Redbridge Safeguarding Adults

REDBRIDGE SAFEGUARDING ADULTS BOARD

Annual Report 2018 – 2019

Contents

Foreword

I am pleased to introduce the Annual Report of the Safeguarding Adults Board for 2018/19. This is the second Annual Report I have been responsible for producing since I took on the role of Independent Chair of the Board in June 2017. I want to start by acknowledging the enormous amount of hard work, skill, and commitment that practitioners and safeguarding specialists in all agencies put in day in, day out, to improve the protection of adults at risk in Redbridge and to promote their right to live free from abuse or neglect. While I think it is the job of the Safeguarding Adults Board Annual Report to identify areas for improvement where necessary, everything else should be read in that context.

One of the Board's main focuses in 2018/19 has been to ensure the implementation of the recommendations of the two Safeguarding Adults Reviews (SARs) completed in 2017/18, and the action plan arising from my review during that year of the effectiveness of the local authority's arrangements for delivering on its safeguarding responsibilities. I am pleased that all agencies responded very openly and positively to reports which did highlight some significant areas for improvement. The Board was able to sign off the SAR action plans as completed at its meeting in April 2019. Progress against the action plan following my review has been less even. There is no doubt that the review, and the commitment of everyone involved, has had a significant impact on both practice and on better working relationships between key component elements of the overall safeguarding system – operational health and social care teams, commissioning and contract management, and the strategic safeguarding team. However, for a range of reasons detailed later in this report, it was not possible during the year to complete some of the concrete actions outlined in the action plan. In the absence of an ongoing programme of peer audit, it is not yet possible to make a definitive judgement about the quality of safeguarding practice. Having said that, it is important to acknowledge that adult social services in Redbridge overall have one of the highest rates of user satisfaction in England, and that Redbridge has also been assessed by an independent consultancy to be the most productive adult social care authority in the country, measuring performance against spend. Furthermore, health and social care services in Redbridge have been judged by the Department of Health and Social Care to be the best performing in England in terms of the interface between health and social care. Although we currently lack firm evidence of the quality of safeguarding practice specifically, the Redbridge health and social care system overall is clearly a high performing one.

The report contains a summary of data on local authority safeguarding activity and outcomes drawn from the annual Safeguarding Adults Collection. Great caution needs to be exercised in drawing conclusions from this data, as the return was incomplete. With that caveat, there are some indicators of potential areas for improvement:

- The 'conversion rate' of initial safeguarding concerns into formal safeguarding enquiries remains very high, and much higher than in the rest of London or in England as a whole. Continued attention is needed to ensure that, while all concerns raised continue to be fully evaluated, matters are not drawn unnecessarily into the safeguarding system.
- The percentage of cases in which, risks having been identified at the outset of the enquiry, those risks were assessed as removed or reduced at the conclusion, was low compared to regional and national benchmarks - 71% of cases in Redbridge, compared to 90% in both England as a whole and in London.
- It appears that continuing attention is needed to embed the principles of Making Safeguarding Personal in safeguarding practice. According to the data returned, only 67% of adults at risk involved in safeguarding enquiries in Redbridge were asked what they wanted the outcome of the enquiry to be, compared to 75% nationally.
- Compliance with the statutory timescale requirements relating to the Deprivation of Liberty Safeguards declined further in 2018/19. Only 55% of applications received during the year had been completed by 31st March, compared to 70% the year before. It is recognised that this reflects a set of requirements which the vast majority of local authorities are unable to meet, and that the position is unlikely to improve at least until a reformed statutory process is implemented in 2020.

There was a potentially very significant change in the gender profile of those subject to safeguarding enquiries compared to previous years, with the majority in 2018/19 being male – 61%. Again, no firm trend should be identified from one year's incomplete data, but there is a suggestion that this may reflect increased recognition of safeguarding issues for younger adults with a learning disability or experiencing mental ill health.

The other issue that leaps out from the data is the year on year increase in concerns that are raised about self neglect. The Board's Self Neglect and Hoarding Protocol, developed in 2017 under the leadership of Samira Natafgi-Roberts, the Council's Head of Safeguarding and Adult Protection, has had a real impact on raising awareness in this area. It is one of the most challenging areas of safeguarding practice. There is a primary principle that adults have the right to make their own decisions about how they live their lives, so long as they have the mental capacity to do so, however unwise those decisions appear to professionals or others. However, there is also a line above which the consequences of those decisions, for the individual and / or for others, are so severe or so detrimental to health and wellbeing, that, even though the individual has capacity to make them, the self-neglect involved should be regarded as an adult safeguarding issue within the terms of the Care Act. Where to draw that line is an extremely difficult decision for professionals to make, and one in which there will not often be a clear cut 'right or wrong' answer.

The most significant development during the period covered by this report which will ultimately impact on safeguarding practice has probably been the roll out across the integrated health and adult social care service in Redbridge of the People Matter approach, described in Section 2 of this report. There is a really striking convergence between the principles of People Matter and the principles that underlie adult safeguarding practice – empowerment, prevention, proportionality, protection, partnership, and accountability.

Looking forward, the focus of the Board's action plan for 2019 - 2020 is on strengthening multi-agency working to safeguard vulnerable adults. The action plan is attached as Appendix 1 to this report. Increasingly, too, the Board needs to consider the overlap between its concerns and those of other partnerships. Contextual and criminal exploitation, domestic violence, sexual violence and online grooming, gang affiliation, county lines and cuckooing, radicalisation, modern slavery and trafficking, are all issues which potentially draw in vulnerable adults with care and support needs unable to protect themselves against the abuse or neglect involved. They are all issues of shared concern between children's safeguarding, safeguarding adults, and community safety partnerships, albeit they might be seen through different lenses. We need to explore ways in which planning and action can be better aligned between the Safeguarding Adults Board, the new Children's Safeguarding Partnership arrangements, and the Community Safety Partnership. An early example of what this might look like is the joint work currently being undertaken between the Safeguarding Adults Board and the Children's Safeguarding Partnership to develop proposals for a co-ordinated approach to transitional safeguarding – ensuring that young people in need of care and support and at risk of abuse, neglect or exploitation do not suddenly fall off the cliff simply because they reach their eighteenth birthday.

I would like to end by expressing my deep appreciation to all members of the Safeguarding Adults Board for their commitment throughout the year, and for their openness to challenge and scrutiny. I would also like to thank Housing colleagues and those voluntary organisations – the Salvation Army, the Welcome Centre, RAMFEL, and the Single Homeless Project – who worked with the Board to confront the shocking and shameful issue of the number of people who died on the streets of Redbridge while sleeping rough during the period covered by this report and since. I do believe the Board has made a really significant contribution to this and other issues covered in this report. However, we could do much more with a modest enhancement of the resources available to support the Board's work in helping and protecting vulnerable adults in Redbridge. As we detail in the report, the Board has no budget, and receives no financial contribution to support its work from any agency other than the Council. This is in significant contrast to the picture across London. The average budget for those SABs who contributed to a survey during the year on behalf of London SAB Chairs was just under £100,000, with CCG contributions of between £5000 and £60000 a year, averaging £23,500. The Redbridge SAB should be doing much more than we are in

terms of scrutinising performance, quality assuring practice, developing multi-agency training, and delivering concrete actions to improve adult safeguarding across the partnership. I believe it is essential that this under-resourcing is addressed in time for the Board to enter 2020/21 with an agreed, even if necessarily modest, budget.

John Goldup

Independent Chair, Redbridge Safeguarding Adults Board

1. What is the Redbridge Safeguarding Adults Board?

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

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

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

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

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

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

The only members of the SAB prescribed in legislation are the local authority, the Clinical Commissioning Group (CCG), and the police. Guidance, however, encourages a wider membership. The Board membership as at 31 March 2019 is detailed in the table overleaf.

John Arnold	DCI, Safeguarding, MPS East Area BCU
Mark Benbow	Community Safety Transformation & Enforcement Lead, LBR
Andrea Crisp	Named Nurse for Adult Safeguarding, BHRUT
Ross Diamond	Chief Officer, Redbridge CVS
Glynis Donovan	Executive Director, Redbridge Carers Support Service (RCSS)
Bob Edwards	Integrated Care Director, NELFT
Stewart Grant	Housing Area Manager, LBR
Andrew Hardwick	Commissioning Manager – Public Health, LBR
Gita Hargun	Service Manager, Families Together Hub, LBR
Jacqui Himbury	Director of Nursing, Redbridge CCG
Leila Hussain	Head of Service/Principal Social Worker (PSW), LBR
Jamie Jenkins	Borough Commander, London Fire Brigade
Eve McGrath	Designated Nurse for Adult Safeguarding , NHS Barking & Dagenham, Havering and Redbridge CCGs
Ian Maxey	Service Manager, Voiceability
Anthony Pardoe-Matthews	Head of Contracts & Procurement, LBR
Samira Natafgi-Roberts	Head of Safeguarding Adults & Protection Service, LBR
Stephen Snell	Learning & Engagement Co-ordinator, LBR
Samantha Spillane	Adult Safeguarding Lead, Bart's NHS Health Trust
Margaret Summers	Chief Officer, One Place East
Cathy Turland	Chief Executive Officer, Healthwatch Redbridge
Janet West	Senior Manager, Age UK RBH
Lesley Wines	Social Work Manager, Jewish Care
Stuart Dunn	Inspection Manager, London Region, CQC (Observer)

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

Unlike the Safeguarding Children's Partnership, the SAB does not have a budget made up of contributions from partner agencies to support its work. Neither does it have any

dedicated staffing resources, other than the Business Manager role shared with the RSCP. The Redbridge SAB is significantly under-resourced compared to both local and London-wide benchmarks. According to the most recently publicly available information, the Barking and Dagenham Board has a budget of approximately £115,000, including a contribution of £30,000 from the CCG and £5000 from the Metropolitan Police Service. The Havering Board most recently reported a budget of £63000, including £15000 from the CCG and other NHS bodies and again £5000 from the police. Information collated on behalf of London Safeguarding Adults Boards Chairs reported that CCGs contributed between £5000 and £60000 to fourteen SABs in London for which information was available in 2017/18, with the average contribution being £23,500. The average total annual budget across the SABs who supplied information was just under £100,000.

This severe under-resourcing inevitably limits the range of work that can be undertaken under the auspices of the Board. There is no dedicated capacity for either quality assurance or multi-agency training.

Reflecting some key mid-year changes, the 2017/18 Annual Report covered the Board's activities from April 2017 to June 2018. To maintain continuity, this report covers the period up to the date of the Board meeting in July 2019. Activity data, however, relates to the twelve month period, 1 April 2018 to 31 March 2019. Published benchmarking data, however, where quoted, relates to 2017/18, as comparative data for 2018/19 has not yet been published.

The legislation sets out two main requirements for the SAB Annual Report. It must set out the actions which the Board and individual members have taken to deliver on the objectives and actions set out in its annual plan, and the outcomes achieved; and it must provide information about any Safeguarding Adults Reviews completed during the year, the findings and lessons learned, and what has been done to act on them. Progress against the 2018/19 Action Plan is outlined in Section 3 of this report. There were no Safeguarding Adults Reviews completed by the Board in 2018-19. The Board was however particularly concerned about the shocking number of deaths of rough sleepers in Redbridge reported in 2017 and 2018, and commissioned substantial work on this which is described in Section 4.

2. Safeguarding activity, outcomes and performance

2.1 Safeguarding in Redbridge 2018-2019

All partner agencies represented on the SAB continue to demonstrate a strong commitment to the safeguarding of vulnerable adults, across both statutory and voluntary sectors. Voluntary sector organisations in particular have worked hard to develop their engagement with statutory services. WDP (Westminster Drug Project), for example, were newly commissioned by the Council in 2018 as the provider of integrated 'one stop' drug and alcohol treatment services. They have reviewed all their work on adult safeguarding across the organisation, through an organisational safeguarding forum, to ensure that staff are able to identify safeguarding issues when they arise and understand referral pathways, to promote best practice, and to disseminate learning across the organisation. Voluntary organisations have been active in referring safeguarding concerns to the Council's safeguarding service, although they do not always feel that they get adequate feedback on the outcome of their referral. They maintain their commitment to ensuring that all staff and volunteers are appropriately trained on safeguarding issues, and have expressed a keenness to work more closely with Council colleagues to ensure that training is up to date.

The Bogus Caller Partnership is chaired by the Borough Commander for the London Fire Brigade. It brings together statutory and voluntary sector organisations to work to prevent bogus caller crime, support vulnerable residents and victims, and prosecute the offenders. The Partnership meets quarterly to monitor bogus caller activity, review initiatives and plan projects. Activity in 2018/19 has included a programme of visits to vulnerable people in their homes by 'Old Protector' volunteers, development and promotion of the 47 'No Cold Calling Zones' in the borough, and support of Trading Standards' work to promote the national Banking Protocol and other Trading Standards initiatives. The Banking Protocol is a national agreement between banks, police and Trading Standards to prevent funds being handed over to vulnerable residents when they are preyed upon by rogue traders. Bank staff can trigger a rapid response from police by using the protocol. The Partnership has also promoted the Redbridge Front Garden Scheme, funded by the London Mayor's Office for Policing and Crime, under which an approved contractor can put in a day to clear neglected or overgrown gardens, which can highlight the vulnerability of the resident and make them a target for burglary, bogus callers, and rogue builders.

The Chair's review of the effectiveness of adult safeguarding arrangements within the local authority, concluded in June 2018, identified an urgent need to strengthen and develop the working relationship between the central Safeguarding Team, locality and other operational teams, and the Contracts and Procurement Team. Much work was put into this by all parties in 2018/19, and all report that relationships and mutual engagement are much improved. Regular safeguarding surgeries have been held to

support front line practitioners, and the Safeguarding Team have supported the management of a number of very complex cases. The Head of Safeguarding Adults and Protection chairs a bi-monthly multi-agency Safeguarding Policy and Practice Group. This is a forum both for dissemination of information and for discussion of professional issues, and has been well attended. Similarly, productive work has been undertaken to clarify procedures, roles and responsibilities between the Council and NELFT Safeguarding Teams, which is critical in an integrated service.

New Safeguarding Strategies were agreed in both NELFT and BHRUT in 2018, replacing what had previously been separate adults' and children's safeguarding strategies. Compliance with mandatory safeguarding adults training at all levels, and with Mental Capacity Act training, has increased in both Trusts. Within the Metropolitan Police, the East Area BCU (covering the boroughs of Barking and Dagenham, Havering and Redbridge) report that the consolidation of specialist safeguarding functions has contributed to an increased concentration on, for example, tackling domestic violence. The East BCU issued 137 Domestic Violence Protection Notices, which impose immediate restrictions on the behaviour or movements of a person suspected of domestic violence pending a court process, in 2018-19, and 106 Domestic Violence Protection Orders were subsequently granted in court. This accounts for over a third of the DVPNs issued across the whole of the Metropolitan Police area.

BHRUT has over 80 Safeguarding Adult/Learning Disability Champions who work across the organisation. The role of the Champions is to provide advice and support in the clinical setting for colleagues and patient's alike. 'Think Family' was the theme for the annual Safeguarding & Learning Disability Champions Workshop held in October 2018. This event brought together staff from adults, children & maternity services. All sessions were very well received with a majority of staff evaluating the sessions as "extremely useful". There was a 10% increase in attendance this year and over 88% of Champions reported their knowledge had increased as a result. Guest speakers included representatives from the Police, London Fire Brigade, NHS England, SafeLines and the National Network of Parents and Carers Forums. The speakers covered a range of subjects including coercive and controlling behaviour, fire risks and interventions, disability among minority groups, elder abuse, the learning disability mortality review programme, and domestic violence and abuse.

Although no Safeguarding Adults Reviews were completed in 2018/19, the Board was made aware of and discussed a number of cases of concern that arose during the year:

- A 50 year old female psychiatric hospital inpatient with a learning disability and mental health difficulties died in May 2018 from choking while eating her lunch on the ward in Goodmayes Hospital. NELFT carried out a very thorough Serious Incident Investigation. A risk of choking from dysphagia had been previously identified, but ward staff were not aware of this and there was a low level of dysphagia awareness. Leadership was unclear in the response to the incident when it happened. The Board

were satisfied that NELFT's investigation had identified the lessons to be learned from this tragic incident, and that a full range of appropriate actions had been taken. There was no cause for concern about multi-agency working, and the criteria for a Safeguarding Adult Review were therefore not met.

- An elderly male was referred to the health and social care First Contact Team by a home care agency with a concern about self-neglect on 8 October 2018. The referral was not prioritised as it should have been, and a home visit did not take place until 31 October 2018. A fire broke out in the home the following day, and sadly the man died as a result of smoke inhalation. The fire investigation report confirmed that the cause and spread of the fire were unrelated to the condition of the property, and the cause of the tragedy was not associated with any issue of self-neglect. Nevertheless, the referral should have been responded to more urgently, and there were clear indications that a preventive fire safety visit should have been suggested. The Board received assurance that the temporary circumstances in the First Contact Team at the time of the referral had been addressed, and robust arrangements were now in place to ensure that safeguarding concerns were responded to on the day of receipt. The London Fire Brigade have strongly emphasised their willingness and wish to receive a referral in relation to any person where a health or social care or any other professional has a concern about fire safety, and have energetically promoted in partnership with the Board the training, advice, and direct services (such as the free fitting of smoke alarms) that they are able to provide. The LFB completed 2656 Home Fire Safety Visits in Redbridge in 2018/19.

2.2 Safeguarding activity, outcomes and performance

Safeguarding activity data is collated in an annual return, the Safeguarding Adults Collection, by the local authority to NHS Digital. For the first time in many years, the number of safeguarding concerns reported as raised with the local authority fell in 2018/19, compared to the previous year, from 998 to 881. However, it is clear that the return, based on information received from locality and other teams within the integrated health and adult social care service (HASS), was incomplete. Further work by the Safeguarding and Adult Protection team has established that a more accurate picture would show that the number of concerns raised was approximately the same as in 2017/2018. The data contained in this report is however based on the return to NHS Digital.

The Board's Annual Report for 2017/18 highlighted the very high percentage of safeguarding concerns in Redbridge that are judged to require a formal safeguarding enquiry under Section 42(2) of the Care Act 2014, compared to other authorities and national data. This 'conversion rate' has remained high. In 2018/19 70% of concerns raised proceeded to a Section 42 enquiry, compared to 72% in 2017/18. In London as a whole the conversion rate is 34%, and in England 37%.

While this report has been in preparation, the Association of Directors of Adult Social Services (ADASS) have published a very helpful framework for decision making on whether or not to carry out a safeguarding enquiry under Section 42(2). The framework acknowledges and reflects the complexity of the issue and the importance of professional judgement. It emphasises that there is no 'right' conversion rate, and that 'data is best used as a 'can opener' to ask pertinent questions about practice', rather than to draw 'general conclusions from published data about the extent to which people are protected'. It also emphasises that a decision not to institute a safeguarding enquiry should not mean 'walking away': issues may still need to be addressed and risks mitigated under other processes and powers.

However, the framework is clear that the duty to undertake a safeguarding enquiry is only triggered if the criteria in Section 42(1) are met: that the local authority has reasonable cause to suspect that the adult concerned has care and support needs (whether or not those needs are eligible to be met or are being met by the local authority; that s/he is experiencing, or is at risk of, abuse or neglect; and that s/he is unable to protect himself or herself against abuse or neglect or the risk of it as a result of those care and support needs. Further information gathering may be necessary before a decision can be made as to whether a safeguarding enquiry should be undertaken. The unusually high conversion rate in Redbridge suggests that the threshold may not always be appropriately applied. It may be that historic and cultural practice in Redbridge has often been to treat that initial information gathering, which may conclude that the criteria set out in S42(1) are not met, as itself part of a S42 enquiry with all the processes and procedures that follow from that. Clarity is not helped by some ambiguity in the statutory guidance, which at some points refers to an 'enquiry' as the activity triggered once it is established that there is 'reasonable cause to suspect' that the criteria in S.42(1) are met; and at others uses the word in a more general sense to include enquiries made prior to a decision on that has been made. Not surprisingly, local guidance reflects this ambiguity: it states for example that 'A safeguarding enquiry refers to any enquiries made or instigated by the London Borough of Redbridge after receiving a safeguarding concern' – potentially blurring the distinction between the initial information gathering to establish whether the criteria for a S42 enquiry are met with the safeguarding enquiry itself. The Chair's 2018 review of adult safeguarding arrangements within the local authority gave a number of examples of matters which were being pursued as safeguarding enquiries which clearly did not meet the S42 criteria. It hypothesised that this 'over-definition' of safeguarding is a main explanation for the high conversion rate of concerns to enquiries in Redbridge, and the workload pressures that follow from that. This requires continuing attention by all levels of management within the integrated Health and Social Care Service, as well as ongoing training and the review of current policies and procedures.

Based on the data returned to NHS Digital, there was a significant shift in the gender profile in 2018/19 of the individuals who became the subject of formal safeguarding

enquiries. 61% of those subjects were male, compared to 35% in 2017/18. This may reflect an increased awareness of safeguarding issues for individuals with a learning disability or suffering from mental ill health. 15% of safeguarding enquiries undertaken in 2018/19 related to individuals whose primary support need was recorded as 'learning disability support', compared to 12% in 2017/18. 18% concerned individuals whose primary support need related to mental health, compared to 13% in 2017/18. This is also reflected in the age profile of those subject to enquiries, with a higher percentage relating to the 18-64 age group: 40% of all enquiries started in 2018/19, compared to 32% in 2017/18.

In 2018/19 64% of individuals who were subject to safeguarding enquiries were white, compared to 69% in 2017/18. For the borough's population as a whole, the latest estimate is that over 65% of residents are from black and minority ethnic backgrounds.

Of the enquiries concluded in 2018/19, 62% related to abuse or neglect in the service user's home, compared to 48% in 2017/18. However it is notable that very few concerns were raised by domiciliary care services: more work may be needed with domiciliary care providers to ensure that their staff are vigilant for signs of potential abuse or neglect and confident about reporting them. Across all settings, service providers were identified as the source of risk in 38% of reported concluded enquiries in 2018/19, compared to 50% in each of the previous two years.

There has been a significant increase in concerns raised about self-neglect over the past few years. Following the implementation of the Care Act 2014 under which self neglect was first identified as a category of safeguarding concern, self-neglect accounted for 9% of the causes for concern raised in 2015/16. This increased to 11% in 2016/17, when the Board's Self Neglect and Hoarding Protocol was developed and implemented, and to 14% in 2017/18. In 2018/19 self neglect constituted 15% of the total causes for concern raised. Awareness of self neglect continues to grow, but it is also clear that it remains very difficult to engage many of the individuals concerned in recognising the risks to which they are exposing themselves, and in supporting them to protect themselves against or to mitigate those risks. One of the outcomes of this is a high rate of repeated referrals for self-neglect, compared to other forms of neglect or abuse.

In 80% of safeguarding enquiries, risks were identified and action taken. This is a higher percentage than that either for England as a whole (69%) or for London (63%) – 2017/18 data. However, according to the Annual Return to NHS Digital, of the cases in which risk was identified, it was removed or reduced at the conclusion of the enquiry in only 71% of cases. The equivalent figure for both England as a whole and London as a whole is 90%.

One of the key principles of adult safeguarding work under the Care Act is personalisation – Making Safeguarding Personal. Among the key measures of this defined by central government are whether at the outset of a safeguarding enquiry the individual or their representative is asked what their desired outcomes are, and whether

those outcomes are achieved or not. 67% of the adults at risk involved in safeguarding enquiries in Redbridge were asked what their desired outcomes were, and desired outcomes were expressed in 56% of cases. Nationally, according to the most recently published data which is for the reporting period 2017/18, 75% were asked about desired outcomes, and outcomes were expressed by 62%. For those who expressed desired outcomes in Redbridge, however, 89% of those outcomes were fully or partially achieved.

In 2018/19, across all BHRUT sites, there were 491 safeguarding adults concerns raised by staff, compared to 660 in 2017/18. The Trust suggest in their Safeguarding Adults Annual Report that 'this decrease may be attributed to the Safeguarding Advisors being visible and available to provide advice and utilise the correct pathways'. 83% related to referrals raised by Trust staff concerning risks arising in the community. By type of concern, self-neglect was the largest category of concern – 28% of all referrals. There was a noticeable decrease in the number of safeguarding concerns raised relating to community acquired pressure ulcers – 38 in 2018/19 compared to 55 in 2017/18. The Trust comment that 'this decrease is positive as it demonstrates increased understanding amongst front line staff (that) not all pressure damage is due to neglect or acts of omission'. 85 referrals were raised by external agencies reporting concerns within the Trust. Six of these on investigation were found to be fully substantiated. As in 2017/18, they primarily related to poor discharge practice, mainly with regard to failure to refer to District Nursing.

There were 504 safeguarding alerts raised by NELFT in 2018, across all services and geographical areas of operation, compared to 477 in 2017, 606 in 2016 and 668 in 2015. Continuing a year on year on trend, there was an increase in enquiries to the internal adults safeguarding advice service, from 2757 to 2994. NELFT report that the Safeguarding Advice Team have supported clinical and operational staff to make appropriate referrals particularly where there has been a concern about domestic violence and pressure ulcers. However the fact that there were almost six times as many requests for advice received as there were safeguarding alerts raised suggest that sound judgement is being exercised in determining what does and does not constitute a safeguarding alert to be raised with the responsible local authority under the Care Act.

A number of NHS providers serving Redbridge patients were subject to CQC inspection activity in the period covered by this report. A focused inspection of medical care (including the care of older people) at King George Hospital in June 2019 continued its overall rating of 'requires improvement", as did a routine inspection of Whipps Cross Hospital in September/October 2018. In both hospitals however inspectors found that staff were knowledgeable about safeguarding and understood their responsibilities in relation to the protection of adults at risk of neglect or abuse.

An inspection of NELFT in May/June 2019, focused on mental health services, resulted in a judgement of 'requires improvement', which led to a downgrading of the Trust's overall

rating from 'good" in 2017 to 'requires improvement'. Inspectors found that "The trust had systems in place to safeguard patients from abuse and the services worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it." However, they also found patient safety compromised in a range of areas:

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

Adult social care services are not subject to external inspection. The Chair's review of adult safeguarding arrangements within the local authority in 2018 recommended that a programme of peer auditing of social work practice within the HASS should be developed, and that safeguarding practice, including the application of thresholds, should be an early focus of such a programme. The recommendation was accepted, but it has not yet been possible to develop such a programme. It remains the case therefore that it is difficult for the service to answer the three questions which Ofsted expects children's social care services to answer in their annual self-evaluation:

- What do you know about the quality of social work practice in your authority?
- How do you know it?
- How do you plan to sustain or improve it?

It should be noted however that, while specific data on the quality of safeguarding practice is not available, across adult social care as a whole Redbridge is one of the best performing local authorities in the country in terms of user satisfaction. In the 2017/18 ASCOF (Adult Social Care Outcomes Framework) service user survey, 76.3% of respondents in Redbridge were extremely or very satisfied with the care and support they received, compared with 62% in England as a whole and 58% across Outer London. In the most recently available performance data on the adult social care/NHS interface, published by the Department of Health and Social Care, Redbridge is the best performing area in the country. In February 2019 Redbridge was also assessed by iMPOWER as the most productive adult social care authority in England, measuring performance against outcomes per pound invested.

2.3 Deprivation of Liberty Safeguards

If a person who lacks the mental capacity to consent or otherwise to the arrangements is deprived of their liberty other than under the Mental Health Act in a hospital or care home (i.e. they are subject to continuous control and supervision, and are not free to

leave), this must be authorised by the local authority. In some circumstances the safeguards can also apply to care provided in a person's own home, or in a supported living situation. For these cases the final authority rests with the Court of Protection.

It has been universally recognised that the current system, the scope of which was massively increased by a Supreme Court judgement in 2014, places requirements on local authorities which they are unable to come close to meeting. The Code of Practice requires 'standard' applications to be completed in 21 days. The average time taken by local authorities to complete applications in 2017/18 (the most recent data available) was 138 days. NHS Digital calculated that if no new applications were received at all, it would take local authorities an average of 7.6 months to clear the backlog of uncompleted applications outstanding on 31 March 2018. Legislation to reform the current system was passed in May 2019 and is expected to be implemented in October 2020.

Having increased by 55% between 2015/16 and 2017/18 (from 541 applications to 842), there was a slight decrease in the number of Deprivation of Liberty Standards (DoLS) applications made to LB Redbridge in 2018/19, to 832. A priority tool developed by the Association of Directors of Social Services was used to prioritise outstanding cases. Nevertheless, only 55% of applications received in 2018/19 had been completed by 31 March 2019. compared to 70% in 2017/18. 137 cases were unallocated, 201 were awaiting scrutiny, and 15 were awaiting authorisation. The SAB received a report on timeliness of dealing with DoLS applications at its meeting in January 2019, and expressed great concern at the lack of progress. At the Board's request, the Chair wrote to the Director of People to express this concern. The response referred to ongoing difficulties, over and above the difficulties inherent in the unreformed system, in the availability of Best Interest Assessors and the recruitment and retention of both permanent and agency staff within the Safeguarding Service. It seems that no significant improvement can be expected at least until the new legislation is implemented in 2020/21.

If a DoLS authorisation is contested, the case must be referred to the Court of Protection. The local authority is also required to seek authorisation from the Court for service users in their own home and those in supported living schemes whose care arrangements deprive them of their liberty. In the Annual Report for 2017/18 we reported a backlog of 25 cases waiting to be progressed to the Court of Protection. At 31.3.19 the backlog stood at 33 cases.

DoLS applications made by BHRUT, across all sites, increased by 33% in 2018/19 - from 1006 to 1338 – having increased by 43% the previous year. This figure includes applications to all boroughs from which patients are admitted, and is not specific to Redbridge. It does however mean that the number of DoLS applications made by BHRUT has almost doubled in two years. There were 83 DoLS applications from NELFT across

the whole of their geographical area of operation, compared to 73 in 2017/18 and 136 in 2016/17.

2.4 People Matter

Perhaps the most significant development which will ultimately affect safeguarding practice in the period covered by this report was the full rollout within adult social care services of the People Matter approach, successfully piloted in 2017/18. This is a radically different way of responding to referrals for care and support, moving away from the traditional assessment and care management approach to a more flexible and person-centred model. Instead of moving directly from referral to formal social care assessment, the model focuses on a conversation with the person to find out what is important to them, what they would like to achieve and how they can help themselves. It is based on three conversations:

- Conversation 1 is about supporting people to identify their own strengths and the community resources available to them, to enable the resolution of difficulties without the need to progress into formal social care processes
- Conversation 2 is about supporting people that are in crisis and 'sticking to them like glue' until their crisis has been stabilised – not putting in long term solutions to respond to a short term crisis, when a person feels at imminent risk of losing independence and/or control over their life.
- Conversation 3 is necessary when longer term needs are identified and some form of ongoing support is necessary to maximise wellbeing and the potential for independence.

The pilot demonstrated that the People Matter approach significantly reduced the need for long term care packages, increased user satisfaction, and was positively welcomed by practitioners as an empowering opportunity to make full use of their professional skills and help to bring about real changes in people's lives. People Matter will be the core practice model across the whole social care service by October 2019.

There is a very close relationship between the principles of People Matter and the six principles of Making Safeguarding Personal embedded in the statutory guidance to the Care Act 2014 – empowerment; prevention; proportionality; protection; partnership; and accountability, as shown in the table overleaf.

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

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

One of the emphases and gains of the People Matter approach has been described as a move away from 'the traditional method of completing long forms and assessments' to 'a focus on the person and their issue' and achieving rapid outcomes which capitalise on individual, family and community resources. Fully translating this approach into safeguarding practice – which, for understandable reasons when individual's safety and right to live free from abuse or neglect are at stake, has arguably tended to become codified in 'long forms and assessments' – is a genuine challenge. It is also though perhaps the key to making safeguarding truly personal.

3. Safeguarding Adults Board Action Plan 2018/19: actions, progress, and outcomes

The Board's Action Plan for 2018/19 identified six priority areas for action. Progress against the headline actions is reported below.

3.1 Implement all actions arising from the Safeguarding Adults Reviews completed in 2017/18

The circumstances of each review, the findings, learning identified, and recommendations, were reported in some detail in the Board's Annual Report for 2017/18. At its meeting of 30 April 2019, the Board was able to confirm that all the recommendations had been fully implemented. Of particular significance was the assurance given on two key issues. Firstly, the Board received very clear assurance on the arrangements now in place to identify those service users with the most complex needs, disabilities and vulnerabilities and to ensure that for each person there is a named professional responsible for the effective co-ordination and review of the care arrangements in place. In one of the cases subject to review, relating to a series of events that unfolded several years ago, those arrangements had been seriously deficient. Secondly, following the criticisms in the other review of the duty system in place in one of the HASS localities in 2016, when the events covered by that review took place, the HASS Senior Management Team had completed a review of the duty functions across the service, and implemented a standardised duty process across all localities to ensure a consistent and effective approach to duty work.

One of the SARs identified the lack of a clear process for use by any professional who disagrees with any decision, action, or inaction on the part of a responsible agency in relation to the safeguarding of an individual vulnerable adult. In September 2018 the Board agreed a Multi-Agency Resolution and Escalation Policy which aims to ensure that all agencies working with adults at risk in Redbridge have access to a straight forward multi-agency policy to quickly resolve, and where necessary escalate, professional differences where there are concerns that the welfare and safety of adults are at risk of being compromised.

3.2 Implement the action plan arising from the 2018 review of the effectiveness of arrangements, structures and practices for discharging the responsibilities of LB Redbridge for the safeguarding of vulnerable adults

The findings and recommendations of this review were described and discussed in detail in the Board's Annual Report for 2017/18. A detailed action plan in response to the recommendations was presented to the Board in January 2019, and progress against the plan was reviewed by the Board at its April and July meetings. It is clear that the review has been widely discussed and welcomed within the HASS service, and all of its recommendations have been agreed by managers at all levels.

Significant progress has been made against a number of the recommendations. Operational and strategic staff agree that relationships are greatly improved. A programme of reflective practice sessions in operational teams has been developed, to build confidence in safeguarding practice and the operation of thresholds. A number of meetings have led to greater clarity about roles and responsibilities between contracts staff, operational teams, and the strategic safeguarding team in relation to issues of concern that arise within provider services. Further strengthening of the engagement of provider services with the safeguarding agenda has been identified as a priority in the Board's action plan for 2019/20.

However, capacity issues, a number of interim management arrangements, and some recruitment difficulties have led to some of the concrete actions outlined in the action plan making slower progress than expected. These include the development of a supervision policy and framework for social care staff, the development of a programme of peer audit of safeguarding practice, the re-establishment of the Social Work Leadership Group, and the development of a safeguarding dashboard to report on and monitor safeguarding performance. There has been no progress on resolving the delays and non-compliance with statutory requirements in the management of the DoLS, and as reported earlier performance has in fact deteriorated.

A central finding of the review was the very wide variation in the thresholds being applied to define what is and is not an adult safeguarding issue, and that in general the threshold was too low. One of the key decision points is the decision that a 'safeguarding concern' should trigger a formal 'safeguarding enquiry' under Section 42 of the Care Act. The 'conversion rate' in Redbridge remains high: in 2018/19 70% of safeguarding concerns in Redbridge progress into formal Section 42 enquiries. In London as a whole, on the most recently available data, the conversion rate is 34%, and in England 37%. It is possible that a number of the developments discussed elsewhere in this report – in particular, the rollout of People Matter as the core model for adult social care practice in Redbridge, the embedding of the Association of Directors of Adult Social Services guidance on decision making in this area, and the ongoing reflective practice work – will have a significant impact on this issue in the future.

3.3 Carry out agency self-assessment of safeguarding compliance and risks to performance

This action was completed. Between September and December 2018, all partner agencies completed a self-assessment of compliance with their safeguarding duties against a set of standards developed by the Association of Directors of Adult Social Services (ADASS). Organisations self-assessed against 27 statements under seven headings. In the 15 completed audits, 12% of these statements were assessed as requiring further development work for full compliance. The section in which the most areas for development were identified was that containing the statements evidencing effective multi-agency working to safeguard and promote the wellbeing of adults at risk,

and in developing its action plan for 2019/20 the Board has prioritised work in this area. The Board agreed an action plan to address specific actions required of agencies arising from the audit. It agreed at its meeting in July 2019 that the actions could be signed off as completed, although an update was and remains outstanding from Bart's NHS Health Trust.

3.4 Implement the Safeguarding Adults Training Framework

The Training Framework agreed by the Board in March 2018 emphasises the importance of professional supervision in agreeing training goals and supporting transfer of learning into the workplace. It includes planned evaluation of the impact of training at three levels:

- evaluation of training feedback forms;
- pre and post awareness training testing, to evidence learning acquired; and
- in depth interviews with a sample of participants, three months after more specialist training, to evaluate transfer of learning and management support in that transfer through supervision.

The Board considered a detailed report on the first year's operation of the framework in April 2019. All training courses delivered in 2018/19 held in 2018/19 were subject to quality assurance observations by the Redbridge Adult Social Care Engagement and Development Team. In this first year of the framework, quality assurance observations focused on trainer effectiveness. In 2019/20, quality assurance observations will be extended to the evaluation of learning content. Training effectiveness was generally evaluated as good or very good. A number of areas for improvement were identified and followed up with trainers.

Two to three months after course completion, telephone interviews were carried out with 20-30% of participants in a range of core courses, to evaluate the degree to which learning from the course had been translated into the workplace and supported through supervision. Satisfaction on the different elements evaluated ranged between 50% and 100%, with an average rating of 82%. The effectiveness of the training itself had a 92% positive rating. Particular suggestions for improvement were made in relation to the course on Improving Mental Capacity Act Assessments, which have been followed through for 2019/20.

The uptake of training was generally good, but there was low uptake of Safeguarding Adults Manager training – training for senior practitioners and managers who oversee and make decisions on safeguarding enquiries. This is surprising, as locality teams and others have expressed concern about a shortage of trained Safeguarding Adults Managers. This requires further exploration.

The Training Framework, and the evaluations carried out, currently focus only on training commissioned by the Council and largely for social care staff. In 2019/20, the

Board will seek to develop a multi-agency adult safeguarding programme, and to strengthen quality assurance of single agency training by engaging peers from partner agencies in observation of training.

3.5 Carry out evaluation of impact of Multi-Agency Self-Neglect and Hoarding Protocol.

The Board considered an evaluation of the impact of the protocol in September 2018. The evaluation was generally very positive, with many examples given of impact in terms of heightened awareness, increased identification of self neglect, and some growing confidence on the part of practitioners in addressing the issue. The visual 'cluster image rating' guides included in the protocol were found to be particularly helpful - "Staff have been enabled to distinguish between general untidiness and poor standards of housekeeping, which are subjective, and hoarding or self-neglect that can be harmful or dangerous to themselves or to others." There is greater awareness of the London Fire Brigade offer of free home safety visits and smoke alarm installation, although there is not as yet evidence of increased referrals from health and social care professionals for this service.

3.6 Improve the sharing of learning from Domestic Homicide Reviews and Safeguarding Adults Reviews across the Barking and Dagenham, Havering, and Redbridge (BHR) area.

Attempts to develop a joint process for identifying and disseminating learning with our neighbouring Boards were not successful in 2018/19. However, the three Boards have agreed to hold a joint Development Day in November 2019, to share learning from SARs carried out across both the BHR area and London more widely.

4. Death on the streets: a thematic review

Between October 2017 and November 2018 there were ten deaths of individuals sleeping rough in Redbridge. The SAB commissioned a thematic review which sought to identify the lessons to be learned from an analysis of these tragic deaths, and the actions that might be pursued to translate that learning into practice. The Board held a special meeting in January 2019, with representatives of all the voluntary organisations working with rough sleepers in the borough, to consider the findings of this review. Sadly there have been more deaths of rough sleepers in Redbridge since the review was completed.

Nationally, both the number of rough sleepers and the number of deaths reported in this population have increased sharply in recent years. The number of people sleeping rough on any given night more than doubled between 2010 and 2017. There was a 22% increase in the number of deaths between 2017 and 2018. However, the increase in the number of deaths in Redbridge is particularly dramatic. According to the Office of National Statistics, there was only one rough sleeper death in Redbridge in 2017, and only eight in the five years 2013 - 2017 altogether.

When considering the profile of those that had died, the Board was particularly struck by two things. Firstly, the great majority were non-UK nationals, with an undetermined immigration status and consequently with no recourse to public funds, including the majority of welfare benefits and homelessness assistance. However, they were not recent arrivals in the UK. Only one of the non-UK nationals had been living in the UK for less than a year and five had been here for over ten years. Five of the ten people who died were Indian nationals. There are a number of obstacles to successful work to achieve either establishing individuals' right to remain in the UK or, where appropriate, voluntary return to their country of origin. RAMFEL, a specialist immigration advice service, reported to the Board that a particular problem was the unresponsiveness of the High Commission of India to requests for information they may hold about their citizens which could be helpful in respect of these issues. Following the discussion at the Board, the Chair wrote to the Indian High Commissioner in April 2019, urging her to take urgent steps to ensure that these requests are responded to and to nominate a specific contact person with whom RAMFEL could liaise on these and future cases. The High Commissioner has now agreed to put those arrangements in place.

The second and most striking point was that, despite a mass of evidence describing the high incidence of mental health difficulties, drug and alcohol misuse, and other care and support needs among the rough sleeper population, the individuals concerned had generally had virtually no contact with statutory health and care services. The one statutory service with which several of those who died had significant contact was the hospital service, with a pattern of repeated A&E attendances or short term admissions, followed by discharge. In 2018 BHRUT recorded 34 discharges of people with no fixed abode, involving nine individuals – an average of almost four hospital admissions in the

year for each person. Revised NHS guidance in November 2018 on delayed discharges from hospital made clear that hospitals may discharge homeless people to the streets if they are not judged to be a priority for housing or further care. While recognising the very limited range of options available to hospitals in planning the discharge of homeless people, the Board recommended that BHRUT should work with relevant voluntary agencies to review the section of their Discharge Policy and Procedure dealing with discharge of those with no fixed abode, to identify any improvements in communication and practice that might be made.

Despite estimates that between 40% and 75% of rough sleepers have mental health problems, it is striking that none of the ten people who died had any recorded contact with mental health services. Voluntary sector partners who contributed to the review felt that mental health services in Redbridge were not sufficiently flexible to respond to the needs of this population. While services are available for those with a diagnosed mental health condition, appointments are only available at a single centralised base, which in practice makes them inaccessible for many rough sleepers; and there are no assessment outreach services to assist in identifying those for whose mental health there may be concern but who do not have a formal diagnosis. Similarly, none of those who died were open to a social care team, and social care had no recorded knowledge of seven of them. Generally, rough sleepers are not a population with which social care have historically engaged. However, the local authority has a duty to offer an assessment of needs to any adult who appears to have needs for care and support, and this duty applies irrespective of the authority's view of the level of those needs or whether they are likely to meet the eligibility criteria for service provision. The decision about eligibility should be made after a needs assessment has been completed. Homelessness or rough sleeping do not of themselves constitute a need for care and support in terms of the Care Act, but it is likely that many rough sleepers will appear to have such needs and ought to be offered an assessment. At least six of the people who died had alcohol misuse problems, but only one had regular involvement with local alcohol support services.

It is likely that a number of those individuals who died, and rough sleepers more widely, will fall within the definition contained in the Care Act 2014 of what should be regarded as an adult safeguarding issue – they have care and support needs, they are experiencing or at risk of abuse or neglect, and are unable to protect themselves against that abuse or neglect as a result of their care and support needs. However, the Board felt strongly that there were far wider issues raised in this review than those specific to adult safeguarding. They are issues about the health and wellbeing of a highly vulnerable sector of the Redbridge population, and the multi-agency response to those issues. The board therefore resolved to take the report to the Health and Wellbeing Board, with a recommendation that the Rough Sleeping Strategic Board, recently established by the Council's Operational Director of Housing, should be charged with developing and delivering a fully multi-agency strategy for meeting the health and

wellbeing needs of rough sleepers. The Health and Wellbeing Board agreed this recommendation in June 2019, and asked that the Rough Sleeping Strategic Board report on progress after six months.

It should be noted that there have been a number of positive developments since the SAB first considered this issue in January 2019:

- The Council agreed a Homelessness and Rough Sleeping Strategy in March 2019, with a commitment to end rough sleeping in the borough by 2022
- The Rough Sleeper Initiative Grant has funded an increased level of support and casework in the Borough
- The CCG has agreed to commission a specialist primary care service for rough sleepers
- A new street outreach service working with individuals with substance abuse problems has been launched
- Regular operational meetings to facilitate joint working with individuals with the most complex needs have been re-established

These developments reflect a growing recognition that the health and wellbeing needs of rough sleepers cannot be met solely by the voluntary sector and the Council, working separately or indeed together. Health partners, both commissioners and providers, social care services, and other agencies such as the police, must play an equally important role.

Appendix 1

REDBRIDGE SAFEGUARDING ADULTS BOARD

Action Plan 2019 - 2020

At its meeting on 30 April 2019, the Safeguarding Adults Board agreed that the focus of its action plan for 2019 - 2020 should be on strengthening multi-agency working to safeguard vulnerable adults. The Action Plan is centred on a commitment to further embedding the principles of adult safeguarding (empowerment, prevention, proportionality, protection, partnership and accountability) and Making Safeguarding Personal in all our work:

PRIORITY	ACTION	LEAD	THEMES
1. Strengthening prevention	• We will review and improve the signposting of adults with care and support needs to support resources in the community, to improve early intervention and promote wellbeing in the least intrusive way. • We will support the further rollout of the People Matters model in health and adult social care services in Redbridge, to promote the early resolution of concerns at an early stage wherever possible, avoiding escalation to more intensive interventions. • We will continue to develop reflective practice learning, to ensure that S42 enquiries are proportionate and only undertaken when an appropriate threshold is met.	Jamie Jenkins, LFB Leila Hussain, LBR Samira Natafgi-Roberts, LBR	PREVENTION PROPORTIONALITY

2. Supporting the voluntary sector	• We will work with voluntary sector organisations to identify areas in which they could be more effectively supported, and support each other, to strengthen their contribution to safeguarding adults in Redbridge.	Lesley Perry, RSAB Manager	PARTNERSHIP
3. Working with providers	We will: • engage commissioned care providers more effectively in the work of the Safeguarding Adults Board; • explore the establishment of a Providers Safeguarding Forum to promote and share best practice; • review our systems and processes for responding to safeguarding concerns that arise in provider services, to ensure that they are robust, streamlined, and explicit about roles and responsibilities.	Samira Natafgi-Roberts, LBR/ Anthony Pardoe-Matthews, LBR	PROTECTION PARTNERSHIP
4. Transitional safeguarding	• Jointly with the Local Safeguarding Children's Board, we will develop proposals for an effective response to the needs of young adults at risk of exploitation, recognising that adolescence as a developmental phase does not suddenly end on the eighteenth birthday.	Mary Byrne, LBR	PROTECTION
5. Workforce development	We will: • seek to develop a multi-agency adult safeguarding programme • strengthen quality assurance of single	Stephen Snell, LBR	PARTNERSHIP ACCOUNTABILITY

	agency training by engaging peers from partner agencies in observation of training		
6. Liberty Protection Safeguards	• We will ensure that all agencies are fully prepared for the implementation of the Mental Capacity (Amendment) Act 2019, and that there are clear and agreed multi-agency procedures in place to support the implementation of the Liberty Protection Safeguards provisions, expected in 2020.	Leila Hussain, LBR	PROTECTION PARTNERSHIP PROPORTIONALITY
7. Hearing the voice of the service user	• We will seek to develop effective ways of hearing, understanding and acting on the voice of individuals who experience safeguarding interventions.	Ian Maxey, Voiceability	EMPOWERMENT
8. Strengthening mutual challenge and accountability	• We will promote a culture of constructive challenge and scrutiny at the Safeguarding Adults Board, holding ourselves and each other to account. We will hold a Development and Challenge Day to strengthen our planning and self-assessment activity.	John Goldup, RSAB	ACCOUNTABILITY