteria.** *The conversation is about finding out what is important for that individual, what they would like to achieve and how can they help themselves. It's about what do they want to tell us, what they want us to know, rather than what do we want to ask them.*
4. Prevention	
Prevention – It is better to take action before harm occurs. *"I receive clear and simple information about what abuse is, how to recognise the signs and what I can do to seek help."*	**You should be open and honest with people and maintain a careful balance between the wishes and needs of the person, any associated risks and what resources are available.** *"We work with people as equal partners and combine our respective knowledge and experience to support joint decision making."*

5. Accountability	
Accountability and transparency in delivering safeguarding. *"I understand the role of everyone involved in my life and so do they."*	**Conversational assessment is founded on trust, honesty and openness.** *"In conversational assessment the relationship between people who access care and support and workers is critical. It should be one of equals, where both people recognise and are respectful of each other's contribution, and understand the constraints and concerns of the other."*

6. Partnership	
Local solutions through services working with their communities. **Communities have a part to play in preventing, detecting and reporting neglect and abuse.** *"I know that staff treat any personal and sensitive information in confidence, only sharing what is helpful and necessary. I am confident that professionals will work together and with me to get the best result for me."*	**People are experts in their own lives, and have resources, skills, experience and expertise to contribute themselves.** *"We look for ways to involve people in their communities where they feel included and valued for their contribution."*

Following pilots, systems change, and roll out across the service, People Matter was formally launched as the Redbridge Adult Social Care service approach in September 2019. Following a practitioner workshop in November, a detailed action plan to ensure consistent delivery of the approach across the service was developed. Delivery of the action plan remains a work in progress, impacted upon by a number of staffing issues and more recently by the COVID-19 pandemic. The service acknowledges the need for further work to refine the interface between People Matter and safeguarding practice. An important aspect of the action plan is the need to improve shared learning, in part through the development of a new supervision policy. The Chair's review of the effectiveness of adult safeguarding arrangements within the local authority in 2018 noted that "There is a need within adult social care for clearer expectations and guidance on supervision, and about the management oversight that should be evidenced on individual care records." A revised supervision policy is currently in draft.

The Chair's review also identified an urgent need to strengthen and develop the working relationship between the central Safeguarding Team, locality and other operational teams, and the Contracts and Procurement Team; and the **2018/19 Annual Report** reported much work that had been undertaken to achieve this. This has continued through 2019/20. The Safeguarding and Adult Protection Team led two very successful and well attended Reflective Practice sessions during the year for health and social care practitioners, designed to create an opportunity to reflect on practice in a safe space. The team also delivered practitioner workshops on the ADASS framework for decision making on when to undertake a safeguarding enquiry, and on mental capacity assessments. Existing forums, such as the Safeguarding Policy and Practice Group and the Best Interests Assessors Forum, also continued to meet regularly.

Voluntary sector organisations continue to play a crucial role in adult safeguarding. The Bogus Caller Partnership, chaired by the Borough Commander for the London Fire Brigade, has continued its work throughout 2019/20. It brings together statutory and voluntary sector organisations to work to prevent bogus caller crime, support vulnerable residents and victims, and prosecute the offenders. One victim supported in 2019/20, for example, was defrauded of £10000 by a bogus caller before intervention was able to prevent the loss of a further £26000. An important preventive development has been the full roll out across the borough of the Social Prescribing Service, run by Redbridge Council for Voluntary Services (CVS). The service is funded by the Department for Health and Social Care, the CCG, and Redbridge Council. It is open to referrals from GPs for adults experiencing social isolation or low-level mental health problems, or with Type 2 diabetes. During the past year the service has been extended to also offer support to carers. It offers intensive 1:1 support over a three-month period, and support with referral to and engagement with over 170 different community-based services. In the twelve months from July 2019, the service received 260 referrals. 85% of the people referred were experiencing social isolation, and 22% mental health difficulties. The largest age group represented (22% of referrals) was people aged between 75 and 84. The service is subject to external evaluation by the University of East London and Ecorys, and an interim evaluation has identified a range of positive impacts on health and wellbeing for those engaged with the service.

If anything, close partnership working between the voluntary and statutory sectors has become even more important than ever in the past year, first because the ability to link people effectively with 'community assets' is central to the successful delivery of the People Matter approach, and more recently because it has been so central to the unprecedented effort to support health and wellbeing during the COVID-19 pandemic. Challenges, however, do remain within this partnership. Voluntary organisations continue to report that they often do not feel they get adequate feedback from the local authority when they make a safeguarding referral, which is particularly difficult when they are continuing to work with the person who has been the subject of the referral. They have also commented that they find the referral pathways confusing, and have suggested that Redbridge consider the development of a Safeguarding Referral Form, similar to that used in neighbouring authorities with whom they often also work. A standardised Multi-Agency Referral Form has been in use in Children's Services for many years, but the route for raising safeguarding adults concerns is by email to an 'adults alert' inbox but without standardised content or guidance for referrers on the information and specification of grounds for concern that should be included. The local authority have agreed to develop such a form, adapted from a form which is currently in use internally, but this work remains to be completed. There is also cause for concern about whether appropriate referrals are always made to voluntary sector organisations supporting service users. Voiceability, who are commissioned by the local authority to provide advocacy services for adults who are the subject of safeguarding enquiries, received only 29 referrals for this service in 2019/20. The Care Act 2014 requires that an advocate be appointed whenever the adult has 'substantial difficulty' in being involved in decision making, and there is no 'appropriate individual' to support them. Given

that 535 safeguarding enquiries were commenced in 2019/20, it is unlikely that these statutory criteria were met in only 29 or 5.4% of cases.

Voiceability was re-awarded the Advocacy Quality Performance Mark by the National Development Team for Inclusion in April 2020 for three years. The assessment noted that the organisation's safeguarding policies and procedures were 'exemplary'.

4. Safeguarding training 2019/20

The statutory guidance to the Care Act 2014 identifies the promotion of multi-agency training, and consideration of any specialist training which may be required, as core functions of a Safeguarding Adults Board. However, the Redbridge SAB does not have the capacity to undertake this activity. There is no programme of multi-agency safeguarding training in Redbridge, other than the safeguarding training offered by the Learning and Development Team within the Council's People Directorate, which is open to all health and social care staff within the integrated health and adult social care service (HASS). The representative of the Learning and Development Team had to withdraw from attendance at the Safeguarding Adults Board during 2019/20, due to reduced capacity within the team. The lack of capacity to address training and broader workforce development issues at a partnership level is a serious weakness in the Board's functioning.

However, a range of safeguarding training was delivered within the HASS in 2019/20:

- Safeguarding Adults Awareness
- Undertaking Safeguarding Adults Enquiries
- Self-Neglect
- Modern Slavery
- Mental Capacity Act and Deprivation of Liberty Safeguards
- Improving Mental Capacity Act Assessments

However, take up was low. Only 47% of available places (120 out of 258) were taken up. The only course that had more than 50% of places taken up was the one on Undertaking Safeguarding Adults Enquiries, for which all twelve places were taken. We reported in the Annual Report for 2018/19, a year in which the uptake of training was generally good, on the low uptake of Safeguarding Adults Manager training – training for senior practitioners and managers who oversee and make decisions on safeguarding enquiries. This was surprising, as locality teams and others have expressed concern about a shortage of trained Safeguarding Adults Managers. This remained an issue in 2019/20: a Safeguarding Adults Manager training course was scheduled for February 2020, but had to be cancelled due to low take up.

Given the size of the workforce within the HASS, the volume of safeguarding training that can be offered within current capacity seems low. Although the comparison can only be indicative, given a whole range of differences between adults' and children's services, it might be noted that there were 705 attendances at training courses delivered by the Redbridge Safeguarding Children Partnership in 2019/20, at 58 separate events.

To support the SAB in its responsibility for the quality assurance of safeguarding training, a number of partners responded to a request for offers to carry out Quality Assurance observations of training commissioned by the local authority. Observations took place of a number of the courses listed above, and several observations of single agency training delivered by other SAB partners were also carried out. The overall effectiveness of courses observed was assessed as very good, with an average rating of 3.7 out of 4.

In November 2019, the Redbridge, Barking and Dagenham, and Havering Safeguarding Adults Boards held a joint conference on learning the lessons from Safeguarding Adult Reviews. This was very positively evaluated by attendees as an important opportunity for both Board and professional development. The conference focused on learning from both local and national reviews. A keynote presentation from Professor Michael Preston-Shoot highlighted recurring issues in SARs around direct practice, the impact of organisational arrangements and cultures, and inter-agency working.

All NHS organisations have training targets for different levels of safeguarding training. BHRUT and NELFT significantly exceeded the 90% compliance target at all levels, with compliance rates between 94.3% and 99%. Whipps Cross exceeded the target at Levels 1 and 2. The more advanced Level 3 training was introduced at Whipps Cross in October 2019. The most recently reported compliance rate was 56%. There was also evidence of training content being reviewed to reflect changes in training need: the Level 3 training at BHRUT, for example, was updated to include more up to date material on domestic abuse, incidence, drivers and recognition.

All voluntary sector organisations represented on the Board report an ongoing commitment to ensuring effective safeguarding training for all staff and volunteers. There is a felt need in some parts of the sector for closer alignment with the training offered within the statutory sector, in particular by the local authority. One suggestion is the development of a generic Safeguarding Adults Training Pack that all organisations could use but could adapt to the needs of their individual organisation. It is felt that this would help to ensure that the understanding of adult safeguarding was consistent between staff working in different organisations throughout the borough. The development of a framework for offering training to the voluntary and private sectors is currently under consideration in the Council's Learning and Development Team.

5. Evidence from inspection and quality assurance

A number of NHS providers serving Redbridge patients were subject to CQC inspection activity in the period covered by this report. BHRUT was inspected in September and October 2019. The overall rating remained as 'requires improvement'. Urgent and Emergency Care at King George Hospital was identified as a site of 'outstanding practice':

> "Staff demonstrated a culture of vigilance and professional curiosity to keep patients safe. They displayed good awareness of different safeguarding issues and took appropriate action. The hospital had ED safeguarding advisers who contributed to safeguarding patients in real time, they supported and empowered staff to assess and manage risks."

However, an unannounced inspection of the Emergency Department at King George Hospital took place in January 2020. The service was graded as 'requires improvement'. It found that "staff did not always follow best practice in relation to safeguarding and the trust's chaperoning policy", and the trust was required to take action to "ensure that all staff are aware of safeguarding and chaperoning policies in respect of the care of children and vulnerable adults and ensure these policies are followed". However this finding did seem to be based on the observation of one doctor's practice with a paediatric patient.

R3 (the substance misuse service provided in Redbridge by the Westminster Drug Project) was inspected in February 2020, and was judged to be "good". Inspectors found that "Staff understood how to protect clients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it." However, safety overall was judged to require improvement as a result of some deficiencies found in record keeping, which inspectors judged could lead to the risk of important information being missed, and new or agency staff struggling to find key documents when working with clients.

An inspection of NELFT in May/June 2019, focused on mental health services, resulted in a judgement of 'requires improvement', and the issue of a statutory warning notice requiring action to rectify breaches of regulatory requirements. Mental health crisis services and places of safety were judged to be inadequate. Concerns included:

- Some practice for patients coming at night to Sunflowers Court, the main mental health inpatient base on the Goodmayes Hospital site, was unsafe. There were examples where delays had resulted in harm to patients.
- The trust had not yet ensured that patients were kept safe following the use of rapid tranquilisation. There was a risk of not identifying a deterioration in a patient's physical health following tranquillisation.
- Not all wards provided a safe environment to care for patients.
- There were concerns about the safety and quality of acute crisis assessment team services

These services were re-inspected in January 2020. Although no graded judgement was made, the trust was found to have made improvements which met all the requirements of the warning notice.

> "The trust had acted to promote the safety of patients and staff. Patients were no longer left unsupervised at Sunflowers Court whilst they waited to be assessed, were being assessed, or waited to be admitted to the hospital. The trust had introduced
>
> - robust arrangements to ensure patients were supervised at all times whilst waiting and appropriate waiting and assessment areas were now available.
> - Improvements had been made to the way the acute crisis assessment team accessed staff with the necessary range of professional skills and experience, including doctors, when undertaking assessments of patients. This meant staff working in the acute crisis assessment team could now access appropriate multi-disciplinary staff for all assessments.
> - Leaders had taken appropriate action to respond to the concerns that staff had raised in relation to 'walk in' patients who presented at Sunflowers Court requiring an assessment by the acute crisis assessment team. Leaders had also started to monitor how effective the acute crisis assessment team was."

In addition to the scrutiny of external inspection, the quality of safeguarding performance is also assessed, particularly within NHS organisations, through ongoing audit programmes. NELFT undertook a number of audits relevant to safeguarding in 2019, including audits of staff understanding of the Deprivation of Liberty Safeguards process, Making Safeguarding Personal (focused on the importance of service user consent to adult safeguarding referrals), the quality of advice from the Safeguarding Advisory Service, and the response to domestic violence. While audits identified much good practice, common areas for improvement highlighted were the failure to update alerts at each contact and incomplete documentation of family and household details, comprehensive recording of which is crucial to the Think Family approach. A monthly Senior Safeguarding Meeting monitors the audit programme and ensures the dissemination of learning. BHRUT reported to the Board on a total of 7 safeguarding audits completed in 2019/20, on topics including the completion rate of various safeguarding screening or trigger assessments tools, Making Safeguarding Personal, and staff knowledge of the Mental Capacity Act and Deprivation of Liberty Safeguards. A number of weaknesses identified in these audits were followed through in staff training and awareness raising work. Repeat audits generally showed an improvement in performance. However, compliance by medical staff with completion of the screening and trigger tools was generally low.

Adult social care services are not subject to external inspection. The Chair's review of adult safeguarding arrangements within the local authority in 2018 recommended that a programme of peer auditing of social work practice within the HASS should be developed, and that safeguarding practice, including the application of thresholds, should be an early focus of such a programme. The recommendation was accepted, but it has not yet been possible to develop such a programme. However, the Safeguarding and Adult Protection Team are planning to begin a programme of case audits in early 2021.

A Local Quality Surveillance Committee is chaired by the BHR CCGs Designated Nurse for Adult Safeguarding. It meets bi-monthly to monitor quality and safeguarding issues in care Homes with nursing, supported living and domiciliary care services across the tri-borough partnership. Representatives from Local Authority Quality Assurance Teams and the CQC attend the meeting. At this meeting, information is shared about any concerns arising in care provider services, with follow up action agreed. Issues raised in 2019/20 included concerns about staff behaviour to residents, medication management, and staff training. Action plans to ensure improvement are agreed with providers, and are monitored and reviewed by the Contracts and Procurement Team, working with the Adult Safeguarding Team when appropriate. A number of safeguarding enquiries have been undertaken, resulting in one case to the dismissal of a care worker.

Within the local authority, quarterly monitoring meetings are held to review all care provider services based within Redbridge, and changes in the local market. Any safeguarding concerns are raised, and action agreed to follow them up. The meetings include attendance from the Safeguarding and Adult Protection Service, Contracts and Procurement, Quality Assurance and the CQC. The Safeguarding Team maintain an ongoing log of all safeguarding concerns raised within provider services, which is scrutinised to identify any trends and patterns. A Provider Concerns procedure is triggered when a pattern of safeguarding concerns is identified in relation to an individual provider. This procedure was triggered in 16 cases during 2019/20. In most cases concerns are resolved through the development and monitoring of improvement plans with the provider, but in one case the concerns led to the non-renewal of the provider's contract for service provision.

6. Themes of concern

Rough Sleepers

- Review of rough sleepers' deaths January 2019

We reported at length in the Annual Report for 2018/19 on the issues arising from a review undertaken by the SAB of the number of homeless rough sleepers who had died in the borough between October 2017 and November 2018. The review found that, despite a mass of evidence describing the high incidence of mental health difficulties, drug and alcohol misuse, and other care and support needs among the rough sleeper population, the individuals concerned had generally had virtually no contact with statutory health and care services, other than through hospital Emergency Department attendances. It identified a pressing need for the development of an integrated multi-agency strategy to address the health and wellbeing needs of rough sleepers. As we said in last year's Annual Report, "the health and wellbeing needs of rough sleepers cannot be met solely by the voluntary sector and the Council, working separately or indeed together. Health partners, both commissioners and providers, social care services, and other agencies such as the police, must play an equally important role."

An updated report from the SAB was discussed at the Health and Wellbeing Board in July 2019. Earlier in the year, Redbridge Housing Service had committed to establish a multi-agency Rough Sleeping Partnership Board. The Health and Wellbeing Board agreed the SAB's recommendations that all agencies should commit themselves to the urgent establishment of this Board, and that it should be charged with the development of the multi-agency strategy which the review had called for, reporting back to the Health and Wellbeing Board on progress after six months. However, no progress on the establishment of the Rough Sleeping Strategic Board had been made by the end of 2019/2020.

- Learning Review: death of Mr A

The Board also undertook a learning review of issues arising from the death in June 2019 of an individual rough sleeper. Mr A was found dead near a car park, with the likely cause of death noted as cardiac arrest. He had been the victim of a serious assault six months earlier, and spent several weeks in the Royal London Hospital, undergoing major surgery to repair broken bones in the skull and around the nose. Prior to the assault, he had been 'sofa surfing' and was not known to the outreach service as a rough sleeper. However, when assessed as fit for discharge from hospital at the end of January 2019, he had become homeless, and was discharged to the Salvation Army Night Shelter, where he continued to stay until his death.

His death was initially referred to the Board for consideration for a Safeguarding Adults Review. The primary reason for the referral was a concern that discharge to the night shelter was wholly inappropriate for someone recovering from major surgery and vulnerable due to the injuries sustained. Following consideration collated from a range of agencies who had contact with Mr A, the Chair decided that the criteria for a SAR were not met. However, he agreed that it would be very helpful for agencies to come together to review this sad case to identify any lessons that might be learned from it to improve future practice. A Learning

Review meeting in November 2019 was attended by representatives of the Salvation Army, the Welcome Centre, RAMFEL, the CCG, BHRUT, the Royal London Hospital Pathway Homeless Team, the London Ambulance Service, and LBR Housing Needs Service. The SAB considered a report from the review at its meeting in January 2020.

Although a full multi-agency chronology had been compiled before the review meeting from information provided by individual agencies, it was only through the process of the meeting and triangulation of information between participants that a fuller, though still incomplete, account of Mr A's life and circumstances emerged. This was in itself a learning point: the extreme difficulty of constructing an accurate picture of the circumstances of someone like Mr A, who lived much of his life 'under the radar' and who did arguably have more care and support needs than any individual agency had been able to realise. One of the conclusions of the review was that we need better mechanisms to identify and consider complex cases requiring multi-agency intervention. For example, Mr A was the subject of two serious assaults in less than two years, and a violent perpetrator on three occasions. If this potential pattern of involvement in violence had been identified, it might have suggested that Mr A was at risk of further assault on discharge from hospital. 'High Risk Panels' or 'Community MARACs', co-ordinating the sharing of information and planning in cases such as Mr A's where there is cause for concern in different agencies but no clear eligibility for service or responsibility, have been established in a number of authorities, and the Board recommended that consideration should be given to establishing such a framework in Redbridge. However, the impact of the COVID pandemic has delayed further consideration of this recommendation.

The review noted that when Mr A's discharge from hospital was being planned in January 2019, no consideration was given to a referral to social care for an assessment of his care and support needs, and concluded that consideration should at least have been given to this. Under Section 9 of the Care Act 2014, the local authority has a duty to offer an assessment of needs "where it appears that an adult may have needs for care and support", irrespective of the authority's view of the level of those needs or whether those needs meet the eligibility criteria. The review noted a recent **report** from researchers at King's College London, reviewing 14 Safeguarding Adults Reviews in which homelessness was a factor. The researchers commented that the threshold for the duty to offer an assessment under Section 9 is low but that in many of the cases reviewed in that report the duty was not met. It is worth recalling that of the ten rough sleepers whose deaths on the streets of Redbridge were reviewed by the Safeguarding Adults Board in January 2019, none were open to a social care team, and social care had no recorded knowledge of seven of them. The review of Mr A's death strengthens the need for the importance of the assessment duty to be re-emphasised in the planned development of updated guidance on adult social care and rough sleeping.

- <u>The response to the COVID-19 pandemic</u>

Although little progress had been made up to March 2020 on the development of the multi-agency strategy which the Health and Wellbeing Board had called for, the onset of the COVID-19 pandemic that month precipitated massive and rapid developments on the

ground. Within three days of the Government requiring local authorities to bring all rough sleepers into accommodation and ensuring that they were able to self-isolate in unshared rooms, the Housing Service, working with commissioned outreach and other partners, had brought all rough sleepers they were able to reach off the streets and moved all those sleeping in shared night shelter rooms into accommodation in which they could self-isolate. Among many other initiatives this involved the rapid conversion of the accommodation at the Ryedale site, which at the outbreak of the pandemic provided only six unshared rooms for rough sleepers, into a hostel with 50 unshared rooms, most with their own bathrooms and shared kitchen spaces. As more rough sleepers were identified, more accommodation was provided. By the end of July 2020, 198 rough sleepers were in accommodation, in Ryedale, Malachi Place (a pop up supported hostel run by the Salvation Army), commercial hotels arranged by the Greater London Authority, or bed and breakfast provision secured by the Council as temporary accommodation.

Crucially, the commitment made by the Council that no rough sleeper provided with accommodation as a result of the COVID-19 crisis should be forced to return to the streets has required a much fuller analysis of the care and support needs of this population, and accelerated the development of multi-agency working to address those needs. 38% of those who have been provided with accommodation have been assessed as having low or medium support needs. 23% have high or very high support needs, primarily around issues of drug and / or alcohol abuse, mental health, and physical health problems or disability. 39% have no recourse to public funds, which means that, while they have a range of support needs, the ability of services to meet those needs is severely challenged by the implications of their status. As the pandemic has developed, much work has been undertaken to ensure that service responses are in place to meet the needs identified and to support individual personal housing or housing resettlement plans. A multi-agency team has been meeting weekly to co-ordinate this work, centred around the development of a lead professional role – co-ordinating support, referral, and solution-finding work for each individual. A cross borough mental health pilot has been established, which engages and undertakes casework with rough sleepers with the most acute mental health needs to support their recovery and, where possible, transition them into mainstream services. An assertive substance misuse outreach team commissioned by the council specifically targets rough sleepers as well as other hard to reach substance misusers. As in so many other areas of public services, agencies' response to the challenges of the COVID pandemic has been extraordinary, responding at pace to the unprecedented circumstances of the pandemic with an equally unprecedented flexibility, capacity to innovate, and readiness to adapt. The challenge, when the crisis finally passes, will be to make sure that the strengthened partnership working which has developed in response to that crisis is consolidated and embedded in a post-pandemic world.

Outcomes of Learning Disability Mortality Reviews

The Learning Disabilities Mortality Review Programme (LeDeR) is a national programme led by NHS England for reviewing the death of all people with learning disabilities over the age of 3. In October 2019 the Board considered a report on findings to date from both the national programme and the 12 reviews which up to that point had been completed in Redbridge. Although reviews identified much good practice, both nationally and locally some very significant areas of weakness in some cases were identified:

- Delays in referral, diagnosis, or treatment
- Low uptake and variable quality of health screening and health checks
- Delays in Mental Capacity Assessments or representation by an Independent Mental Capacity Advocate
- Lack of effective care co-ordination
- Poor engagement with families and poor recording of information

The Board expressed extreme concern about some of these findings. Ultimately, it appeared clear that in at least some cases people with learning disabilities were dying prematurely or even avoidably, as a result of weaknesses in professional practice and service delivery. The Board resolved to use part of a Board Development Day planned for March 2020, with expanded participation by service users, carers, and local professionals with expertise in learning disability services, to rigorously explore the local position and to develop an action plan for the SAB to address failings or weaknesses within the system. Unfortunately, however, the even had to be cancelled due to the immediate impact of the COVID-19 pandemic. The Board intends to return to examination of this issue in 2020/21, including scrutiny of whether people with learning disabilities have been disproportionately at risk of death or serious illness from COVID.

7. Safeguarding Adults Board Action Plan 2019/20: actions, progress, and outcomes

The **Board's Action Plan 2019/20** identified eight priority areas for action. Progress against the headline actions is reported below.

7.1 Strengthening prevention

There were three strands for action under this priority:

- To review and improve the signposting of adults with care and support needs to support resources in the community, to improve early intervention and promote wellbeing in the least intrusive way. In support of this priority, a review was commissioned of the Redbridge First Response Service (ReFRs), examining ways in which the service could be strengthened. ReFRs is a multi-agency scheme which links individuals referred for help to support their wellbeing, safety, choice and independence with trusted providers such as the council, police service, fire service, voluntary groups and other organisations who work with vulnerable adults. It is designed to provide easy access to services for people who may not meet the threshold for social care services. The review was completed, but it was not considered by the Board as the meeting at which it was due to be discussed was cancelled to relieve pressure on services in the early stages of the COVID pandemic. Consideration of the ReFRs review was therefore carried forward into the 2020/21 work programme.
- To support the further rollout of the People Matters model in health and adult social care services in Redbridge. Early detection of risks and putting in place measures to mitigate them can prevent risks from escalating into formal safeguarding processes and reduce the associated impacts upon the individual's health and well-being. Progress against this objective during 2019/20 is described in Section 3 of this report.
- To continue to develop reflective practice learning, to ensure that S42 enquiries are proportionate and only undertaken when an appropriate threshold is met. As noted earlier in this report, the Safeguarding and Adult Protection Team led two very successful and well attended Reflective Practice sessions during the year for health and social care practitioners. The data reported in Section 2 shows a reduction in the percentage of safeguarding concerns deemed to meet the threshold for a formal safeguarding enquiry from 70% in 2018/19 to 59% in 2019/20.

7.2 Supporting the voluntary sector

In the first half of the year the Board Business Manager led a consultation with the community and voluntary sector, jointly with Redbridge CVS, on their self-identified learning and development needs. Following this consultation, a series of safeguarding learning events were planned on the topics identified by the sector as priorities – safeguarding in organisations; the exploitation of children, young people and vulnerable adults; violence against women and girls; and mental health and safeguarding. The first two were delivered

with 100% take up of the available places. The others, however, scheduled for the end of March and early April, had to be cancelled due to the impact of the COVID pandemic.

There was a very positive response to this initiative from the sector. Less positively, however, as noted earlier in Section 3, some of the difficulties in effective partnership working reported by the sector in previous years have been repeated in contributions to this report. Too often, voluntary organisations feel that they get no or inadequate feedback from the local authority when they make a safeguarding referral. They have also commented that they find the referral pathways confusing, and have asked that Redbridge consider the development of a Safeguarding Referral Form to replace the current reliance on email alerts, without guidance to referrers on the information and specification of grounds for concern that should be included. The local authority have agreed to develop a Safeguarding Referral Form, to support the consistent and full recording of appropriate referral information, but this work has not yet been progressed.

7.3 Working with providers

The objective of this priority was to engage more commissioned care providers in the work of the Safeguarding Adults Board, to ensure that their voice and perspective is reflected in all its work. A representative of the Care Homes Provider Forum joined the Board in March 2020. Following the letting of locality home care contracts, a new Home Care Provider Forum was in the process of being established when it was suspended due to the impact of the COVID pandemic. It is hoped that engagement with this forum in 2020/21 will secure representation of the domiciliary care sector on the Board.

A new Safeguarding Adults Forum, bringing practitioners and care providers together to promote a shared understanding of adult safeguarding principles and procedures, was launched by the Adult Safeguarding and Protection Team in October 2019. It was well attended with a commitment to regular future meetings. Capacity issues within the team, and then the disruption of the COVID pandemic, have to date meant that it has not been possible to organise further meetings, but it is hoped that the forum will be revived in 2020/21.

7.4 Developing an effective response to transitional safeguarding

This is a joint project with the Redbridge Safeguarding Children Partnership (RSCP). The objective is to develop proposals for an effective response to the needs of young adults at risk of exploitation, recognising that adolescence as a developmental phase does not suddenly end on the eighteenth birthday. Following a practitioner workshop, work was undertaken to establish a cross-service task and finish group to take the project forward. The Board has identified the completion of this work as a priority for 2020/21. It is likely, however, to be significantly impeded by the disruption of the COVID pandemic.

7.5 Workforce Development

This priority was primarily concerned with the development of multi-agency training. However, as noted in Section 4 of this report, the SAB has not had capacity to make progress against this priority.

7.6 Preparing for the implementation of the Liberty Protection Safeguards

Under the Mental Capacity (Amendment) Act 2019, Liberty Protection Safeguards will replace the existing Deprivation of Liberty Safeguards provisions. At the outset of the year, the Government had indicated that the new arrangements would be implemented in October 2020. A project group was established to prepare for implementation. However, there were very significant delays at Government level, particularly in the delay and eventually the non-publication of the draft Code of Practice without which only limited preparatory work could be undertaken. The Government have now announced that implementation has been delayed to 2022.

7.7 Hearing the voice of the service user

This has been a key priority for the SAB. The Board committed itself to seeking to develop effective ways of hearing, understanding and acting on the voice of individuals who experience safeguarding interventions. However, it has been a very difficult priority to progress. A survey of partner agencies did not suggest ways forward. As part of Making Safeguarding Personal, a service user feedback form should be completed as part of the Council's adult safeguarding procedures. Feedback should be sought and recorded at every stage of the safeguarding process. It is clear, however, that in practice the use of the form is limited. Moreover, the form is solely linked to the individual service user's record on CareFirst, and there is no way that information from feedback forms completed can be extracted to give a wider view of service users' issues and experiences.

At its meeting in January 2020, the Board agreed to pursue a proposal to generate some qualitative information about service users' experience by identifying and interviewing, with their consent, a small sample of users who have experienced safeguarding enquiries, on their experiences and suggestions for improvement. However, it has not been possible to identify from partners' resources appropriate capacity to undertake the interviews and produce a report. The Board has no budget from which it can fund an organisation to undertake this work. The Board regards making progress on this issue as a major priority for 2020/21. It will however remain extremely difficult to progress unless resources can be identified.

The Board has also sought to recruit Lay Members, to increase the strength of the community if not the service user voice in its work. Following an unsuccessful recruitment campaign at the end of 2019, a further round of publicity attracted a number of applications,

and interviews were scheduled for the end of March. They had however to be cancelled due to the Covid crisis. We will continue with this initiative in 2020/21.

7.8 Strengthening mutual challenge and accountability

A Board Development and Challenge Day was scheduled for 25 March 2020. The first part of the day was to be spent on developing an action plan to tackle the issues arising from Learning Disability Mortality Reviews, described in Section 6 of this report. The remainder of the day was planned around a challenge to the way the Board itself worked and how effectively partner agencies contributed as Board members. While the Care Act itself prescribes only three things that a SAB must do, statutory guidance is more extensive about what a SAB 'should' do. The Care and Support Statutory Guidance sets out fifteen distinct expectations which a SAB should meet. The Development and Challenge Day was to be structured around challenging ourselves and each other on how well we currently perform against these expectations, and what we need to do to improve.

Unfortunately, at short notice, the day had to be cancelled as a result of the onset of the COVID pandemic. The commitment to such an event has however been rolled forward into 2020/21.