Redbridge Safeguarding Adults

REDBRIDGE SAFEGUARDING ADULTS BOARD

Annual Report 2020 – 2021

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Foreword

I am pleased to introduce the Annual Report of the Safeguarding Adults Board for 2020/21.

It does not need saying that this was a year absolutely dominated by the impact of the Covid pandemic, which is discussed very fully in Section 2 of this report. I want to pay tribute here to 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 through this period. Equally extraordinary was the speed of the response and the rapidity with which services adapted. Just to give one example from the body of the report, the Council established the Wellbeing Service, initially as a telephone line for residents to contact for help with food and medication support, within 24 hours of the announcement of the first lockdown. Within a week, a delivery service had been put in place in partnership with the London Fire Brigade and local volunteers recruited. The speed and flexibility with which the voluntary sector in Redbridge mobilised to support vulnerable people was deeply impressive. And while it is invidious to pick out one service from others, the work of the Council's Housing Service in getting rough sleepers, at great risk of infection, off the streets and in many cases on the road to settled accommodation and support, and the partnership work this involved with both other statutory agencies and the voluntary sector, can only be described as inspiring.

I also want to recognise the cost to staff and volunteers right across the partnership who worked tirelessly and nonstop, and in many cases well beyond the call of duty, throughout the year and beyond to ensure the continuity of support and services in the most challenging of circumstances. Many will have experienced personal loss as a result of the pandemic, and I know that everybody represented across the partnership would want to express their most sincere condolences to everybody involved in this work who has suffered bereavement during this time. I know also that the cost is one that colleagues continue to bear, having had little chance of respite as they now contemplate the demands of an uncertain but almost certainly difficult winter.

Nobody, and no community, escaped the impact of the pandemic. For our most vulnerable citizens, and particularly those at risk of abuse or neglect, the impact was enormous. The report chronicles this is some detail – the risks of isolation and forced proximity to other family members when people were unable to leave their homes; the explosion in domestic violence; the increase in mental health difficulties and the emergence of a group, previously hidden to services, who had been living, often alone, with severe mental illness for a number of years; the huge stress on carers; financial hardship; perhaps most of all, the awful toll on residents of care and nursing homes, however hard professionals from a range of agencies, led by Public Health, worked to mitigate that toll. It is striking how, in the early stages of the pandemic and lockdown and when normal access to services was heavily restricted, demand was displaced into emergency services – the increase in mental health presentations at Accident and Emergency Departments, and the increased volume of calls

related to mental health to the police. I am particularly concerned about the impact of the pandemic on people with learning disabilities. As we say later in the report:

> It seems clear that the only exacerbated pre-existing systemic deficiencies in the health care of people with learning disabilities, which without determined action to address will continue long after the pandemic has finally come to an end. This is an issue which the Safeguarding Adults Board must prioritise for future action.

Many services, of course, moved to largely online delivery for much of the year. This undoubtedly created difficulties for many. We heard at the Board, for example, heartfelt descriptions of the frustration of many older people and others confused by multiple options and stuck in telephone queues when trying to get through to their GP practice. There were however some interesting positives – the increased take up and reduced drop out from anger management programmes, and the increased engagement of family members and carers in safeguarding meetings, for example. The risks of digital exclusion in an increasingly digital world are well highlighted in the report, and some of the efforts agencies have made to counter this – for example, the investment in the Sparko resource by Age UK – are impressive.

This is the fourth Annual Report I have been responsible for producing since I took on the role of Independent Chair of the Board in June 2017. It will also be the last, as I have decided, after seven and a half years of chairing safeguarding boards in Redbridge, to stand down from both the Safeguarding Adults Board and the Safeguarding Children's Partnership at the beginning of 2022. It has been challenging, stimulating and deeply rewarding to work with so many colleagues in the Redbridge partnerships with such a strong commitment to working together to safeguard, empower and enhance the life chances of vulnerable children and adults.

Two years ago, I said that my ambition 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. I recognise that I have not fully succeeded – and perhaps, given the very different contexts in which each operates, it was never an entirely realistic ambition. I do think that the Safeguarding Adults Board is more effective now than it was four years ago, and I really appreciate both the commitment of partners to engage with the Board and the openness to challenge and scrutiny with which they do so. I remain frustrated with the lack of capacity in the Board to fully meet the expectations of the Care Act guidance in relation to rigorous quality assurance and the promotion of multi-agency training, although I very much welcome the increased resourcing of the Board's work through the £30,000 contribution agreed by the CCG, which will allow some modest expansion of the Board's activity in these areas. The final challenge I would like to leave behind me relates to training. I fully appreciate that in comparing the safeguarding training available to the children's services workforce with that available to staff working with adults in need of care and support, one is not comparing like with like. I also appreciate that the Board does not have a full overview of the training available in all partner agencies. Nevertheless, I do not think that the comparison we can make – 94 staff in the integrated health and adult social care service able to take up safeguarding training

in 2022/21, compared to 620 attendances at multi-agency training organised by the Redbridge Safeguarding Children Partnership – is acceptable. The fact that since 2019/20 the representative of the Learning and Development Team has had to withdraw from attendance at the Safeguarding Adults Board, due to reduced capacity within the team, does I think raise the question of priorities. A well trained and confident workforce must surely be a critical element in driving and sustaining continued improvement in practice.

Finally, I want to say a deep, deep thank you to Lesley Perry, Business Manager of both the Safeguarding Adults Board and the Safeguarding Children Partnership. Whatever the SAB has or has not achieved in the last four and a half years, it would not have achieved anything or functioned at all without Lesley's commitment, energy and professionalism.

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 eighteenth 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 fulfilling 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 2021 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	Designated Nurse for Adult Safeguarding, NEL CCG
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
Terry Chaplin	Borough Commander, London Fire Brigade
Tim Buck	Named Nurse, Safeguarding Adults (Interim), BHRUT
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
Ian Young	Senior Safeguarding Lead, Department of Work and Pensions
Cllr Mark Santos	Cabinet Member for Health, Social Care, Mental Health and the Ageing, LBR
Heli Alam	Lay Member
Margaret Bruce	Lay Member
Patricia Johnson	Inspection Manager, London Region, CQC (Observer)

In January 2021, the Board was pleased to welcome Ian Young, Senior Safeguarding Lead at the Department of Work and Pensions (DWP), as a new member. This represented a strong wish on the part of DWP to build relationships and collaborative working with relevant

agencies, and was intended to open up a channel for better communication on safeguarding issues and strategies.

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.

Previous reports have commented on the significant under-resourcing of the Redbridge SAB compared to both local and London-wide benchmarks. It is pleasing to report that during 2020/21 the Clinical Commissioning Group agreed an annual contribution of £30,000 to support the work of the SAB. As a result, the SAB entered 2021/22 with some limited capacity to undertake multi-agency training and quality assurance work, neither of which has it previously been able to provide.

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. The year was of course dominated by the impact on service users, on services and staff, and on the community by the Covid-19 pandemic, and this is discussed in some detail in Section 2 of this report. Progress against the 2020/21 Action Plan is outlined in Section 5. The Board published two Safeguarding Adult Reviews during 2020/21, and these are discussed in Section 6.

The Board met three times in 2020/21. One meeting was cancelled due to the impact of the Covid-19 pandemic.

2. Adult safeguarding in Redbridge during the Covid pandemic 2020/21

The year under review in this report was almost totally dominated by the impact of the Covid-19 pandemic. In late March 2020, services and communities had to re-adjust and reshape themselves, virtually within 24 hours, to a sudden and total national lockdown. In social care, voluntary sector and many health services, face to face contact between service providers and service users virtually ceased overnight, although emergency access was maintained wherever possible. There were three periods of national or regional lockdown during the year, interspersed with brief periods of loosened restrictions. By 31 March 2021, 32,950 cases of Covid infection had been identified in Redbridge. 733 people had died within 28 days of a positive Covid test, and 857 deaths had Covid-19 recorded on the death certificate as one of the causes of death. At one point Redbridge had one of the highest rates of infection in the country.

The story of 2020/21 is one of immense stress on both services, staff, and communities, and, for many, terrible grief and loss. It is also one of great resilience, commitment, and creativity in responding effectively to dramatically changed circumstances, on the part of both statutory and voluntary sector services. Service provision in both sectors adapted almost overnight. The First Contact Team in adult social care was extended to seven day a week to ensure access to services for people seeking help and support. Within 24 hours of the announcement of the first lockdown, the Council had established the Wellbeing Service, initially as a telephone line for residents to contact for help with food and medication support. Within a week, a delivery service had been put in place in partnership with the London Fire Brigade and local volunteers recruited. The service was initially staffed by day opportunities staff, subsequently supported by a Council-wide redeployment effort. In the first phase of the pandemic, it was open for twelve hours a day, seven days a week. The service offer adapted and flexed as circumstances and demand changed: over the year it delivered almost a thousand food parcels, supported over 26,000 shielding residents, and made over 58,000 telephone calls to vulnerable people.

The Safeguarding Adult Board meeting scheduled for April 2020 was cancelled, to allow all partner agencies to concentrate available time and resources on the immediate response task in the context of a national lockdown. At each of its subsequent meetings through the year and beyond, the Board reviewed in detail the risks, the demands and the responses to those risks and demands on the part of partner agencies. From the outset, priority was given to identifying key safeguarding risks to vulnerable adults during the pandemic, the actions in place to mitigate those risks, and potential further steps that could be taken to mitigate them further. Senior leaders from a number of statutory agreed a summary of the identified risks, and an initial assessment of the severity of each risk, which was regularly reviewed. The risks were RAG rated as 'red' (high risk), 'amber' (medium), and 'green' (low risk). A total of 14 headline risks were identified, of which six were assessed as 'red'. These were:

- Increased stress on carers and households leads to increase in neglect and abuse of vulnerable adults and increased risk to carers.
- Increased opportunities for financial abuse and scams.
- Increase in self-neglect and reduced likelihood of identifying it.
- Risks of deteriorating wellbeing and mental health in lockdown and reduced access to services.
- Reduced access to drug and alcohol services leading to increased risk of self-neglect and vulnerability to abuse.
- Potential disproportionate risk of death for people with learning disabilities during pandemic.

Some of the data which supported an evaluation of risk is discussed in detail in Section 3 below. On the key risk of an increase in neglect, self-neglect and abuse, the data does not suggest that this materialised. While there was a very significant increase in the number of safeguarding concerns reported in the year, both the percentage of those concerns and the absolute number which were assessed as requiring a safeguarding enquiry under Section 42 of the Care Act actually fell. Similarly, the number of safeguarding enquiries undertaken as a result of concern about self-neglect was very similar to pre-pandemic levels. Within a broader context of vulnerability, however, it is very clear from the reports of all agencies, and in particular the voluntary sector, that there was an enormous increase in stress, anxiety and isolation for many vulnerable people. The Redbridge Carers Support Service, for example, reported on the impact on carers:

> Carers have reported an increase in poor physical and mental ill-health. Some carers have had problems accessing health services, whilst others fear contracting coronavirus if they leave the house. Others have stopped having paid carers visit and have been particularly worried about lack of adequate PPE. Carers have reported feelings of loneliness and anxiety. Working carers have reported home working has meant more time with their families, whilst others have lost part-time jobs and therefore face financial hardship. Many isolated and vulnerable carers have been shielding. Carers have been hugely impacted by the loss of respite services, such as the closure of day centres. Many carers have lost a loved one due to COVID. Though telephone support has been invaluable, the lack of face-to-face empathy and emotional support has been difficult for some carers who just wanted a hug!

The number of incidents encountered by the police involving adults who were recorded as vulnerable increased by almost 20% in 2020/21, compared to the year before. Age UK report a very significant increase in bogus callers and financial scams targeted at older people, and put considerable effort into a range of communications alerting people to the dangers of this form of financial abuse and how to protect yourself against them. The number of safeguarding concerns relating to financial fraud and scams received by the local authority also increased in the latter part of the year.

The London Fire Brigade were forced by the circumstances of the pandemic to stop or massively reduce their level of Community and Home Fire Safety Visits, which make a very important contribution to safeguarding, particularly in cases of self-neglect and hoarding. The LFB also noted that one effect of this was also a reduction in the number of safeguarding concerns raised by fire crews, due to the much reduced number of properties visited.

Mental health during the pandemic

Both the mental health of many individuals and mental health services were under great pressure throughout the year. During the first lockdown, access to community-based mental health services was severely restricted, with virtually all services being online only. In the first quarter of the year there was a 30% fall in the number of referrals received. Demand was displaced into emergency services: there was a very substantial increase both in the number of people presenting with mental health issues in the Emergency Departments at BHRUT and in the number of mental health related calls to the police during this period. In the first quarter of 2020/21, mental health issues were noted in 63% of ED presentations. This figure fell to 11% in Quarter 2, as lockdown measures eased and community services started to become more accessible. However, in the second half of the year, mental health issues again figured heavily in ED presentations: an element in 48% of presentations in Quarter 3, and in 38% in Quarter 4.

As restrictions eased, face to face services began to be reinstated and referrals to secondary mental health services began to rise, although not to pre-pandemic levels. By the end of October referrals were still down by 18% compared to the year before. Demand accelerated steeply in the second half of the year, peaking in the third national lockdown in the first three months of 2021. Referrals during the third lockdown were 22% higher than in the first lockdown nine months earlier.

Mental health referrals increased in both complexity and acuity throughout the pandemic. There was a particular increase in the number of people accessing mental health services for the first time. In many cases they had been living, often alone, with severe mental illness for a number of years, but had not previously come forward or come to the attention of services. Other evident impacts of the pandemic included a rise in referrals for anxiety and depression, with the social impact of lockdown such as financial hardship, loss of employment, and marital stress being given as a common cause for a decline in mental state. There was an increase in the severity of depression in referrals to the Older People's Mental Health team, linked to isolation. Mental health services continued to see an increase in people suffering with conditions such as Obsessional Compulsive Disorder (OCD), associated with cleanliness, along with presentations associated with eating disorders, irritability and anger issues. Practitioners also reported a rise in people requesting assessments for Attention Deficit Hyperactivity Disorder (ADHD). However, this was often the result of self-researched diagnosis, and an outcome of lockdown anxiety and monotony leading to an increase in restless behaviour and difficulty in concentrating, rather than a clinical condition. The burden on carers was very high, particularly within Dementia and

Learning Disability Services as a result of the reduction in activities and the loss of regular patterns of life caused by the restrictions. Primary Care Mental Health Services (Improving Access to Psychological Therapies / Talking Therapies) also experienced a significant rise in referrals from the general public and from staff seeking support for more low level common mental health disorders. This included a variety of pandemic related presentations: generalised anxiety disorders and low mood, OCD associated with hand sanitising and fear of touching surfaces. and anxiety and depression associated with loss of employment or furlough. Domestic violence and an increase in family conflict, particularly between parents and adult children, also featured heavily in referrals.

As demand peaked in the post-Christmas lockdown, community mental health services increased the level of contact with service users, seeking to avoid a rise in crisis presentations as restrictions were reduced. There was a reduction in the number of referrals for assessments under the Mental Health Act, potentially as appositive outcome of increased contact. Similarly, the Older Adult Mental Health Team, the Memory Assessment Service and the Community Learning Difficulty Team made a determined effort to increase support to carers during this period.

In the first lockdown, as already noted, the number of referrals to mental health services fell sharply, as face to face access became almost completely unavailable. Face to face services were reinstated as that first lockdown ended, and were not withdrawn to the same extent in subsequent lockdowns. Some forms of online engagement, however, were very successful. There was increased demand for and increased uptake of online anger management groups, and a significant decrease in the dropout rate.

<u>The impact on care homes</u>

Nationally and locally, the pandemic had a devastating impact on residents of care homes. Between January and December 2020, 19% of all deaths in care homes were Covid related. In addition to this awful toll, residents suffered many months of anxiety, isolation, and loss of contact with family and visitors. The partnership mobilised very quickly at the outset of the pandemic to provide robust and focused support to care providers – not only care and nursing homes, but also supported living providers, domiciliary care, extra care provision, and children's homes. Co-ordinated by LBR Public Health, the response brought together the CCG, Primary Care Networks, LBR Contracting and Quality Teams, and Community Clinical Support Teams. A designated COVID-19 provider response team was established within the Council. This included a Consultant in Public Health and a designated Health Protection Officer, as well as the Contracting and Quality Team, who maintained regular contact with all providers to provide support and ensure that cases, outbreaks, and clusters were picked up at the earliest possible stage. At the height of the pandemic this contact was maintained daily. Where an outbreak occurred, an Incident Management Team was established, both to maximise support to the provider and residents affected and to ensure that learning could be shared with all providers to inform future responses. It should be noted, and it may be some evidence of the effectiveness of this support, that a far lower percentage of Covid deaths in Redbridge occurred in care homes than either in London as

a whole or nationally. Between January and December 2020, 9% of all Covid deaths in Redbridge happened in care homes, compared to 13% across London and 25% nationally. From January 2021, with the spread of the Delta variant, there was a significant increase in cases, outbreaks, and clusters. At the end of January, Public Health reported that there had been six significant outbreaks since December, in homes which all had strong infection control practices in place. It remained the case, however, that deaths in care homes made up a lower proportion of all Covid deaths in Redbridge than elsewhere. Between January and September 2021, 7% of all Covid deaths, compared to 19% in England as a whole.

Drug and alcohol services

At the beginning of the pandemic, drug and alcohol services in Redbridge ceased all face to face contact with service users, although access was gradually expanded as changes in government guidance and restrictions allowed. There was a marked increase in calls from partners and other family members raising concerns about an individual's increased substance misuse. The R3 Service developed a risk register to identify service users at increased risk as a result of Covid 19. The register was reviewed daily, and interventions escalated when necessary. In the last quarter of the year, the R3 Assertive Outreach Team launched an innovative project to offer lateral flow testing and vaccination to all rough sleepers in temporary accommodation, setting up pop up clinics on site. Take up was reported to be high. Given a high level of concern about the vulnerability of this population, it was encouraging that of the first 100 tests delivered, there were only two positive results, with both individuals then self-isolating to prevent spread.

Rough sleepers

In March 2020 the Government asked all local authorities to act immediately to bring all rough sleepers off the streets, to protect them from the pandemic. Within two days, the Council repurposed Ryedale, which had been intended as emergency hostel provision for homeless families, to provide 50 single rooms for rough sleepers, 40 with en-suite bathrooms, with 24-hour support services available. Within the first week, Redbridge had accommodated 50 rough sleepers. The numbers rose rapidly, and by August 2020 224 rough sleepers were in temporary accommodation. As move on arrangements began to take effect, and some decided to return to the streets, numbers fell gradually, but by the end of January 2021 186 people remained in temporary accommodation.

As an immediate response to the needs of rough sleepers during the pandemic, a multi-agency, multi-service team was established, to carry out a comprehensive assessment of each individual's needs, and to develop a personalised support and move-on plan. Of the first cohort assessed, 58% had support needs related to substance abuse or mental ill-health. 49% of those assisted have no recourse to public funds. Nevertheless, at the end of February it was reported that 115 rough sleepers had moved on, many with a positive solution – for example, entry into the private rented sector with support, or supported housing, inside or outside Redbridge. 20% of the cohort had chosen to leave without any known accommodation to go to. It was expected that 117 people were likely to remain in

temporary accommodation into 2021/22, mainly people with no recourse to public funds. Most of those requiring supported housing were expected to move on in the first quarter of 2021/22, as accommodation options became available.

Learning Disabilities Mortality Reviews

Last year's Annual Report recorded the Board's extreme concern about some of the findings of the Learning Disabilities Mortality Review Programme (LeDeR), both nationally and locally. Some very significant areas of weakness had been identified in too many of the cases reviewed:

- 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

"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 had planned a Development Day for March 2020, to rigorously explore the local position and to develop an action plan for the SAB to address failings or weaknesses within the local system. Unfortunately, however, the event had to be cancelled due to the immediate impact of the COVID-19 pandemic.

A potential disproportionate risk of death for people with learning disabilities during the pandemic was identified as a "red" risk in the risk register drawn up at the outset of the pandemic. The early data confirmed this risk. While a high level of co-morbidities in this population would be expected to increase vulnerability, there was a large increase in deaths notified to the Learning Disability Review Mortality Review Programme in April 2020.

- Across the Barking and Dagenham, Havering and Redbridge area, 22 deaths were notified in April 2020 compared to 2 in April 2019.
- In Redbridge, there were eight deaths in that month: no deaths were notified in April 2019 or in April 2018.
- Rapid reviews completed on the cases suggested that factors in some cases included:
    - delayed presentations to hospital
    - delayed discharge in two cases leading to increased risk of contracting Covid19
    - some poor communication between hospitals and care providers
    - lack of PPE in supported living provision
- 50% of people with learning disabilities who died from Covid 19 in North East London in March and April 2020 were in a supported living provision. 25% were in residential care and 25% were living in the community.

- Although the increase did not continue at the same rate, between April 2020 and February 2021, 22 deaths in Redbridge were notified to the LeDeR programme, compared to 8 in the same period a year earlier.
- 13 of those deaths were linked to Covid 19.
- 6 of those deaths occurred in the first wave of the pandemic (March to June 2020), and seven in the second wave from November 2020. A report from the North-East London Commissioning Alliance, considered by the Board at its meeting in April 2021, suggested that learning and action taken following analysis of deaths in the first wave, had led to better outcomes in the second wave. In particular, the report pointed to a greater awareness of Covid symptoms on the part of both care staff and service users; the greater availability and accessibility of public health information in a variety of formats; the greater availability of personal protective equipment; and the increased accessibility of testing and the reliability of results. Public health and commissioning teams in Redbridge had paid particular attention to raising awareness of Covid 19 symptoms and the need for an urgent response in supported living provision.

This picture was reflected nationally. A report from Public Health England found that between 21 March and 5 June 2020 people with learning disabilities died from Covid at 6.3 times the rate of the general population.

It seems clear that the pandemic only exacerbated pre-existing systemic deficiencies in the health care of people with learning disabilities, which without determined action to address will continue long after the pandemic has finally come to an end. This is an issue which the Safeguarding Adults Board must prioritise for future action.

Mobilisation of the voluntary sector

The voluntary sector in Redbridge played a huge part in responding to the needs of the most vulnerable people in the community during the pandemic. As the great majority of contact with service users became telephone based or online, staff in all agencies made great efforts to maintain contact. As restrictions began to ease, organisations used a range of creative and flexible ways to maintain contact – doorstep and garden visits, small park meet ups instead of coffee mornings, Zoom exercise classes, and many other imaginative adaptations. Staff also "went the extra mile" over and over again: Age UK staff kept the phone lines open throughout the Christmas period, recognising the stress and isolation many older people were exposed to following a Christmas cancelled at short notice. Jewish Care staff worked over Jewish festivals and bank holidays to ensure a response to service users in need.

Many staff and volunteers experienced a very rapid learning curve as they came to terms with the challenges of virtual and digital communication. Agencies also gave great priority, however, to supporting their service users in gaining confidence in entering and acting in an initially unfamiliar online world. Age UK secured funding to provide access for service users to Sparko, a "virtual retirement community". In their contribution to this report, they describe this as

> "a life changer for some people as they are able to join in group activities through the Sparko box and their TV and interact with other older people, participate in activities and form friendships with other people. Sparko also allows service users to link up with their family through the box."

There is a strong commitment to promote the digital inclusion of older people:

> "Our aim is to secure further funding to support older people to embrace technology that is user friendly but whilst having a point of contact for support. This has been crucial within a number of our services where staff have supported with confidence building in using the equipment. Our Sparko service has continued during the lockdown to get as many installations done as possible so that service users can use the device to participate in a wide range of activities such as music, exercise, art classes, poetry and many more. We also used Sparko to provide Advice & Information sessions and this has led to referrals to the service."

The Redbridge Carers Support Service secured a grant to deliver a Carers Online Project, which they describe as "helping isolated, home bound carers get access to devices and remote training, with the help of volunteers, enabling them to find new ways of staying in touch with services, family, and friends." Twenty volunteers were recruited to help support carers to get online. Some Jewish Care staff were redeployed to care homes to support residents in maintaining online video communication with families.

A number of voluntary agencies commented that co-operation between the statutory and voluntary sectors has been strengthened as all parts of the system have pulled together to respond to the pandemic. The Carers Support Service worked with the Council to create a joint LBR/RCSS letter to confirm the status of a carer for priority access to shopping, at a time when this was an area in which many carers were experiencing difficulties. This improved communication, however, was not the experience of all agencies. One voluntary sector organisation reported "social workers simply 'logging out' of telephone systems and either not providing mobile numbers or mobile phones being often unanswered." There has been a longstanding request from the voluntary sector for the creation of a streamlined Safeguarding Referral Form, simplifying referral pathways and giving clear guidance for referrers on the information that should be included. Following consultation with potential referrers, such a referral form is now in place, and has been much welcomed. However, voluntary sector agencies still report too often that they do not 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.

Voluntary sector agencies have also reported stronger links and co-operation within the sector as one impact of the pandemic response. Healthwatch Redbridge report:

> "Collaboration between partner agencies has been a positive outcome of the pandemic. Voluntary organisations have shared limited resources in new and innovative ways. We have worked with organisations to plan services, such as the possibility of sharing staff if the need arose."

The Redbridge Carers Support Service valued the support of Redbridge CVS in recruiting volunteers for their Carers Online Project.

A concluding note

While nothing can mitigate the damage and loss that so many have suffered from the pandemic, there has also been important learning. Perhaps this can be summarised in a contribution from the CCG to this report:

> "The crisis response has broken down longstanding barriers between different health and care settings and functions. For those concerned by the fragmentation of services, this could be considered the greatest gain of all. We now have an opportunity to redesign services around user journeys rather than top-down reorganisations. It has demonstrated the need for all organisations to be more agile and flexible, have more resilience with fewer single points of failure, and harness the understanding of what motivates the frontline and engages the public. Values of selflessness, care for colleagues, creativity, and kindness have shone through and was demonstrated by staff in all agencies."

It cannot be over-emphasised that this has been gained at an enormous cost borne by staff across all agencies. This has been reported by all partners, and no one agency should be picked out as particularly affected. However, the comments made in a report to the Board in April 2021 from NELFT Adult Mental Health Services might stand for all:

> "The performance of staff during the pandemic has been impressive…. Staff have shown themselves to be flexible by stepping up to adapt to new ways of working, whilst arguably placing themselves at risk, delivering front line services. As with all people in our communities they have also faced high levels of stress on a personal level through their own loss of family and loved ones, as well as seeing the effects on service users and colleagues, who have also been lost to Covid 19 during the pandemic.
>
> There are concerns that staff are showing signs of burnout. For some their own mental health will be 'very fragile'. NELFT and LBR have ensured that there has been good emotional, psychological and practical support for our staff during the pandemic, which has been well received and effective. This has probably been the most challenging year of staff's professional and personal lives.
>
> Fatigue is now becoming a major problem, as the need to provide services has been continual and the background stress that we are all facing during the pandemic is equally felt by front line NHS and social care staff too.
>
> Staff are helping their service users cope with stress, anxiety and sometimes loss, while also managing their personal stresses relating to those same issues.

In these unprecedented times, staff have reported feeling helpless, while they are present and validate what the service user is experiencing; they themselves are going through the same feelings and emotions.

Staff have continued to serve the people of Redbridge throughout the pandemic and will continue to do so as it eases."

Staff in statutory agencies have consistently spoken positively of the support they have received from colleagues, managers, their organisations, and the counselling and other services that have been made available to them. Voluntary sector colleagues, however, have questioned whether the same level of support, from outside of the resources of their own agency, has always been available to their staff. Given the crucial role of the voluntary sector in a crisis on the scale of the Covid 19 pandemic, and the demands placed upon their staff and volunteers, this is a question to which the system and the partnership may need to pay more attention.

3. Safeguarding activity and outcomes 2020/21

Local authority safeguarding activity data is collated in an annual return, the Safeguarding Adults Collection, to NHS Digital. In 2020/21, 1272 safeguarding concerns were reported as raised with the local authority. This is a 40% increase on the number of concerns raised in 2019/20, and the highest figure since at least 2010/11. However, only 38% of the concerns raised were judged, when further information was gathered, to meet the threshold that triggered a safeguarding enquiry to determine action that needed to be taken to protect the individual concerned: 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. The number of safeguarding enquiries undertaken in 2020/21 actually fell by 9% compared to 2019/20, from 535 to 489.

On the face of it, this data is very striking – a 40% increase in the number of safeguarding concerns raised, and a 9% fall in the number of safeguarding enquiries undertaken. The unprecedented context of delivering an adult safeguarding service in the eye of a pandemic storm mean great caution must be exercised in analysing this data. 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. This conversion rate has historically been around 70%, compared to most recently (2019/20) 37% in England as a whole. It fell in 2019/20 to 59%. It is possible that the further fall in 2020/21 to 38% reflects continuing management attention to ensuring that potentially intrusive or distressing enquiries are not undertaken unnecessarily, supported by continuing dissemination of the 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). It may also be that the sharp rise in the number of concerns reflects high levels of anxiety for the welfare of vulnerable adults during the pandemic. It will be important to scrutinise emerging 2020/21 data to seek to identify whether the rise in concerns and the fall in the conversion rate reflect a continuing trend or an exceptional response to an exceptional situation.

ADASS and the Local Government Association have published two reports on adult safeguarding activity during the pandemic - the Covid-19 Adult Safeguarding Insight Project. The reports were based on a voluntary data return from around two thirds of English local authorities. The first report covered the period to June 2020, including the first national lockdown. The second includes data up to December 2020. Both reports give an invaluable and detailed insight into the national experience of adult safeguarding during the pandemic. While the data shows great variation between individual local authorities, the picture painted by the Redbridge data is broadly similar to this wider picture, although both the increase in the number of concerns raised and the fall in the number of enquiries undertaken appears

to be sharper in Redbridge than elsewhere. Authorities providing data to the Insight Project reported a sharp decline in the number of safeguarding concerns raised as lockdowns started, followed by steep increases as lockdowns ended, often sustained to the end of the lockdown period. Although the number of concerns raised in Redbridge over the year as a whole went up by 40%, they fell by around 10% in the first three months – April to June 2020. Authorities in the Insight Project also reported receiving a high level of safeguarding concerns regarding adults who did not have care and support needs. Although the NHS digital data for 2020/21 has not yet been published, this might suggest that a fall in the national conversion rate could be anticipated.

The converse of the data on concerns and enquiries reported above, of course, is that in 62% of the cases where concerns were raised – 783 cases of concern – a safeguarding enquiry was not initiated. This does not mean, of course, that no response was needed to safeguard and ensure the welfare of those individuals. The local authority should not simply 'walk away' once it has determined that the criteria for a safeguarding enquiry are not met. An assessment of need under the Care Act, linking the individual in with community sources of support, the provision of advice and information and other forms of signposting may be required. We do not have any data on what happened in the 783 cases which were judged not to require a safeguarding enquiry, or what the outcomes for those individuals were. This is a significant gap in the data. This does not imply that the appropriate responses were not made, or that the outcomes were not good. We simply do not know.

In terms of the increase in safeguarding concerns raised, BHRUT data shows a similar picture. 1056 concerns were raised by Trust staff with the relevant local authorities – almost twice the number raised in 2019/20. 141 of the concerns raised (13%) were about Redbridge residents. Overall, the number of concerns rose steadily in the first four months of the year, coinciding with the period of the first national lockdown, and peaked in July as that lockdown came to an end. Thereafter it fell back month by month to the end of the year, back to the usual expected levels. However, the vast majority of the concerns raised were not assessed by the local authority concerned to meet the threshold for an enquiry under adult safeguarding procedures. 44% of the concerns raised related to "emotional / psychological concerns', compared to only 7% in 2019/20 – in terms of numbers, a twelvefold increase. This data demonstrates very clearly the impact of the pandemic and the experience of lockdown. There was a dramatic decrease in the number of safeguarding concerns raised relating to community acquired pressure ulcers – 19 in 2020/21, compared to 145 in 2019/20. This may reflect an increased understanding amongst front line staff that not all pressure damage is due to neglect or acts of omission. Conversely, 94 safeguarding concerns were raised by BHRUT related to domestic abuse, compared to 61 in 2019/20.

The Trust was asked to undertake a total of 72 safeguarding enquiries by local authorities relating to practice within the hospital, compared to 104 in 2019/20. The great majority of these enquiries came from Havering. Only five related to Redbridge residents. 22 of the concerns were found to be substantiated or partially substantiated. The majority of these related to poor discharge planning and liaison - not excused by, but understandable in relation to, the huge impact of the pandemic on hospital services and inpatient flow.

The number of enquiries to the NELFT Safeguarding Adults Advice was very similar to that in 2019/20 – 3426 compared to 3412. Within this total, the NELFT Annual Safeguarding Report notes a "particular increase" in enquiries from staff concerned about domestic abuse.

Sunflower Court, Goodmayes

Towards the end of 2020, the local authority safeguarding service were made aware of a number of safeguarding concerns that had arisen at Sunflower Court, the NELFT inpatient mental health facility at Goodmayes Hospital. Although NELFT had investigated and where necessary taken action on all these incidents, it became clear that there was confusion about the requirement to report them as safeguarding concerns to the local authority and the management of those concerns once reported. As a result, the data submitted to NHS Digital, and discussed above, did not include all the safeguarding concerns that had arisen at Sunflower Court, or the safeguarding enquiries undertaken. Intensive work undertaken between the Council's Head of Adult Safeguarding and senior staff in NELFT has subsequently revised and clarified these processes.

The incidents of particular concern were three serious allegations by patients of assault by staff, and a number of allegations of sexual assault of patients by a student nurse, currently being pursued through the criminal justice system. In response, and with the engagement of partner organisations and the Care Quality Commission, NELFT implemented an extensive Quality Transformation Plan, as well as a range of disciplinary investigations and actions. The Plan has included (this is by no means a comprehensive itemisation):

- An urgent external review of the quality of care at Sunflower Court. Initial themes identified included patient and staff safety, violence and aggression levels on the wards, poor record keeping and leadership development needs.
- Large scale redeployment of staff to create fresh teams with new cultures
- The full-time deployment of a Named Safeguarding Professional on site
- Daily weekday visits to wards by two MIND advocates to encourage patients to voice concerns
- An increase in out of hours support to wards, including leadership and senior management presence
- Intensive work to promote a Speak Up culture for both patients and staff through a range of approaches
- Resources allocated to improve the environment and transparency of behaviour, including the introduction of a new CCTV system and a pilot of body worn cameras

There is initial evidence of improvement, including reductions in patient to patient aggression and in the use of restraint. Progress against the plan is regularly monitored at the most senior level in NELFT, and will continue to be closely monitored by the Safeguarding Adults Board throughout 2021/22. The Care Quality Commission, as the regulator, are also closely engaged.

It is clear, from the seriousness with which NELFT has taken the concerns, that what came to light during 2020/21 was a major issue about safety and quality of care at Sunflower Court. This had not however surfaced through the use of safeguarding adults' processes, as

it should have done. Indeed, with hindsight, the low level of safeguarding concerns being raised from such a unit, particularly in relation to patient on patient aggression, should have raised alarm bells. This is crucial learning for the future.

Safeguarding enquiries undertaken by or on behalf of the local authority

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: 45% of all enquiries started in 2020/21 concerned people aged 18 to 64, compared to 40% in 2019/20 and 2018/19 and 32% in 2017/18.

In 2020/21 55% of individuals who were subject to safeguarding enquiries were white, compared to 60% in 2019/20, 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. 55% of safeguarding enquiries relate to people aged 65 and over. The most recent population estimate is that 59% of the borough's 65+ population are white.

50% of safeguarding enquiries undertaken related to potential abuse or neglect in the service user's home, compared to 52% in 2019/20. This contrasts with the findings of the Insight Project report, which identified a significant increase in the number of Section 42 enquiries with the risk located in the individual's home during the pandemic. In 27% of enquiries in 2020/21, the location of risk was a care or nursing home, compared to 30% in 2018/19 and 30% in 2017/18. Across all settings, service providers were identified as the source of risk in 39% of enquiries in 2019/20, compared to 41% in 2019/20. The highest number of allegations that led to a safeguarding enquiry were against private service providers – 43% - followed by allegations against a relative or carer at 17%.

One of the "red" risks identified at the beginning of the pandemic was an increase in self-neglect, potentially associated with a reduced risk of identifying it. This was seen as an inherent risk with increased isolation and reduced professional and community contact. However, the risk, at least in terms of identified cases, did not appear to materialise. Through lockdown and for the year as a whole, the number of safeguarding enquiries as a result of a concern about self-neglect remained stable: 40 in total in 2020/21 compared to 43 in 2019/20. Awareness of the risk, however, was high. 50% of the concerns raised with the BHRUT safeguarding service in the first two months of lockdown were about self-neglect. Over the year as a whole, 258 safeguarding concerns relating to self-neglect (24% of the total) were raised by BHRUT, compared to 129 (23% of the total) in 2019/20. Community nursing staff also reported an increased number of concerns about self-neglect.

In 74% of safeguarding enquiries, risks were identified and action taken. This is a slightly higher percentage than that for England as a whole (70%) – 2019/20 data.

No referrals were made to the Disclosure and Barring Service, which exists to ensure that unsuitable people are prevented from working with vulnerable adults or children, in 2019/20 or 2020/21 following a safeguarding enquiry. Given that 34 cases in 2020/21 resulted in

criminal prosecution, police action, removal from a property or service, or disciplinary action, this is potentially a cause of some concern. It may be that employers and voluntary agencies are not always sufficiently aware of the DBS and the requirement to refer to it in certain circumstances. The Safeguarding Adults Board has taken action to raise awareness among all partners.

Making Safeguarding Personal

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. 64% of the adults at risk involved in safeguarding enquiries in Redbridge were asked what their desired outcomes were, and desired outcomes were expressed in 59% of cases. This is a decline in performance from 2019/20, when 77% of subjects were asked about their desired outcomes, and outcomes were expressed in 66% of cases. This may reflect some of the difficulties of engagement with very vulnerable people in a period when the great majority of safeguarding activity was carried out by telephone or video calls. For those who expressed desired outcomes 88% of those outcomes were fully or partially achieved.

Conversely, however, there was a marked increase in participation by family members in safeguarding strategy meetings and case conferences. This is likely to reflect the opposite impact of a reliance on online engagement – that, for people with access to and confidence in using the necessary technology, ease of participation may well be increased.

Deprivation of Liberty Safeguards

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.

807 Deprivation of Liberty Safeguards (DoLS) applications were received by LB Redbridge in 2020/21, compared to 815 in 2019/20. 73% of the applications received during the year were completed by 31 March. Of the completed applications, 83% were "not granted". Overwhelmingly, this was because the subject of the application sadly died before consideration of the application was completed – a clear impact of the Covid pandemic. 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, 98 applications were granted during the year. At 31 March, 98 were awaiting authorisation, 72 were awaiting scrutiny, 18 were awaiting allocation, and 33 had been allocated for assessment but assessments had not yet taken place. Although temporary arrangements were made in the second half of the year to increase the capacity to deal with DoLS authorisations, the

backlog of applications awaiting completion on 31 March 2021 was almost identical to that on 31st March 2020. While full account must be taken of the enormous impact on workload pressures of the pandemic, it remained the case, as in previous years, that it was not possible to meet either demand or statutory obligations.

The number of DoLS applications made by BHRUT, across all sites, continued a year on year rise, from 1,832 in 2019/20 to 1,921 in 2020/21. However, the number of applications to Redbridge fell by around 10%. There was a fall in DoLS applications in the first quarter of the year. Department of Health Guidance issued in April 2020 on the application of DoLS during the pandemic stated:

> 'Where life-saving treatment is being provided, including for the treatment of COVID-19, then the person will not be deprived of liberty as long as the treatment is the same as would normally be given to any person without a mental disorder. The DoLS will therefore not apply'.

This meant that the number of patients where it was appropriate to make a DoLS application was reduced.

BHRUT note in their contribution to this report:

> "The main reason for a DoLS being authorised was for close supervision. During 2020/21 the main reason for close supervision may be attributed to family/carers not being able to visit and spend time with service users while they were an inpatient as visiting restrictions were put in place due to the COVID-19 pandemic; in addition there was also an increase in patients suffering with mental health issues that used Trust services noted during this time period and may have required 1:1 supervision."

Following a trend of year on year decline, the number of DoLS applications made by NELFT in 2020/21 increased, from 74 applications in 2019/20 to 178 in 2020/21. 15 of those applications were made to Redbridge.

Under the Mental Capacity (Amendment) Act 2019, the Deprivation of Liberty Safeguards will be replaced by the Liberty Protection Safeguards. This will relieve some of the pressure on local authorities, as under the LPS hospital managers will be able to authorise applications. However, there have been very significant delays at central government level in the necessary preparations for the implementation of LPS, even before the pandemic, and there is concern in the sector about the feasibility of implementation at the revised target date of April 2022.

4. Safeguarding training 2020/21

The restrictions created by the Covid pandemic meant that all training during the year under review moved to online delivery. A range of safeguarding training continued to be delivered within the integrated health and adult social care service (HASS) in 2020/2:

- Safeguarding Adults Awareness
- Safeguarding: The Legal Context
- Safeguarding Adults Manager Training
- Safeguarding: Chairing Meetings and Decision Making
- Safeguarding: Self Neglect and Hoarding

Significantly fewer places were available than in 20i9/20: 116 compared to 258). Take up of the available places was much higher, with 81% of places taken up compared to 47% in 2019-20. However, this still meant that in total there were only 94 attendees at LBR safeguarding training in 2020/21, compared to 120 in the year before. A small number of attendees from partner organisations were recorded.

We commented in the Annual Report for 2019/20 on the very low level of adult safeguarding training available in Redbridge, compared to the scale of training available to the safeguarding children workforce. This contrast was even starker in 2020/21. There were 620 attendances at training courses delivered by the Redbridge Safeguarding Children Partnership during the year, at 56 separate events.

It should be noted, in considering the volume of training available and taken up, that in 2020/21 training on the Mental Capacity Act and the Deprivation of Liberty Safeguards was available through a modular training programme developed by the Social Care Institute for Excellence and delivered via webinar. This was promoted throughout the HASS as part of the online "learn without boundaries" programme developed in response to the loss of in-person training. Once the webinar series finished, the training continued to be promoted as recorded webinars. However, it not been possible to determine how many staff completed these modules.

Very limited feedback is available from participants on the online training received, as there has been an inconsistent rate of return of the feedback forms distributed with the calendar invitations and links to the training. It can be noted, however, that that all the feedback that was received was positive about the training experience. Similarly, there was no quality assurance and training evaluation conducted in 2020/21.

We have noted in previous Annual Reports that the Redbridge SAB has never had the capacity to promote or deliver the multi-agency training which is identified in the statutory guidance to the Care Act 2014 as one of its core functions. This remained the case in 2020/21. The improvement in funding for the SAB, referred to earlier in this report, should allow some modest activity in this area, and this will be very welcome.

All NHS organisations have training targets for different levels of safeguarding training. BHRUT significantly exceeded the 90% compliance target at all levels, with compliance rates at between 98.4% and 100% - improving again on the previous year's very strong

performance. A programme of additional training on the Mental Capacity Act and the Deprivation of Liberty Safeguards designed to enhance staff knowledge was initiated across both hospital sites following concerns raised about staff knowledge in this area during a CQC inspection which took place in Q4 2019/20. While the initiation and delivery of this training was heavily disrupted by the extraordinary pressures of the Covid pandemic, 8 of the planned 14 sessions were delivered, and the programme will continue into 2021/22. The NELFT Annual Safeguarding Report confirms that "safeguarding training has remained available" and has been delivered via agreed Health Education England online training packages, but does not include data on compliance rates. The report describes the increase in Deprivation of Liberty Safeguards applications, from 74 in 2019/20 to 178 in 2020/21, and attributes this to the training delivered by the Named Professional for Safeguarding Adults with the MCA lead.

5. Safeguarding Adults Board Action Plan 2020/21: actions, progress, and outcomes

The Board's Action Plan for 2020/21 identified six priority areas for action. Inevitably, however, the demands of the Covid pandemic meant that is was difficult to progress many of the intended actions, as for the greater part of the year resources had to be concentrated on the response to those demands. The Department of Health and Social Care wrote to all Boards in May 2020 to acknowledge that the unique challenges of the pandemic might mean that annual plans needed to be delayed or streamlined.

Priority One: Ensuring the effective safeguarding of adults during the coronavirus pandemic

This priority dominated the Board's work in 2020/21. At the beginning of the year, senior leaders from across the partnership met to agree a multi-agency safeguarding risk register, identifying key safeguarding risks to vulnerable adults during the pandemic, the actions in place to mitigate those risks, and potential further steps that could be taken to mitigate them further. Throughout the year, the Board prioritised at each meeting a review of risks, demand, emerging needs, and agency responses. The issues that emerged and were addressed are discussed in detail in Section 2 of this report.

Priority Two: Transitional safeguarding

This priority was carried forward from work begun in 2019/20. The Board is committed to developing proposals, jointly with the Redbridge Safeguarding Children Partnership, 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. It was not possible to progress this work in 2020/21, but the Board is committed to taking it forward in 2021/22.

Priority Three: Hearing the voice of the service user

A number of actions were planned to enable the Board to develop effective ways of hearing, understanding and acting on the voice of individuals who experience safeguarding interventions. Again, the capacity to progress these actions was limited by the extraordinary circumstances of the year. In January 2021, the Board discussed a report from Voiceability, contracted to provide advocacy services in Redbridge, on some of the feedback they have received from service users. It was stressed that this was anecdotal feedback, and drawn from feedback across a number of local authorities with whom Voiceability work, rather than specific to Redbridge. It was, however, very useful in opening up questions for local exploration. Feedback included:

- The circumstances in which advocacy should be considered and requested when a safeguarding enquiry is triggered need to be better understood.
- There is little evidence of desired outcomes being discussed or shared early in the interventions with service users
- Formats and channels for people to get information about the safeguarding process are unclear.
- Information needs to be appropriately adapted for people with neurodiversity.

- In nearly all cases the abuse was reported by a third party. It was unclear what support had been given to the service user to report the abuse.
- Service users do not always understand the role of everyone involved.
- Advocacy is too often seen by professionals as something that will hamper effective safeguarding, rather than as something that will support it.
- Advocacy is even more important during a period of 'virtual' delivery.

In 2020/22 the Board will undertake a small quantitative survey of service users with experience of the safeguarding process in Redbridge, to learn for that experience and inform the improvement of practice.

We commented in the Annual Report for 2019/20 on the very low rate of advocacy in the safeguarding process in Redbridge, with only 5.4% of safeguarding enquiries involving a referral for advocacy. The rate remained low in 2020/21. One of the Board's priorities for 2021/22 is to promote the use of advocacy.

In October 2020, two lay members were recruited to the Board. Their contributions have been invaluable in bringing a community perspective to discussions which can be dominated by professionals.

Priority Four: Police engagement with adult safeguarding arrangements in Redbridge

In November 2020, the Board received a presentation on the East Area BCU Safeguarding Strategy. This is organised around three priorities: a victim-focused approach; tackling offenders; and supporting and developing staff. Under each priority, the strategy identifies a range of mechanisms and processes through which the priority is to be delivered. The strategy also includes specific quantitative success measures and targets in relation to domestic abuse, rape, and hate crime.

The Board welcomed the presentation but was keen to have an opportunity to assess its impact in practice. The Head of Public Protection agreed to report back to the Board on the impact of the strategy in a year's time.

The Board was keen to gain assurance on the effectiveness and consistency of police engagement with adult safeguarding arrangements in Redbridge, particularly in the light of the report of the national inspection of the police and CPS response to crimes against older people published by the Justice Inspectorates in July 2019 – The Poor Relation: the Police and CPS Response to Crimes Against People. This report had included an assessment of the effectiveness and consistency of police engagement with adult safeguarding arrangements in the areas inspected, and described 'a bleak picture of the state, resourcing and effectiveness of these arrangements'. The Head of Public Protection in the East Area BCU presented a comprehensive report to the Board in April 2021, outlining both the Met-wide and local response to the report. A number of improvements had taken place or were planned:

- A review of the way in which police officers and staff recognise and respond to vulnerability was undertaken and as a consequence new processes and guidance had been published for staff.

- The MERLILN system which captures this information has (for the first time) a clearly defined set of operating principles and this is monitored on a regular basis to ensure that adults (and others at risk) are provided with the appropriate help and support.
- A force wide communications plan was to be launched in May to highlight the vulnerabilities of adults and would continue throughout the year.
- Planned changes to what was described as an 'antiquated' IT system were expected to facilitate better recognition and recording of vulnerability and safeguarding needs.

However, on the fundamental question – how well do front line officers understand when they should recognise a safeguarding concern, and what they should do about it? – both the report and the discussion recognised there is much more to do. The Board recommended that the recent guidance from the Association of Directors of Social Services on "Understanding what Constitutes a Safeguarding Concern" should be actively promoted throughout the BCU. It also welcomed an initiative from the Kingston SAB, who have produced a single sheet learning tool for dissemination to front line police officers which highlights the definition of a safeguarding concern, police responsibilities for recognising and reporting adult safeguarding concerns, and some of the legal powers available to them which are relevant to action in relation to safeguarding. The Board agreed to pursue the application of this imitative within the East BCU.

Priority Five: Increasing the capacity of the Board

Action on this priority was dependent on progress on the historic under-resourcing of the Board. Previous Annual Reports have consistently noted that "The Redbridge SAB should be doing much more than we are in terms of scrutinising performance, quality assuring practice, developing multi-agency training, and delivering concrete actions to improve adult safeguarding across the partnership." The agreement, in late 2020, of a £30,000 annual contribution from the CCG to support the Board should finally enable some progress in these areas in 2021/22.

Priority Six: Strengthening mutual challenge and accountability

The Board has continued to promote in its work a culture of constructive challenge and scrutiny, and has sought to reflect this culture in the preparation of this report. It had planned to hold a Development and Challenge Day in the fourth quarter the year under review. However, this was the time when the second wave of the pandemic was at its height. Regrettably, this commitment had to be postponed, as it had been in March 2020 in the first wave.

6. Safeguarding Adults Reviews 2020/21: lessons learned and action taken

Redbridge SAB published two Safeguarding Adults Reviews in 2020/21. The full reports are available on the Redbridge Safeguarding Adults Board website.

Alice

The review was published in November 2021. Alice was a white British care experienced young person, who took her own life in July 2018. She had only lived in Redbridge for the last four weeks of her life, having moved into a supported living placement from a placement in another borough. Both as a care leaver and as a young person with serious mental health issues, the responsibility for her care rested with the London Borough of Wandsworth, and had done since she first came into care at the age of ten. The Redbridge SAB agreed to conduct the review on the basis that she had been resident in Redbridge at the time of her death, but she was not at any time in receipt of any services provided by a Redbridge agency, and the findings of the review included no specific learning for the Redbridge partnership. However, the Board felt strongly that the review contained learning for all safeguarding adult and safeguarding children partnerships across London and nationally, and took steps to disseminate the report as widely as possible.

Alice had a complex and difficult early life, suffering parental neglect. She was in the care of LB Wandsworth from the age of ten to the age of eighteen. She was variously diagnosed with a mild learning disability, autism spectrum concerns (ASC), attention deficit disorder hyperactive disorder (ADHD) and early indicators of an unstable personality disorder. She also experienced sexual assault and sexual exploitation. As she moved into adulthood, it was recognised that she would need a specialist placement to address her complex needs. With no such placement being available, she moved back to live with her mother, with little support or work done to seek to repair their extremely damaged relationship. This arrangement broke down within seven months. In a crisis, she moved to an emergency placement in a supported living setting in Newham. Over the next four years, she lived in four different supported living placements, had nine admissions to psychiatric inpatient care for periods of between ten days and three months, and spent three and a half months in an alcohol rehabilitation unit in Gloucestershire, which she was asked to leave before the completion of the programme. Throughout this period her behaviour was characterised by alcohol and drug misuse, suicidal ideation, and increasingly dramatic incidences of self-harm. There was a lack of clarity about her mental health needs that continued over time; she was both labelled with a personality disorder, but also often described as having no underlying mental health disorder. There were various care plans developed by all the agencies Alice came into contact with, but none of these were coordinated and the lack of a complex response to complex needs contributed to a sense of chaos in service delivery which echoed the chaotic nature of Alice's circumstances. There were complex and chaotic transfer arrangements which meant there were no connections made between the relationships in one placement to another and the understanding of Alice's needs was lost. She died from a drug overdose at the age of 23

The review found a number of systemic failures in Alice's care, which the authors believed were indicative of wider weaknesses which went far beyond the individual agencies and local systems involved with Alice. These were summarised as:

- Work with children living in or leaving care does not sufficiently prioritise working with them and their birth families to address the complex relationships between them, in anticipation of their transition to adulthood. Without this, the corporate parent risks leaving the child burdened with the responsibility for understanding the reasons they originally came into care. In addition, the corporate parent effectively abandons some care experienced young people to further crises and rejection when they do return home, compounding their trauma and escalating their distressed behaviours including self-harm.
- Local authority processes for transition planning and support for young people leaving care are not set up to differentiate the level of seriousness of a young person's circumstances, based on an evaluation of factors known to increase vulnerability. This means that pathway plans are usually not adequate for complex cases where the young person needs a coherent, integrated plan across a range of adult services. This increases the chances that the most vulnerable young people end up catapulted into adulthood, with a range of disparate and ineffective care plans across agencies, that do not address the seriousness of their circumstances, with no social worker from adult social care involved and no routes for escalation to the corporate parent despite the desperate circumstances of their young charge.
- For young people with diagnoses of autism and co-occurring conditions, including emerging personality disorder, whose distressed behaviours of concern manifest in drug misuse, self-harm and attempts to take their own lives, there is often a mismatch between the seriousness of their situation, and the response from mental health services. This leaves young people without any experience of being understood, and unqualified supported living staff trying but failing to provide the necessary support for young people who have a history of parental neglect, sexual abuse and sexual exploitation, and re-abuse created by crises driven responses by services.
- The absence of functioning local authority leaving care processes for complex cases (Finding 2) and/or effective mental health interventions creates fertile ground for routine victim blaming, that sees young women with unregulated emotional behaviour including violence to others and property, drug and alcohol misuse, and concerted self-harm, held individually accountable for their behaviours. This risks inadvertently blaming the young women concerned, when a trauma-informed approach that acknowledges the history of parental neglect, sexual abuse and sexual exploitation, and re-abuse created by crisis driven responses by services, is more appropriate. It creates the conditions where awful self-harm, and increasingly determined efforts by young women to take their own lives, become normalised.
- For extremely vulnerable young care leavers who experience a pattern of reactive, crisis-led responses, which do not necessarily recognise or meet their needs as vulnerable people, there are inadequate mechanisms to forge a continuity over time.

This risks deepening the young person's sense of being continually rejected, of being unlovable, and being totally alone. It makes it less likely that a holistic life story is pulled together over time, that travels with the young person and includes the legacy of people who liked and cared about them (akin to life story work), or that the young person is helped to build a non-professional support network, including identifying a person beyond their parent(s) who could be more permanent for them.

As previously noted, the Redbridge SAB has an outstanding priority, jointly with the Redbridge Safeguarding Children Partnership, to develop a more effective response to transitional safeguarding, recognising that adolescence as a developmental phase does not suddenly end on the eighteenth birthday. Alice's story vividly illustrates the importance of this. As she entered adulthood, she entered a world in which she was assumed to be fully capable of making her own decisions, and to be held accountable for the consequences of those decisions. The review describes how, on leaving care, she was "catapulted" into adulthood: from this point, she was not seen as a young person on the road to adulthood, but as an adult with full responsibility for herself and her behaviour. One professional recorded this during one of her hospital admissions in this way: "she is able to appreciate her wrongdoing but wilfully chooses to continue along this path".

Given the particular context of this review, it made no findings which were specific to Redbridge. The Board, however, committed to holding a learning event in 2021/22, bringing together local Leaving Care Services, child and adolescent mental health services, and adult mental health services, to ask the question: if Alice had been a Redbridge young person, how sure can we be that her experience would have been different, and what do we need to make sure that her experience would be different?

George

This review was published in February 2021. "George" was a 73-year-old white British man resident in Redbridge. He died in January 2019 whilst an in-patient in an acute hospital in Essex, having been admitted in December 2018 following concerns that a combination of physical and mental health conditions had resulted in significant and sustained weight loss over the preceding 12 months. Following his death, a coronial inquest in January 2020 found the cause of death was starvation, with achalasia, depression and anxiety as secondary causes. Achalasia is a rare disorder of the oesophagus, caused by degeneration of the nerves resulting in failure to contract correctly. The ring of muscle can fail to open to allow food or liquids to pass to the stomach. This can mean food and drink can become stuck and, often, bought back up. Over time, the oesophagus can also become dilated.

George had both serious physical health problems and mental health difficulties. In the last six months of his life he had two admissions to inpatient psychiatric care, as well as two emergency presentations in A&E with concern about his mental health. Throughout this period, he was monitored and supported by the Older Adults Mental Health team in Redbridge. The review found that while the relevant specialists paid attention to George's physical health needs, and mental health services focused on his mental health needs, there was no co-ordination between the specialisms and shared risk management, and as a result George's complex needs were never addressed in a holistic and integrated way.

Assessments were conducted to ascertain if George met operational service 'thresholds' and care was focused on addressing the immediate risk. Where issues were identified, this was managed by onward referrals rather than any form of joint working. Even within specialisms, co-ordination was poor: a number of different mental health services were involved, in two different hospital trusts and in the community, and the review describes mental health support as "particularly fragmented and insular".

The review made a number of recommendations for both immediate and longer-term action. It recommended that the Redbridge SAB Self Neglect and Hoarding Protocol be reviewed, to include explicit reference to risks associated with a person's inability to maintain compliance with medical treatment or care plans, and the adoption of a Malnutrition Universal Screening Tool. This recommendation was actioned and completed immediately. The SAB was recommended to seek assurances from the Clinical Commissioning Group and health providers on a number of issues, and this is ongoing. An audit of the quality of mental capacity assessments – an issue in George's case – is scheduled in the SAB's work programme for 2021/22. The review also recommended action to raise professional awareness of the legal obligation to actively consider advocacy duties in relation to practice under the Care Act, Mental Health Act, and Mental Capacity Act. This is also planned, in partnership with Voiceability, the commissioned advocacy provider, as part of the 2021/22 work programme. A multi-agency, multi-professional working group has been brought together to the final to explore, in line with the final recommendation of the review, what help is available to proactively support those with co-morbidity conditions to navigate the complex health and care systems, assist with engagement and reduce the likelihood of self-neglect or organisational disconnect. However, it has not yet been possible, within the capacity of the SAB and partner agencies, to progress other recommendations relating to ongoing quality assurance of practice standards and a full programme of multi-agency training across primary and secondary health care and social care.