Redbridge Safeguarding Adults Board

Redbridge Safeguarding Adult Board (RSAB)
Annual Report
2021 - 2022

Safeguarding Adults – Working to Keep People Safe

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Introducing our 2021-2022 Annual Report

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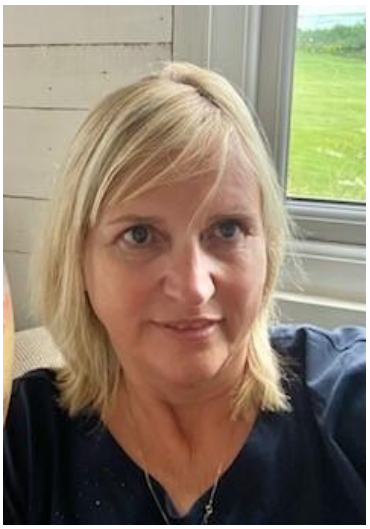


Each year the Board's annual report identifies progress made over the past 12 months against the intentions laid out in the strategic plan and sets out the work programme for the next 12 months. As this is my first annual report, I have reflected on the progress the Safeguarding Adults Board (SAB) has made over the past year through consultation with partners, review of minutes and action plans from the previous 12 months.

As the incoming Chair, I would like on behalf of the Redbridge Safeguarding Adults Board, to express our thanks to the retired Chair, John Goldup, for the commitment and leadership of the SAB through this reporting period and the years before.

At the start of the year the RSAB priority was to monitor and support multi-agency planning for recovery from the COVID-19 pandemic, as we all know the perceived recovery faltered with the impact of new variants and subsequent prolonged the "working with" Covid period.

It is commendable that partnership working in safeguarding and delivery of the Board responsibilities under the Care Act 2014 continued during these challenging times. Partners engagement in Board and Subgroup meetings despite pressure did not falter.

Over the last year, partners identified to the RSAB the ongoing close working relationships between health and social care, and mobilisation of the voluntary sector in response to the pandemic. They have developed new ways of working, innovations and flexible service delivery using 'virtual platforms"- not only to ensure continuity of service but ensuring ongoing delivery of safeguarding training and the development of the multi-agency referral form for safeguarding adult referrals.

Partners however reported that towards the end of year staff were fatigued due to the prolonged and ongoing response to the pandemic. Partners provided assurance and shared resources available to support staff wellbeing through these difficult times. The pandemic has increased complexity and acuity of needs of service users, but also more residents needing help and support. Data identifies that pre pandemic safeguarding notifications to LBR totalled 881 for period 2018-19, the number for the end of this reporting period are 1442. There has been a year-on-year increase in demand. Healthwatch reported increased numbers of people needing signposting, particularly in accessing

services such as health. The use of digital technology to respond to challenges of the pandemic, has created some inequalities for those who are digitally excluded and struggle with telephone appointment systems. Although more and more services are now becoming face to face, the increased use of technology is likely to remain and services need to remain mindful of those services users including older or disabled patients, and those from ethnic minority communities who are disadvantaged digitally and will require support to access the services they need.

Through review of the RSAB activity over the 2021-22 period it is evident that there is strong working across many multi-agency strategic partnerships in Redbridge. It is essential that this work continues to keep safeguarding central to all activity to ensure the health, wellbeing, and safety of Redbridge residents, at a time where there is significant reorganisation across the health and care sector in response to the Health and Care Act 2022.

An additional challenge brought in by the Health and Care Act 2022 is the introduction of the regulation of local authority functions relating to adult social care by the CQC, which will require preparedness when the framework is announced. The RSAB needs to reflect on the data it currently gathers for assurance of effective multiagency safeguarding arrangements to support the evidence required for any inspection and implementation of the new Liberty Protection Safeguards (LPS), replacing Deprivation of Liberty Safeguards (DOLs), within its current capacity.

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

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

In conclusion, I would like to take this opportunity to register my thanks to colleagues for extending me a warm welcome, especially the Board Manager and team in supporting my induction to Redbridge.

Warmest regards

Eileen Mills

Independent Chair

2. What is the Redbridge Safeguarding Adults Board (RSAB)?

The RSAB is a partnership of statutory and non-statutory organisations, representing health, care and support providers and the people who use those services across the borough.

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

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

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

3. Purpose of the Annual Report

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

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

The specific progress against priorities and single agency contribution is included in the next sections.

To fully reflect the work of the RSAB several key lines of enquiry need to be considered.

Key Lines of Enquiry for Safeguarding Adult Boards

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

Findings in response to Key Lines of Enquiry

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

   Through the data set submitted to the SAB it is evident that referrals are made from a variety of settings and the public. The Board has noted those safeguarding referrals are not reflective of the diversity of the population and that more work is required to raise awareness within different communities of Redbridge. 53% of referrals relate to residents who identify as White British. Previously established awareness raising activity had to be stopped due to the restrictions in place through the COVID-19 pandemic but are to be revisited as part of the priority actions for 2022-23.

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

   As highlighted above the RSAB does reflect on the data and use it to support development of priorities, however at the present time this is an annual return so has limitations in proactively supporting the monitoring of trends and themes to support timely responses. A priority for the 2022-23 period is to develop a quarterly multiagency data set to promote better understanding of themes and trends and reflective of current priorities.

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

   The Annual Safeguarding Adult Data return 2021-22 identified in 58% of cases were safeguarding investigations had concluded the relevant person or their representative stated their desired outcome had been met.

   In addition to the data return he RSAB commissioned Health watch to undertake a piece of work and produce a report as part of the priority Hearing the Voice of the Service User. They produced a report (Making Safeguarding Personal: hearing the voice of the service user A report to the Redbridge Safeguarding Adults Board, 2022, which was presented at the April 2022 meeting, the findings of which are contributing to the 2022-23 priorities. The aim was to “hear the voice of service users with experience of the process of being part of safeguarding review, either directly or as a family member, or as an advocate working closely with the service user”. Although the number of respondents was small it did bring out some themes consistent with similar reviews in other areas of the country.

   - Service users had a lack of awareness of safeguarding systems

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

The RSAB recognise there is further work to improve the reporting of outcomes and the experience of service users and are utilising the Healthwatch report to improve the communication and experience of service users. The work prompted a lot of discussion at the RSAB and identified that agencies that make referrals do not always get feedback, it was felt that this was due to increasing demands on adult social care.

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

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

Increasing demand on services is adding additional pressures to teams how this is impacting on their ability to work in a personalised way is not yet evident and should be an area the RSAB considers how it may capture the experience of the frontline.

In order to triangulate impact of Board activity and reporting a series of "Meet the Chair" events have been arranged to gather the view of frontline practitioners in 2022-23.

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

The overriding strategy that can be seen to prevent abuse and neglect is the commitment and passion of all services voluntary and statuary to continue to deliver a service throughout the pandemic.
Not only did agencies adapt to restrictions and create innovative ways of works to ensure as much continuity as possible, but they also sought out the most vulnerable known to them to, as one lay member describes "they (RSAB) made sure no one was left behind".

Although a key legacy from the pandemic is increasing need and complexity, without the actions of RSAB partners this may have been even more severe.

Two specific pieces of preventative work stand out as preventative strategies:

- Rough sleepers work in pandemic – multi-agency outreach to the most marginalised and vulnerable. Despite the lock down there was an offer of face-to-face visits to this highly vulnerable population and provided unique opportunity to directly gauge the risks and make early interventions.
- The recognition and response to increasing rates of Domestic abuse

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

The membership of the RSAB includes Healthwatch Redbridge, Lay Members and community and voluntary services. Healthwatch Redbridge were commissioned to undertake a piece of work to seek feedback from individuals and their families who have been the subject of safeguarding enquiries. This has provided the Board with information to inform an action plan, which is being taken forward.

The RSAB would be strengthened going forward by continuing developments to gather service user feedback to inform its work.

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

There is significant and positive cross membership of the Redbridge Children Safeguarding Partnership (RSCP) and the RSAB; there is joint working through he shared priority of transitional safeguarding. There are links from the Community Safety Partnership, but the RSAB has recognised that the links need to be strengthened further. The CSP, RSAB and RSCP are looking to develop a one panel for reviewing of all statuary reviews under the three remits to share learning and prevent silo working.

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

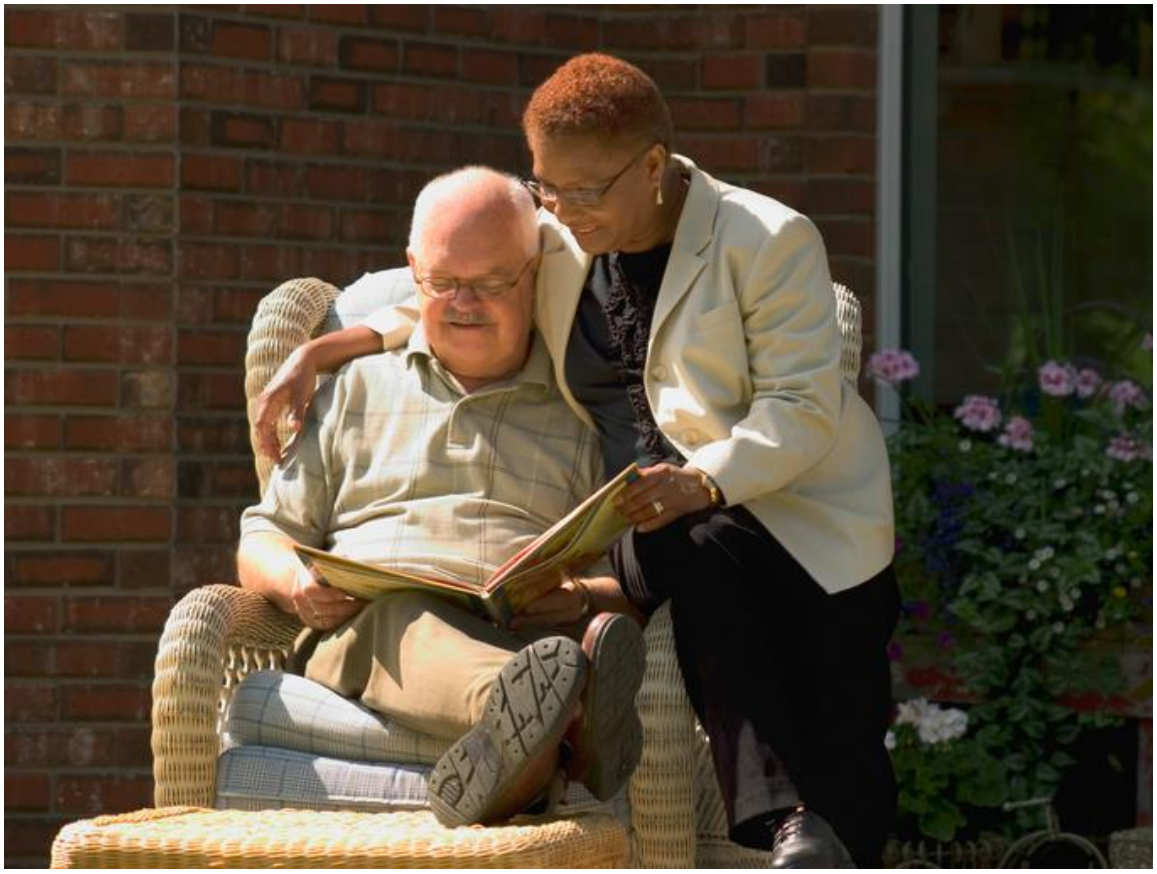
Whilst it is reassuring through feedback from partner agencies to hear that safeguarding adult training continued during the period of the pandemic, due to issues with capacity only limited multi-agency training has been made available. Evidence of impact has been confined to the evaluations (see page 13). There is evidence gathered from training needs analysis, comments made during evaluation and through the Subgroups of a need for additional multi-agency training to ensure that professionals

across Redbridge understand each other's roles and responsibilities and can develop strong working relationships.

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

Over this reporting period there has been strong co-operation and collaboration in response to the pandemic.

There has been regular consistent attendance, with partners sharing challenges and experiences and creating joint solutions. The RSAB also challenge each other to ensure practices align with the principles of adult safeguarding. The use of a COVID-19 safeguarding risk register has helped to focus on the key priorities as a partnership.



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

The priorities agreed for the period 2021 – 2022 were as follows-

- Monitoring and supporting multi-agency planning for recovery from the COVID-19 pandemic
- Transitional safeguarding - completing and implementing work, jointly with the Redbridge Safeguarding Children Partnership (RSCP), to deliver an effective response to the transitional safeguarding of young adults at risk of exploitation
- Hearing the voice of the service user
- Promoting the appropriate use of advocacy in adult safeguarding practice
- Establishing effective mechanisms to assure the Board of the quality and effectiveness of both single and multi-agency safeguarding practice, including implementation of the Safeguarding Adults Partnership Audit Tool (SAPAT)
- Establishing a programme of multi-agency safeguarding training

Response to priorities

Monitoring and supporting multi-agency planning for recovery from the COVID-19 pandemic

The anticipated recovery from the pandemic was impacted due to the emergence of the Omicron variant at the later end of 2021. The RSAB maintained an oversight of the impact on safeguarding and addressed emerging issues as they presented.

- All services provided an update and assurance to the RSAB on a quarterly basis as to how their services responded to the impact of Covid -19.
- Identification of changing trends in safeguarding referrals – increased number of referrals in general but specific increase relating to fraud and scams; self-neglect. As the year progressed those presentations are more complex than pre pandemic.
- Shared recognition of the impact on frontline staff and sharing of resources for support for emotional wellbeing.
- Assurance by October 2021 staff transitioning back to face to working and blended approaches.
- Strong multi-agency action to reduce number of rough sleepers-300 individuals were made safe during the pandemic through the Government's "everyone in" approach

The pandemic is going to have a long-term impact on both the volume of demand and the nature of that demand on all services, both statutory and voluntary. This alongside a very tired workforce where recruitment and retention of staff is more challenging. This must be an ongoing concern of

the Board to ensure services are able to respond in timely and person-centred way to safeguarding concerns. The RSAB priority for 2022-23 is to improve the multiagency data set to support this oversight.

- **Transitional safeguarding - completing and implementing work, jointly with the Redbridge Safeguarding Children Partnership (RSCP), to deliver an effective response to the transitional safeguarding of young adults at risk of exploitation**.

  - Transitional Safeguarding local protocol has been developed
  - Recommending the development of a multi-disciplinary panel
  - The panel will help focus and plan how to work through some of the very complex cases, that don't necessarily meet the criteria of services under the Care Act

The RSAB are maintaining this as a priority for 2022-23 to evaluate the impact of the panel.

- **Hearing the voice of the service user.**
  - The RSAB supported a pan London initiative led by the London SAB and ADASS to hear voices of service users by publicising the opportunity for local safeguarding service users to join the London Safeguarding Voices Group. No individuals have so far been identified but this opportunity continues to be promoted on the RSAB website and via the Safeguarding Adults Network Forum
  - Healthwatch commissioned to gather views of service users who have experienced being part of the safeguarding system.

The findings of the report will be responded to in the 2022-23 priorities

- **Establishing effective mechanisms to assure the Board of the quality and effectiveness of both single and multi-agency safeguarding practice, including implementation of the Safeguarding Adults Partnership Audit Tool (SAPAT).**

  - The Mental Capacity Assessments and Best Interest planned MA audit had to be stepped down due to the capacity of services to participate due to the ongoing impact of the pandemic
  - There was good participation in completion of the SAPAT – with agencies developing their own action plans in response to the self-assessment
  - The RSCB received assurance reports from several agencies including
    - An Assessment of Police Adult Safeguarding Practice at East Area BCU – A response to the **HMICFRS 2019 report 'The Poor Relation'**
    - Progress update on the previous safeguarding concerns relating to Good Mayes hospital
    -

- **Establishing a programme of multi-agency safeguarding training.**
  - Two multi-agency training courses were delivered - Working Together to Safeguard Adults and Self Neglect and Hoarding training facilitated by the LBR Safeguarding Adults Team. Feedback included:

"Being aware to ensure that Home care Providers have measures in place to support an individual with self-neglect and hoarding to reduce the risks."

"This was a valuable insight into trying to engage, e.g. don't rely on "rational" arguments and do use the support from other agencies. The training also helped give confidence to persevere"

"The importance of not working in isolation but rather ensuring that multi-disciplinary working is conducted in all cases"

- An external trainer was commissioned to deliver Safeguarding Adults at Risk of Exploitation training. This course was well evaluated but there was clear evidence of the desire for more in-depth training on each of the different forms of exploitation which is a complex area
- All three of the multi-agency half-day training courses, delivered 'virtually', were well received and whilst there is limited funding available from the RSAB to re-commission, these are being made available to partners that are members of the Redbridge Learning Collaborative in 2022 – 23
- As part of a training needs analysis, the RSAB commissioned a series of one hour Introduction to Safeguarding Adults Briefings, delivered by the Local Authority's Head of Safeguarding Adults, which took place in September, October, November 2021, January, and February 2022. This were open to professionals and volunteers from across all agencies working with families and adults at risk in Redbridge. There was a wide range of agencies represented, including local voluntary and community groups. The Briefings provided those whose daily work may give opportunities for identifying abuse the information they needed in order to spot the signs and make a referral

- **Promoting the appropriate use of advocacy in adult safeguarding practice**

- A number of activities have taken place to raise awareness and increase use of advocacy in safeguarding adults. These include presentations to the Policy & Practice Subgroup and to the local authority HASS managers meeting. The RSAB website now has a dedicated page of information relating to advocacy and guides provided by Voiceability have been circulated widely. Uptake is being monitored via Local Authority Contracts and Commissioning Team. It is acknowledged, however, that this is an area where promotion needs to be sustained and a continued programme of awareness raising implemented partly due to turnover in staff across agencies

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

The RSAB did not commission any Safeguarding Adults Reviews (SARs) in this period. However, the recommendations of the **SAR "George",** which concluded in the period 2020-21, were completed in this review period.

This included the Board's **Multi-Agency Self-Neglect and Hoarding Protocol** being revised in response to a recommendation in that it should include guidance on medication and malnutrition issues.

Learning from SARs undertaken in other local authority areas is routinely shared across agencies, particularly those undertaken in neighbouring Boroughs which are highlighted as part of the BHR Safeguarding Adults meetings which take place quarterly attended by Independent Chairs and Business Managers. The Safeguarding Adults Partnership Audit Tool (SAPAT) did highlight that there was still some room for development in the way in which agencies learn from SARs and other case reviews.

6. The performance of member agencies and how effectively, or otherwise, they are working together

As part of the RSAB quality assurance role, at the end of the reporting period, every agency is asked to complete a Partner Agency Contribution Template. For the period 2021-22 partners were asked to respond to the challenges of safeguarding adults during the COVID-19 pandemic, by answering a series of questions. A total of 25 returns were received from partners.

The following is a summary and evaluation of the responses

a) *The main impacts of the pandemic and associated restrictions from your agency's perspective on your service users?*

Several specific safeguarding risks were identified

- increase in scams targeting older people
- significant increase in Domestic Abuse across the whole of London during the period of the pandemic, driven by being forced to live more closely with their abusers and cut off from sources of support, or the ability to leave the home to report matters to the police in person
- heightened mental health issues for our service users

Services also identified issues relating to service users requiring care and support namely;

- No face-face access to their loved ones during the height of the pandemic
- Because of visiting restrictions difficult to obtain information from care agencies and residential homes and hard to have access to service users in care homes
- Choice of placement for residential and nursing was negatively impacted in order to maintain discharge and throughput from the acute units and at various points by covid-19 outbreaks and the ability for homes and providers to accept new residents or care packages

b) *The impact of providing services during the pandemic been on staff and volunteers.*

- Services overwhelmingly recognise the personal toil that their employees and volunteers have experienced.
- Staff and volunteers during this time have dealt with many challenging and life changing experiences in their personal lives as well as continued requirement to adapt and change service delivery at pace.

- For those services which had to deliver face to face services were supported to work within best practice guidance for infection control however it has created anxiety for staff in managing the unknown.

c) *how has your service/agency responded to these impacts?*
   - A key feature of all return's is the reflection on how flexible services have been in adapting to using alternative methods than face to face contact.
   - That partners have gone above and beyond to ensure service delivery.

d) *what are you particularly proud of in terms of your service's/agency's response, and are there things that with hindsight you think should have been done differently?*

   - Partners are again proud of the resilience and flexibility of their services remaining service user focused.
   - The innovation in use of technology and creativity to engage service users.
   - Agencies acknowledge decisions had to be made apace at times, but a reflection is that ensuring the right stakeholders are engaged in decision-making. This was especially relevant to the care home and residential providers.

e) *Can you give any examples of ways in which multi-agency working has been strengthened during the pandemic, and of any ways in which it could have been better?*

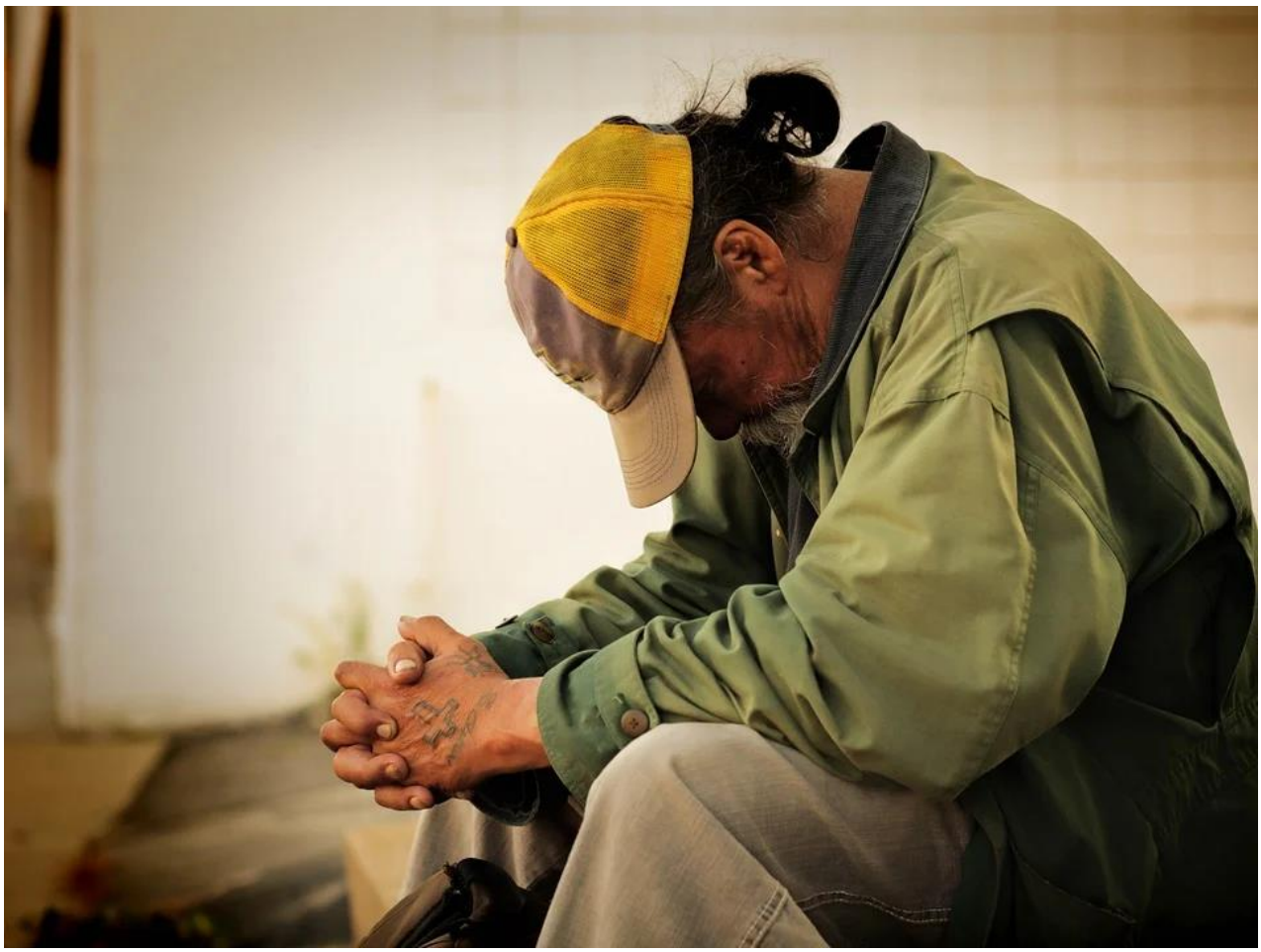
- In general, the pandemic has demonstrated the value of voluntary, community and statutory sector organisations working together to support local communities.
- The recognition of the residential and care home providers as partners in the system and not just a commissioned service.
- Community Health Services had seen several important lessons learned from the previous pandemic periods and implemented a number of improvements. These included a shared care plan for cases jointly managed with informal carers, joint allocation meetings, and monitoring of staffing levels centrally to support services across all four localities.
- The development and use of Complex Case Discussion meetings (which include representation from a range of community health services alongside adult social care) is being rolled out to other services as they are effective in joint planning, mitigating risk and ensuring that people remain safe.

f) What do you think you have learned from the experience of providing services during the pandemic?

- Staff need access to good quality IT equipment.
- Good quality equipment has been key to being able to communicate. Utilising new technology has enabled older people to be able to communicate on virtual platform using "Sparko"

- Alternative methods of delivering safeguarding training
- Identifying and growing the awareness of provider input into the risks and concerns of the system.

f) *Anything else you think is relevant to chronicling the impact of the pandemic on adult safeguarding?*
    - The loss of valued and long-standing staff who were not vaccinated to comply with the then Government rules
    - Removing the barriers of bureaucracy which were unnecessary to taking informed decisions



7. Strategic Priorities – Looking ahead to 2022 - 2023

Reflecting on the achievements and learning from 2021-22, the RSAB have developed the following priority areas of work for **2022 – 23**.

Transitional Safeguarding

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

- Development of a Transitional Safeguarding Panel for provision of a multi-agency support plan for young people 17+ whose will be closed to Children's Social Care at 18.

Making Safeguarding Personal (MSP)

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

- Reviewing public and professional facing information on how to make a safeguarding adult referral
- Resumption of multi-agency RSAB Introduction to Safeguarding Adults Briefings which include information on making a referral for awareness raising and improve confidence amongst professionals and volunteers.
- Mapping of key points in the safeguarding enquiry process for communications and feedback to the service user and referrer.

Quality Assurance

Holding partner agencies to account through presentation of quality assurance activities, including audit, in relation to safeguarding adults.

- Partners working together in demonstrating readiness for and effective implementation of Liberty Protection Standards (LPS)
- Development of a multi-agency safeguarding adults data set aligned to the priorities of the Board

Modern Slavery

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