Redbridge Safeguarding Adults Board

Redbridge Safeguarding Adult Board (RSAB) Annual Report 2023 – 2024

Safeguarding Adults – Working to Keep People Safe

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1. Foreword from the Chair & Cllr Mark Santos

I am pleased to introduce the 2023-2024 Annual Report for the Redbridge Safeguarding Adult Board (RSAB). The annual report is a strategic requirement for the Board and acknowledges the challenges and achievements of the previous year.

I am grateful for the engagement of all our partners and the amount of work that has taken place over the last year, not only to safeguard people from abuse and neglect but also to support the activity of the Board.

The Local Authority, Integrated Care Board, Metropolitan Police Service, and many other organisations come together to form the RSAB. Collectively we are committed to addressing strategic safeguarding issues and share learning to improve adult safeguarding.

It is important that together as members of the Safeguarding Adult Board we continue to challenge ourselves to deliver better services, ensure there is sufficient resource to support the work of the RSAB, support people who are at risk in our communities and further identify practices which provide a collective response to safeguarding. In the coming year, I am keen to build on the progress highlighted in this report. Particularly, I want to ensure an effective system is in place for learning from Safeguarding Adult Reviews, including connections and strategic links to other boards and partnerships in Redbridge.

One of the key purposes of the annual report is to promote the role 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 RSAB and partner agencies websites.

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

People in Redbridge have the right to live a life free from harm, where communities:

- have a culture that does not tolerate abuse
- work together to prevent abuse
- know what to do when abuse happens

So please take time to read the detail within the report and feedback to us your views and thoughts on the work the RSAB does and how we can ensure all agencies are working effectively to support and protect vulnerable adults in Redbridge.

Warmest regards

Eileen Mills

Independent Chair

Safeguarding is all of our concern. Our Safeguarding Adults Annual Report 2023/2024 demonstrates this through showing how all of our key stakeholders in Redbridge are working together to deliver our shared vision.

This report highlights our continued journey to constantly be better. It sets out our achievements such as starting the work of engaging and raising awareness of safeguarding amongst underrepresented communities, creating a Safeguarding Hub and work that was done addressing the safeguarding needs of Asylum Seekers placed in hotels in the Borough.

The report highlights our challenges from appropriate levels of resourcing through to accessing data to support the work. Finally the report details our priorities for 2024/2025 as the work is never complete.

The success of our Safeguarding Adults Board is down all of our partners playing their role. However, none of this would be possible without the leadership of our Independent Chair Eileen Mills and Lesley Perry our Safeguarding Adults Board Manager. We are very grateful to them both for their passion and commitment to this important work.

Councillor Mark Santos

Cabinet Member for Adult Social Care and Health

2. What is the Redbridge Safeguarding Adults Board?

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

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

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

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

- London Borough of Redbridge (adult health and social care, children's services, community safety, housing, public health, and commissioning)
- Metropolitan Police Service (MPS) East Area (EA) Basic Command Unit (BCU)
- Barking, Havering, and Redbridge University Hospital Trust (BHRUT)
- Barts Health NHS Trust (BHNT)
- Partnership East London Cooperatives (PELC)
- Department for Work & Pensions (DWP)
- Healthwatch Redbridge
- London Fire Brigade (LFB)
- National Probation Service (NPS)
- NELFT NHS Foundation Trust
- North East London (NEL) NHS Integrated Care System (ICS)
- Age UK Redbridge, Barking & Havering (RBH)
- Voiceability
- One Place East
- Redbridge Carers Support Service (RCSS)
- Sanctuary Housing
- Jewish Care
- Redbridge Community Action (rebranded from Redbridge CVS in February 2024)
- Cabinet Member for Adult Social Care & Health, LB Redbridge
- Lay Members
- Care Quality Commission (CQC) - Observer

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

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

Following a review of the structures underpinning the RSAB in this year there is new established

- **Learning and Improvement subgroup** which has been developed to lead on the development and implementation of Action Plans from any Safeguarding Adult Reviews (SARs). Disseminating learning and oversee multi-agency audit programme.
- **Joint Data Subgroup** this remains in the developmental stage but aspires to bring together multiagency data across children and adult services to inform priorities and provide assurance on multiagency performance.

The RSAB and RSCP (Redbridge Safeguarding Children Partnership) come together as a joint **Executive Group** to provide multi-agency strategic leadership to the both the RSCP and RSAB, overseeing the strategic aims of the RSAB and RSCP within the context of wider system reform and national developments. The Executive Group also ensures development and maintenance of strong links with other strategic boards, with a focus on joint working and a holistic approach to safeguarding. These include, but are not limited, to the Community Safety Partnership and the Health and Wellbeing Board.

RSAB Resource

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

This last year has seen an increase in the number of SARs being undertaken, which has increased the burden on the small existing resource.

The current resource for the RSAB is 0.5 (Full Time Equivalent (FTE)) Board Manager and three days a month for the Independent Chair. There is no administrative support to organise and provide secretariat for the Redbridge 'One Panel' and SAR Panels. The main RSAB and Subgroup meetings are supported by the Local Authority Safeguarding Hub.

The extra demands created by the additional SAR activity this year has served to highlight the gap. A recent survey of SABs in London identified that only one other SAB had no administrative support.

The RSAB members need to consider the resource allocated to the support the functioning of the RSAB or the activities it wishes to undertake.

3. Purpose of the Annual Report

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

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

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

Key Lines of Enquiry for Safeguarding Adult Boards

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

Findings in response to Key Lines of Enquiry

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

The Safeguarding adult network has led on the RSAB priority to develop and deliver a multi-agency action plan to improve the understanding of safeguarding and how to make referrals in racialised communities by establishing trust in public bodies, addressing barriers to engagement.

Age UK Voices of Experience Service has conducted a survey to gage the level of understanding that older people have about Safeguarding and if they know what to do to get help. They continue to send these out and have planned some work specifically with BAME groups to get a better understanding of what their understanding and needs are regarding Safeguarding. These results will be fed back to the RSAB

All agencies in their single agency returns (Appendix 1) identify how they train and support professionals to recognise and respond to safeguarding concerns in the communities they work in. Examples include the DWP developing a suite of comprehensive guidance and learning products are readily available for all colleagues on how to deal with vulnerable citizens including those citizens who discuss harming themselves. The ICB have supported a roll out of the IRIS Programme (a specialist domestic violence and abuse training, support and referral programme for General Practices).

This Has to Stop Campaign led by the Community Safety Partnership to raise awareness of Street harassment promote "Step In" which is aimed at safely stepping in if you witness harassment.

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?***

At the present time the only data the RSAB reviews is the nationally required NHS Digital annual return. Therefore, there are limitations in proactively supporting the monitoring of trends and themes to support timely responses. It has been a priority for the 2023-2024 period to develop a quarterly multiagency data set to promote better understanding of themes and trends and reflective of current priorities. A set of data requirements have been developed but at the time of writing the report there is not the capacity or resources to develop this work further. This does and will continue to be a risk for RSAB. Until it can be established the ways in which data can be analysed and interrogated to increase the SAB's understanding of the prevalence of abuse and neglect locally the board will continue to not meet the supplementary requirements of the Care Act 2014.

As the Local Authority develops its data following the implementation of a new case management system and in readiness for inspection carried out against the new Care

Quality Commission (CQC) assessment framework for local authority assurance, this will be shared at the RSAB as a starting point over the next year, for how the RSAB can extend to gathering data from across the partnership.

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

The Annual Safeguarding Adult Data return in 2021-2022 identified in 58% of cases where safeguarding investigations had concluded, the relevant person or their representative stated their desired outcome had been met. In 2022-2023 this had increased to 69%, which demonstrates positive progress for the service. In 2023-2024 the data shows this had decreased slightly to 64% of adults were supported to achieve their desired outcomes, 26% partly achieved their desired outcomes and in 10% of case the desired outcomes expressed by adults at risk were not achieved.

The RSAB has previously and continues to promote and prioritise the voice of the service user and record progress on their outcomes. it is hoped the new Case Management System that has come into operation in the reporting period will assist in providing accuracy and scrutiny of data. Every effort is being made with the introduction of the Adult Safeguarding Hub as of the 1 June 2024 to focus on the desired outcome for the relevant person and /or their representative.

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

Despite previous work done in response to the Health Watch Report in 2021 the Safeguarding Adult Network and the partnership single agency returns (Appendix 1) highlight that communication remains an issue for professionals in knowing the outcome of referrals and safeguarding investigations, which can impact on future working and support to the service user. This issue was also raised in last year's annual report.

At the present time there is no data to show the impact of previous work completed in the Local Authority safeguarding data. Over this year a new Case Management System (LAS) has been introduced across Health and Social Care Community Teams. The LAS system replaced the CareFirst case management system which had been in use within Redbridge for several years. The implementation of the new system has enabled Adult Social Care to have achieve a streamlined recording, data collation and reporting process for managing safeguarding proceedings. The system can now record that referrers have been contacted following referral. The RSAB hope to receive reporting on this as the data reporting develops in the meantime all agencies are asked to escalate their concerns if they do not receive a response to a referral made.

Agencies have policy and process in place to support Making Safeguarding Personal, in some cases this is supported by audit activity.

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

The single agency returns identified several initiatives to increase awareness of safeguarding issues and how to respond.

On a multiagency basis there has been the development of the

- Management of High-Risk Cases;
- Multiagency and guidance and response to cuckooing; and
- the development of a Community MARAC (CMARAC).

The RSAB also received assurance on the work being undertaken to support victims financial abuse by loan sharks.

In partnership with the RSCP, the safeguarding of asylum seeks living in hotels in Redbridge has been reviewed, following concerns raised by Healthwatch Redbridge. Partners, led by the Independent Chair, reviewed intelligence and data surrounding hotels in Redbridge to identify areas of concern that may need further scrutiny and review.

The outcome of the work has led to increased contact with Home Office and its accommodation providers, closer working with the hotels to support them in how to make referrals. A review of the partnership arrangements to strength the multiagency oversight of this group, improve co-ordination of activity and early identification and response to emerging concerns.

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. Their contribution of cannot be underestimated in how they bring the voice of service users and support the work of the RSAB.

This year Age UK, as well as chairing the Safeguarding Adult Network, have been leading the work on engaging with racialised communities as part of the RSAB priority to understand why the reporting of safeguarding concerns is disproportionate to the population of Redbridge.

The Independent Chair and Board Manager are members of the National and London Business Managers Networks and Chairs Network and the NEL SAB Chairs and

Managers group, which provides a broader remit of feedback on issues affecting services users.

The RSAB supported the London SAB awareness raising campaign on social media and shared training opportunities during National Safeguarding Adults Week 2023. The Terms of Reference and membership of the Safeguarding Adult Network have been reviewed which now provides us with a broader membership and range of views, with additional feedback from service users.

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

Increasing the links across strategic forums in Redbridge has been a significant improvement over the last year. Following the completion of SAR Hilary the report and findings were presented to the Community Safety Partnership (CSP) to highlight the need to ensure community or contextual risk is managed alongside induvial safeguarding risks. This had led to the development of Cuckooing guidance and a CMARAC.

The Independent Chair is now a member of the CSP and in turn CSP representatives attend the RSAB to ensure that there is influence and alignment of agendas and increased opportunity to work together. They are also engaged through the work of the Redbridge 'One Panel' in connection with Domestic Homicide Reviews (DHRs).

Improved links have developed with the Housing Service, with their participation in a number of SARs and as a standing member of the Redbridge 'One Panel'. In February, the Board Manager presented to a Housing Service Meeting providing a briefing on the work of the Board and the current priorities.

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

The offer of multiagency training is an area for improvement due to the limited capacity to support its development. However, the single agency returns (Appendix 1) demonstrate that agencies have a training offer for their organisation.

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

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

All agencies has struggled with the increased demand on them to participate in the SAR activity of the RSAB, at times this has led to inconsistent attendance at panel meetings and lack of quality assurance of information provided for reviews. Actions are being taken to address and support agencies in their work with SARs.

There is always enthusiasm to support the work of the RSAB and to come together and support each other however at times competing demands have created delay.

The priorities agreed for the period 2023-2024 were as follows:

To address the issues identified in the data provided to the RSAB that the number of safeguarding referrals is not representative of the local population.

- To develop and deliver a multi-agency action plan to improve the understanding of safeguarding and how to make referrals in racialised communities by establishing trust in public bodies, addresses barriers to engagement.

To improve multi-agency oversight and management of high-risk safeguarding cases. Quality Assurance

- To develop a multi-agency approach for the understanding of what constitutes a high-risk, tiered approach to management.
- Establish a panel for multiagency oversight and management of high-risk safeguarding cases.

To ensure that the RSAB has assurance that local safeguarding arrangements are in place as defined in the Care Act.

- Review current structure of the RSAB to:
- Enhance multi-agency learning and development from themes and reviews both locally and nationally.
- Provide quality assurance to the RSAB (including transition of into adulthood, voice of the service user); and
- Provide data and intelligence to inform future planning.

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

Progressing the priorities this year has been challenging largely due to the capacity in the RSAB team to pull together groups, provide secretariate etc. But also, the capacity of agencies to commit to the work required due to competing demands.

Response to priorities:

To address the issues identified in the data provided to the RSAB that the number of safeguarding referrals is not representative of the local population.

- Promotion of safeguarding adults at local events through partner agencies
- Offers of presentations to local community groups
- Development of a questionnaire to use in community groups

To improve multi-agency oversight and management of high-risk safeguarding cases. Quality Assurance

- Terms of Reference developed
- Every HASS has a weekly meeting to discuss high risk cases
- These meetings extended to wider partners
- Increased access to legal advice
- Development of a Community MARAC
- Close working with CSP
- Development of a Cuckooing process

To ensure that the RSAB has assurance that local safeguarding arrangements are in place as defined in the Care Act

- Arrangements reviewed and new structure in the process of implementation
- Revised Terms of Reference (ToR) developed for Subgroups
- Establishment of the Learning and Improvement Subgroup
- Preparation for Data Subgroup identifying multiagency information required in the developing data set
- Independent Chair's 'scrutiny exercise' in relation to safeguarding asylum seeking families placed in hotels – joint work with the Redbridge Safeguarding Children's Partnership (RSCP) (see page 15)

Scrutiny of Safeguarding Asylum Seekers in hotels in Redbridge

Why?

At the end of 2022 there was significant increase in the number of families being placed in Redbridge hotels. At a similar time Healthwatch produced a report which had been shared with the Local Authority and Health on conditions in hotels, which included those in Redbridge. The Independent Chair felt that this was an appropriate area for scrutiny to seek assurance for the RSAB.

How?

Literature review and development of an audit tool by the Independent Chair to review practice.

A series of meetings took place over the year to explore information and intelligence held within different agencies.

Findings:

Working well

- Already meeting lead by the Local Authority had been held with partners from the ICB, Public Health and other agencies including Care for Calais and Ramfel looking more broadly at conditions in hotels
- Informal forum already in place that had developed in response to the Home for Ukraine scheme, which was being utilised for discussion of concerns

Challenges

- The Independent Chair requested safeguarding assurance from Clear Springs, but this was never forthcoming at a local level and is being pursued at a regional level.
- All agencies working hard to address needs as they were identified but not central collation of themes and co-ordination of effort outside of the local authority

Impact

- Meetings were established by the Local Authority's Corporate Director of People with the provider of accommodation Clear Springs and the Home Office to explore their safeguarding pathways and concerns identified in Redbridge resulting from information sharing and the impact of the volume on new people coming into the borough.
- Direct work with the hotels to reinforce how to make a safeguarding referral
- Single Point of Contact identified for the hotels – to develop relationships and early identification of safeguarding concerns and increase awareness of services available for support
- NEL NHS ICB were developing a service specification for the health offer for Asylum seeking families

- The Asylum Dispersal Grant used to improve capacity with the Local Authority, including employment of a new dedicated manager in Public Health, employing a teacher with expertise on English as an additional language and provision of a dedicated post in the MASH.
- Joint visits by Childrens Social Care and the PREVENT Manager
- Development of the multiagency operational meeting for Asylum and Refugee Arrangements – bringing together partner agencies from across the borough to direct activity and provide assurance on the local implementation and delivery of our explicit responsibilities to ensure safeguarding of children and vulnerable adults; educational provision for children; and access to healthcare.

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

During the year, the RSAB completed three SARS, two of which have been published. A third, SAR 'Barbara', was presented at the January 2024 RSAB meeting but is not ready for publication due to some additional information still outstanding.

The published SARs include recommendations, the RSAB Learning and Improvement Subgroup have reviewed the recommendations and created action plans in response to the findings of the report.

SAR Hilary

Hilary was 67 years old when she was murdered in her own home in October 2022. Hilary had been under the care of mental health services for several years and in receipt of support services due to her complex needs which included hoarding. In the years leading up to her death, she was financially exploited by different members of the community living around her. There are two people in particular who are referenced within the report; person 1 who features earlier in the timeframe, and person 2 who financially exploited Hilary later in the timeframe and who is now convicted of her murder. Hilary's GP identified a diagnosis of "obsessive compulsive disorder" and her psychiatrist recorded a diagnosis of "hoarding behaviour in the context of personality disorder (dependent type).

Since the review the RSAB and partners have:

- Promoted the use of the Redbridge Multi-Agency Hoarding and Self-Neglect Protocol
- Developed the High-Risk Panel Meetings
- The Chair of the RSAB now a standing member of the Community Safety Partnership
- Development of multi-agency 'cuckooing' guidance
- Development of a Redbridge Community MARAC (CMARAC)
- Included Making Safeguarding Personal (MSP) as a standing item on the Policy and Practice Subgroup agenda
- Ensured that safeguarding of those living in any specific area of concern is considered by the Community Safety Problem Solving Group (PSG)

SAR 'JS' (Discretionary)

JS was a 38-year-old male when he sadly passed away. Originally from the South West of England, JS was diagnosed with learning disabilities, Prader Willi Syndrome (PWS), diabetes, and mental health issues. JS died in an acute general hospital in North East London in December 2021.

In the year preceding this, JS went from living in a community setting, to being in acute psychiatric and acute general hospital settings in the South West of England, with numerous readmissions between services in a short space of time. Following these admissions, JS was then moved to a specialist placement in North East London where he lived for less than a month before he was admitted to an acute psychiatric hospital, followed by an admission to an acute

general hospital due to rapid deterioration in his physical health. JS remained here for six months, during which time he appeared to make some recovery. JS unfortunately became critically unwell again and sadly passed away in December 2021. The cause of death was septic shock, fungal pneumonia, obesity, fatty liver, and hypertension.

The review shone a light on the challenges the national system, as opposed to local, in meeting the need of people with complex needs like 'JS'. These include:

- gaps in service provision for people who have acute physical and mental health needs;
- gaps in service provision for people with Prader-Willi Syndrome;
- the ability of acute medical wards to be able to manage the needs of people with complex learning disabilities/mental health issues on a long-term basis.

Since the review:

- The RSAB Independent Chair has written to NHS England and Integrated Care Boards in the South West, to ask them to consider the findings of the reviews so that in turn they can respond to the findings.
- NHSE has shared the report with the NHS England Learning Disability and Autism Programme.
- South West NHS England along with South West Local Government Association and Association of Directors of Adult Social Services (ADASS) are currently updating the Out of Area Placement Toolkit.
- The Health and Care Act 2022 introduced a requirement that regulated service providers must ensure their staff receive learning disability and autism training appropriate to their role. The Oliver McGowan Mandatory Training on Learning Disability and Autism is the standardised training that was developed for this purpose and is the government's preferred and recommended training for health and social care staff. Training is currently being rolled out nationally.

At a local level:

- All partners are reviewing the findings and considering if carer policies acknowledge the challenges when family members are placed out of the local area.
- Those responsible for specialised commissioning to develop a process and meeting schedule for patients who are "stranded" in hospital due to lack of suitable placement.
- The Chair has written to the PWSA with the findings of the SAR to see if they are willing to support a local learning event on PWS.
- A checklist to prompt commissioners to ensure that all relevant steps have been taken when placing someone out of borough is being designed by Adult Social Care and ICB commissioners.

There is a plan to present the learning the SARS to a wider multi-agency audience.

During 2023-2024, the Redbridge 'One Panel' received a number of referrals for consideration of a SAR, including SAR 'Barbara', there are five further reviews in train at the time of writing this report.

6. Strategic Priorities – Looking ahead to 2024 - 2025

The priorities for 2024 – 2025, are developed from the RSAB Strategic Plan 2022 – 2025 and the five areas that work needed to align to which are safe services; transitions; informing; listening and engaging; and partnership. Consideration was given to the progress of the current priorities and the decision was made to continue to work with the previous year priorities.

Priority	Description	Reason
To address the issues identified in the data provided to the RSAB that the number of safeguarding referrals is not representative of the local population.	To develop and deliver a multi-agency action plan to improve the understanding of safeguarding and how to make referrals in racialised communities by establishing trust in public bodies, addresses barriers to engagement	The work in engaging with racialised communities needs to continue to fully understand any barriers to making safeguarding referrals and to respond to those findings
To improve multi-agency oversight and management of high-risk safeguarding cases.	To develop a multi-agency approach for the understanding of what constitutes a high-risk, tiered approach to management. Establish a panel for multiagency oversight and management of high-risk safeguarding cases.	The Terms of Reference are in place but further work is required to increase the multiagency involvement in the panels and also map out the high risk panel meetings place amongst other high risk arrangements e.g. MARAC, C MARAC, MAPPA etc.
To ensure that the RSAB has assurance that local safeguarding arrangements are in place as defined in the Care Act.	Review current structure of the RSAB to: • Enhance multi-agency learning and development from themes and reviews both locally and nationally. • Provide quality assurance to the RSAB (including transition of into adulthood, voice of the service user); and • Provide data and intelligence to inform future planning.	The new structure has been developed and agreed. The Learning and Improvement subgroup has only met once, and the data group is yet to be established. There needs to be more to embed the changes and consider the impact

Appendix 1

Redbridge Safeguarding Adults Board Partner Contribution Statements

2023-2024

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

The return rate has been 50% with variable quality of information provided. This is a reflection of the capacity of the system to respond to requests to participate in the production of the annual report. The returns do however give insight into how the work of the RSAB is further enhanced through member organisation and challenges they face.

Returns were received from:

- Safeguarding Adults, LBR
- Community Safety, LBR
- Department for Work & Pensions (DWP)
- VIA
- NEL NHS ICB
- Barts Health NHS Trust (BHNT)
- Age UK RBH
- Healthwatch Redbridge
- Redbridge Carers Support Service (RCSS)
- LBR Learning & Development
- Jewish Care

Agencies that did not submit a return:

- East Area BCU MPS
- London Fire Brigade
- Housing Service, LBR
- Families Together Hub
- HASS, LBR
- Contracts & Commissioning, LBR
- NELFT
- BHRUT
- PELC
- Redbridge CVS/Redbridge Community Action
- Voiceability
- Sanctuary Care

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

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

1. Introductory statement of commitment

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

Summary of responses:

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

2. Key Safeguarding achievements for 2022-2023

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

Communications and Engagement

Summary of responses:

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

Highlights include

- The DWP developing a suite of comprehensive guidance and learning products are readily available for all colleagues on how to deal with vulnerable citizens including those citizens who discuss harming themselves.
- DWP introduced mental health training for Work Coaches, which has better equipped staff to identify customers' mental health issues or vulnerability and take appropriate action to support them.
- The ICB have supported a roll out of the IRIS Programme (a specialist domestic violence and abuse training, support and referral programme for General Practices).
- This Has to Stop Campaign lead by the Community Safety Partnership to raise awareness of Street harassment and schools' pilots to promote Step In which is aimed at safely stepping in if you witness harassment.

Person Centred Approach

Summary of responses:

All response state that offering person centred services are central to their practice and form part of their business as usual. Ensuring that adults at risk are consulted and are central to all

safeguarding activities involving them thus, ensuring that work is carried out in line with best practice guidelines of the organisation

Highlights include

- Via have an introduction to Trauma Informed Care training which explores how ACEs (Adverse Childhood Experiences) can impact on adult service users and underpin their use of substances to manage trauma.
- Adult Social Care - appointing formal advocates to support adults at risk throughout safeguarding enquiries where necessary.
- All carers registered with RCSS receive a person-centred plan and are involved in the development of their own action plan detailing their support needs.
- The service offered by Reach Out Domestic Abuse Service centres around the survivor's wishes and needs. Reach Out provides wrap-around support to survivors including safety planning, accommodation, physical and sexual health, immigration advice, debt advice and access to employment. By providing access to all the above via one professional, aims to reduce the survivor having to repeatedly recount their trauma.
- BHNT undertake a Making Safeguarding Personal audit

Prevention

Summary of responses:

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

Highlights

- LB Adult Safeguarding Team run a bi-monthly Policy and Practice Forum and deliver briefings to various services within the borough including care homes. The forum has attendance from a diverse membership which provides the opportunity for good practice to be adopted across services and for group learning and understanding the training needs of practitioners and others.
- RCSS launched a new Mental Health and Wellbeing Project, focused on preventative support for carers who have or care for someone with a mental health illness. The one year pilot will provide dedicated support and counselling/coaching and holistic wellbeing services to help carers in or approaching crisis to better manage their situation and caring role. The project will also focus on developing self-help tools to embed in support work and help carers take active steps to improve their own wellbeing.
- The ICB Designated Professionals ran a Primary Care - Redbridge (GP) Protected Learning Event in November 2023. This session focused on SAR Learning from recent reviews and Statutory Reviews and Role of Primary Care and LeDeR Annual Report 2022/2023 feedback.
- VIA as an organisation produced and rolled out guidance about working with service users who are experiencing self-neglect, including guidance about making appropriate referrals to Adult Social Care and working with other agencies to support recovery and reduce risk.

Summary of audit findings that have been undertaken in the last year

From the returned in formation the majority of identified that no audit of safeguarding activities had taken place, except for:

- Adult Social Care using a case management tool to gain an overview of volume of safeguarding activities received and processed by Adult Social Care. Use of this recording and reporting facility allows for a smart approach to collating data and its use will no doubt be beneficial to service delivery and the accuracy of data reporting going forward. 2034 -2024 was the first year of use and as stated above, collation and analysis of the data and for the 2023-2024 reporting period is ongoing.
- BHNT undertook an MCA and DoLS audit. The findings identified that there was a moderate level of staff knowledge of what mental capacity is; and that there is 100% compliance with Mental capacity assessments when a DoLS is applied for.
- In the Reach Out Service, the Manager carries out monthly audits of Reach Out and Spotlight case files to understand the quality of work and to highlight areas for improvement. The findings are shared in team meetings.
- VIA quarterly case management audits are randomly pulled for each practitioner, and the audit tool includes a section on adult/child safeguarding (where applicable). Areas of best practice, and learning opportunities, are fed back to the individual, along with any immediate actions that are identified as needed, and the overall learning and themes is synthesised for monthly Local Integrated Governance meeting.
- VIA recent case management audits indicated that professionals are regularly assessing for safeguarding risks and concerns within their assessments and treatment reviews – including making onward referrals to ASC where identified – for DVA or self-neglect most commonly. They are also discussing cases in supervision with their line manager, and are documenting on the case management system their interactions with ASC, MARAC, IDVA etc.
- In October 2023, the Trustees of Jewish Care commissioned an independent internal audit of the Safeguarding and Deprivation of Liberty Safeguards (DoLS) Policies, Procedures and practice within Jewish Care, reviewing and commenting upon their compliance with legislation, regulation and accepted current good practice. Recommendations from the audit have been presented to the Safeguarding Adults Steering Group and the Internal Audit and Risk committee for discussion and implementation.

Actions taken to address to promote equality and reduce inequalities

Agencies identified a variety of training options to increase staff awareness, knowledge and understanding.

Highlights

- Redbridge Carers Support Service have reviewed their leaflet and marketing materials to make them more inclusive and accessible. Stakeholders were consulted with and involved in the design.

- Redbridge Carers Support Service are developing an Outreach Strategy and Plan to raise awareness and reach and engage more carers from diverse communities.
- The Safeguarding team at the NEL ICB established connections with the NEL Population Health and Health Inequality Steering Group. A presentation was provided of the health inequality themes that arose from recent Domestic Homicide Reviews (DHR's), Safeguarding Adult Reviews (SAR's) and Child Safeguarding Practice Reviews (CSPR's)
- Organisationally, VIA has made the Oliver McGowan training (standardised training for organisation so that they meet the Core Capabilities Frameworks on Autism and Learning Disability) mandatory, and VIA Redbridge are now at 97% completion across all our VIA Redbridge Services. This training ensures our workforce have the right skills and knowledge to provide safe, compassionate, and informed care to autistic people and people with a learning disability.
- VIAs Women's Space supports women to access treatment, as does the late-night clinic support people who might have difficulties accessing VIA during the day.
- Jewish Care has rolled out training across the organisation to better understand the needs of the LGBTQ+ Community & Intersectionality. The opportunity to discuss race, ethnicity and cultural heritage is offered to all staff via the REACH group. Additionally, there is a Pride group. The theme for this year's World Social Work Day event was Unconscious Bias for which an expert trainer delivered a half-day in person session to the Social Work Service and members of Directorate, including Jewish Care's CEO.
- The Reach Out service has supported typically 'hard-to-reach' groups including asylum seekers (through outreach support in hotels), the traveller community and clients who are deaf (through Spotlight Programme).
- Health Watch Redbridge have recently agreed a contract with Newham Language Shop to provide online and in-person interpreters where required. This service is also providing a range of translated material to support our outreach and projects. When producing material or video's we work with interpreters to ensure the information is accessible to all.
- Age UK Voices of Experience Service has conducted a survey to gage the level of understanding that older people have about Safeguarding and if they know what to do to get help. They continue to send these out and have planned some work specifically with BAME Groups to get a better understanding of what their understanding and needs are regarding Safeguarding. These results will be fed back to the RSAB.

Responses to the findings of SARS

All agencies describe how they disseminate learning via briefings and staff meetings and forums and reflect on them in relation to practice.

Highlights

- VIA in response to SAR 'Hilary' although not directly involved with the case recognised the self-neglect and hoarding protocol was not clearly referenced or applied in Hilary's case and hoarding was managed and seen through a mental health lens and not a safeguarding lens, this key learning above was brought back to the team. VIA hare part of the development of the Redbridge Community MARAC.
- The Designated Professionals at NEL ICB upload all SAR findings into the NHS England Safeguarding Case Review Tracker, which provide a NEL summary and contribute to

national findings. The findings are presented at NHS NEL Safeguarding Forum, and Primary Care (GP's) at Protected Learning Events.

- The ICB produced a summary of SAR that have taken place and presented at a NEL safeguarding event in conjunction with NEL SAR Chairs.

3. Partnership

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

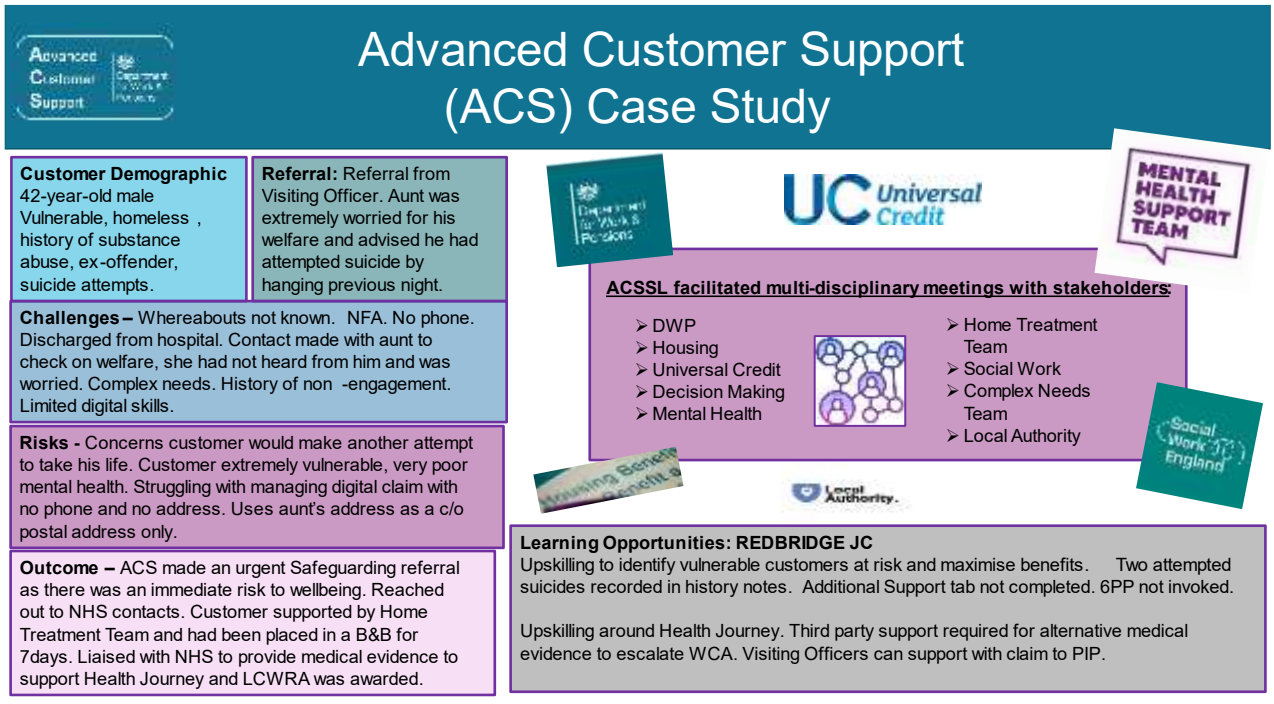
Summary of responses:

All response demonstrated their active participation in partnership working.

Highlights

- The LA Safeguarding Team have worked with the Contracts and Quality Assurance Teams with who are involved in safeguarding activities and jointly use feedback from enquiry findings to support with the development and implementation of improvement plans.
- The LA Safeguarding Team utilise the expertise of internal and external stakeholders as well specialist services such as the Tissue Viability and District Nurses services by causing them to take the lead role for enquiries.
- The DWP engage in with the Redbridge 'One Panel' and RSAB.
- The new Reach Out service offer was shaped by local partners through a series of workshops, with oversight from a multi-agency Project Board**.**
- Reach Out has created fast-track pathways with a local female-led pharmacy, and the borough's substance misuse service**.**

The DWP provided the following case study to show the impact of partnership working.



On a less positive note, Redbridge Health watch who completed a project for RSAB in 2022 (Hearing the Voice of the Service User), remain disappointed that the recommendations which were initially accepted and formed part of the RSAB priorities for 2022-2023, have not been fully implemented.

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

Partners were asked to evidence the impact of their work

Summary of responses:

- VIA report on a range of positive case studies from our Rough Sleeper/Outreach Team who work with some of Redbridge's most complex, vulnerable, and multiply disadvantaged individuals, with feedback from the individuals themselves and other professionals about the positive changes seen in these individuals. Several of these individuals have been supported to access the Pan-London Rough Sleeper provision at Guys and St Thomas' including detox unit and the Mildmay Rehabilitation and Stabilisation Centre. That these individuals have stayed with the residential treatment even when wanting strongly at times to leave, evidences the strong work of the team in preparing people for this often-transformational treatment pathway and helping them manage the difficult emotions and behaviours that can emerge when they achieve abstinence of the problematic substance that has often been their coping mechanism for many years.
- BHNT report the impact of the Safeguarding team and partnership work has led to better staff engagement. Utilising an open office door and encouraging staff to talk through cases with the team to ensure patient safety. Understanding the safeguarding process in Redbridge and where to go for feedback on safeguarding.

5. Key Challenges in 2023 - 2024

Summary of responses:

- Several agencies identified not receiving feedback following making safeguarding referrals.
- self-neglect that can be a result of fluctuating capacity as a result of substance misuse, but more commonly coexisting mental health alcohol and drugs (COMHAD, aka Dual Diagnosis). More help is required for practitioners understand the thresholds and support pathways available via the two pathways (safeguarding versus care and support needs).
- Challenges accessing appropriate housing for un-housed service users following completion of a residential detox and/or rehab funded by the local authority.
- Maintaining oversight of safeguarding activities across Mental Health Services due to differences in the recording systems used in Adult Social Care and Mental Health teams.
- The restructuring of the LA Adult Safeguarding service meant changes to the staff complement and the working arrangements within the Safeguarding Team during the period of change and had an impact on the oversight the team had of safeguarding activities and the support the HASS teams received from the service.

- Under-representation of certain ethnic groups in relation to the volume safeguarding activities undertaken is also an ongoing concern.
- Financial sustainability especially for smaller organisations who rely on grant funding
- Primary Care - involvement in Statutory Safeguarding Processes.
- No domestic abuse-informed therapeutic provision for adult survivors – while Free Your Mind are commissioned to provide therapeutic support for children and young people affected by domestic abuse, there is no local provision for adult survivors. This is a huge gap in provision – research suggests that 1 in 8 of all female suicides have a clear link to domestic abuse.
- No pathway for adult survivors of Domestic Abuse with no recourse to public funds – there are very few refuges that accept clients with no recourse to public funds, and help cannot be accessed via the council's Housing Service. Unless there are children involved, these clients have limited routes to access accommodation.
- There has been an identified increase in mental health cases in the Jewish Community since the onset of the war in Israel particularly but also more generically due to the cost-of-living crisis; challenging the service and wider organisation.

6. Good practice case studies

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

These included:

- VIA Redbridge's "Family and Friends" Service, identification of abuse of parents by some adult service users. Reports included examples of financial and emotional abuse, allegedly perpetuated by their adult child, who is also in treatment with VIA R3. VIA have been able to appropriately make safeguarding and/or MARAC referrals for these individuals, whilst the Family and Friends Service continues to provide advice and support, as well as peer-groups, that helps them to understand more about substance misuse and VIA's treatment pathways for their family member or friend, support them in finding ways to hold healthy boundaries, whilst also updating our risk management plan for the service user/alleged perpetrator.
- Practitioners demonstrating escalation with Via Redbridge Management to advocate on behalf of a service user who is on the 'Rough Sleeper' pathway (temporarily housed) following concerns about the outcome of the first Community Care Assessment, VIA requested.
- A person was signposted to us by Age UK BHR chasing up care for their relative (95 years old with dementia) who they felt was not receiving the right amount of care. Due to some communication difficulties, the information given was unclear and some things did not seem to make sense.
- Healthwatch during contact with a service user their messages disclosed a safeguarding alert had been raised by the Head of Continuing Health Care. Although staff were told the alert had been dealt with and closed, from discussions it appeared the service user had a live-in Personal Assistant (PA) (through direct payments) who was working 24/7. The information provided showed that from August 2022, Direct Payments had been stopped and the PA was no longer being paid. We raised a safeguarding referral regarding the personal assistant with the local HASS team. Staff also signposted the carer

to the local advocacy service (Voiceability). Despite following the safeguarding referral route, we are unaware of the outcome of the referral.

- BHNT Emergency Department (ED). A 69-year-old came to Whipps Cross University Hospital ED and found to have a fractured ankle. They did not wait in ED to see the orthopaedic team and left without any preventative medication. After many failed attempts to contact the patient, they raised an internal safeguarding alert. The hospital Safeguarding Team liaised with neighbouring hospitals and LBR partnership police officer to check the whereabouts of the person in case he was in prison. It was confirmed that he was not in prison and police officer advised to call 101. On contact with 101 who advised that this did not meet threshold for Right Care, Right Person welfare check as there was no threat to life. Advised to call London Ambulance Service. They advised to call the police on 101 as this was not a medical emergency. This situation was fed back to the partnership police officer who checked it out and was happy with the decision making. Age UK in the hospital were contacted and request for a welfare check to be made. A safeguarding referral was sent to the local authority. A LB Redbridge Duty Social Worker conducted a welfare visit and was unable to find the flat in the block. The Whipps Cross University Hospital Safeguarding Team contacted the Virtual Ward Matron at the hospital. Through East London patient records they found a neighbour's number. The neighbour was contacted who said he was seen taken away by police in the last few months and that he has behavioural issues, they referred to another neighbour who reported to have seen in in the last few days. The patient did eventually reattend for treatment.

7. Priorities in relation to safeguarding adults for your organisation in 2024 - 2025

All agencies had continued focus to raise awareness of safeguarding through targeted training offers. Each identified they had specific areas they wished to focus on in the coming year, this list is not inclusive of all the activity taking place but demonstrates either repeated themes or examples of the breath of activity that contributes to safeguarding adults in Redbridge.

- Continue to develop the VIA Redbridge Women's Safe Space, collocating other relevant services at the space to help women access support and advice as needed.
- Develop pathways and tools for individuals with learning disabilities and autism to have appropriate access to support for problematic alcohol or drug use.
- To further develop and implement systems to quality-assure practice across Adult Social Care Services particularly in the areas of decision-making about safeguarding concerns and practice relating to completing enquiries.
- Improving performance in practice relating to feedback to referrers and stakeholders.
- Strengthening links with services, internal and external stakeholders to drive through prevention-focused approaches to minimise harm and reduce the number of serious incidents occurring across the Borough.
- Using publicity strategies and facilities such as the Intranet and other key settings such as GP practices, public service settings and various provider settings to raise awareness about abuse and ensure safeguarding data is representative of demographic composition of population of the borough.

- Building on the professional training opportunity to raise awareness and improve partnerships and cross referral networks to improve early identification and positive interventions for carers.
- Encouraging/increasing carer involvement in forums e.g. Adult Safeguarding Network.
- Shared events and awareness campaigns with partners.
- Primary Care: To provide a reflective safeguarding forum for Redbridge GPs.
- Understand the profile of Violence against Women's and Girls from Redbridge dentists and pharmacies to help support the Redbridge Violence against Women and girls (VAWG) Strategy.
- To secure funding for DA-informed therapeutic support/ counselling for adult survivors.
- To secure funding to respond to an increased demand for domestic abuse services.
- Developing Awareness of Safeguarding amongst smaller Community Groups.
- Targeted work and resources to raise awareness of Safeguarding amongst BAME Communities.
- Better communication between Adult Social Care and Referrers particularly working in partnership with voluntary sector organisations.

8. What are the three key issues that ought to be addressed by the SAB next year?

Given the need to continue to embed the work following the 2023-2024 priorities over 2020-2025, the following feedback with be considered in the 2025 review of the RSAB strategy.

- Develop greater awareness and understanding within all key partnerships around identifying and working with Fluctuating Capacity in Substance Misuse and Mental Health.
- Ensuring that learning from SARS is embedded into practice.
- Ensuring that safeguarding training is accessible to external stakeholders.
- Ensuring that the links between Adult Social Care and other stakeholders are broadened and strengthened.
- Ensuring we engage all diverse communities and help raise awareness of Safeguarding in a culturally sensitive and meaningful way.
- Deliver at least one major event with all partners to raise awareness of Safeguarding and how to escalate and resolve concerns.
- Work together to identify and address barriers to improving health, wellbeing and quality of life – to reduce the risk of safeguarding.
- High priority safeguarding areas for DWP are Domestic Abuse, People who are not engaged with services, Modern Slavery.
- The response/ pathway for adult survivors with No Recourse to Public Funds (NRPF) who are homeless, as these cases are impacting Adults Social Care.
- The SAB may be interested in supporting Reach Out with its aim to establish therapeutic support for adult survivors of domestic abuse – a Task & Finish Group is being set up on the advice of the Redbridge Place-Based Partnership Board.
- Timely responses within Care Act timescales.