Redbridge Safeguarding Adults

REDBRIDGE SAFEGUARDING ADULTS BOARD

ANNUAL REPORT 2017/2018

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Foreword

I am pleased to introduce the Annual Report of the Redbridge Safeguarding Adults Board for 2017/2018. I took on the role of Independent Chair of the Board in June 2017.

The report makes clear that in many respects 2017/2018 was a transitional year for the Board. Although it had in place at the beginning of the year a 'broad brush' strategic plan, published in 2015, it had not complied with the requirement in statutory guidance to refresh and update it annually since publication. There was little clarity, therefore, about what specific action the Board and its partner agencies were committed to undertaking in pursuit of its statutory objective - to help and protect vulnerable adults in the Borough whose circumstances fall within the criteria set out in the legislation. It was a significant achievement for the Board to move quickly to agree its initial action plan for 2017/2018. It is now working against an agreed action plan for 2018/19 which is an Appendix to this Report.

Much of my time in my first year as chair has been focused on bringing two Safeguarding Adult Reviews (SARs) to completion, and on carrying out an independent review of the effectiveness of the arrangements in place within the integrated health and social care service for delivering the local authority's responsibilities for safeguarding adults. The findings of this review work are described in some detail later in this report.

In my foreword to the Annual Report for 2016/2017, which had been produced before my appointment as chair, I suggested that the aim of future Annual Reports should be to meet the same expectations as those placed by statutory guidance on the Local Safeguarding Children Board (LSCB): that the Annual Report should provide a rigorous and transparent assessment of the performance and effectiveness of local services, identifying areas of weakness, the causes of those weaknesses and the action being taken to address them. I wrote:

> *Fundamentally, the Annual Report should answer the question: how well are vulnerable adults in Redbridge safeguarded? This Annual Report for 2016/17 helps to begin to answer that question. I hope in a year's time to be introducing an Annual Report that enables a clear and comprehensive judgement to be made.*

I am aware, a year on, that I have not been able to wholly fulfil that ambition. There is much that is encouraging in the information that is presented in this report. I think in particular that the positive comments made by the Care Quality Commission (CQC), following inspections carried out during the year, on the robustness of safeguarding in both BHRUT (Barking, Havering and Redbridge University Hospitals NHS Trust) and NELFT are extremely encouraging. However, there is no external independent inspection of adult social care services other than those subject to regulation such as domiciliary and residential care. In the absence both of independent inspection evidence, and of any

ongoing audit and quality assurance activity in adult social care in Redbridge, I have not yet found it possible to reach any clear conclusion about the performance and effectiveness of that key service. Both Safeguarding Adults Reviews (SARs) exposed some serious concerns, one about historic practice in an individual case, and one about more recent dysfunction in a particular locality. However, it is not possible to say at the moment whether these reflect current or systemic issues, or are aberrations in a generally positive picture. My review certainly raised some fundamental questions about the pressures on the system and some of the apparent structural and cultural factors which exacerbate them or make them more difficult to deal with; but I was not able to adequately address the question in the review's terms of reference, 'Is there consistent and robust management oversight of practice?'. This was no doubt in part due to limitations in my methodology, and lack of time for the systematic evaluation of a sample of representative cases; but I did also conclude that:

> *The key elements in being able to see the management footprint in case management do not appear to be present. There is a need within adult social care for clearer expectations and guidance on supervision, and about the management oversight that should be evidenced on individual care records.*

I have not been able to get a clear answer to the question, 'How effectively are concerns about potential abuse or neglect in provider services addressed?'. Again, this may reflect the limitations of my understanding, or that I have not asked the right questions, and there is no doubt that staff in different parts of the organisation take such concerns seriously and work hard to try and address them. The issue seems to me about lack of co-ordination and uncertainty about who is responsible for what. One of the recommendations of the review was:

> *Much greater clarity is needed about the respective roles of the Contracts and Procurement Team, the Safeguarding Adults and Protection Team, and operational teams who hold responsibility for individual service users, in investigating concerns or allegations about providers. There is an urgent need for a single, coherent and clear procedure which is explicit about roles and responsibilities.*

I do think this recommendation needs to be progressed as a priority.

There is a very labour-intensive volume of data on local authority safeguarding collated annually, to meet the requirements set down by the Department of Health and Social Care (DHSC); but it is very hard to say what most of it means, in terms of the quality of practice. It is of course a characteristic of service data generally that it is very useful in telling you what questions to ask; but it very seldom tells you the answers. The system needs more capacity to try and find out the answers.

I want to end though on two very positive notes. The first is a thank you to the members of the Safeguarding Adults Board who have been keen to support the development of a Board which actually makes a difference, and very open to more challenge and scrutiny of their and the Board's work. And the second to is to warmly welcome the piloting within

adult social care of the 'People Matter/Three Conversations' approach, which is briefly described in Section 3 of this report. This model, with its focus on person-centred engagement and informal resolution of problems wherever possible at an early stage, has the potential, I believe, to transform social care delivery. Similarly, there are some very interesting suggestions from NELFT, for example, that a year on year fall in the number of safeguarding alerts raised may at least in part be an outcome of an increasing number of requests from staff for safeguarding advice at an earlier stage, facilitating the resolution of concerns without formal escalation. Perhaps there are glimpses in these developments of a less bureaucratised and more person-centred future for adult safeguarding work?

John Goldup

Independent Chair

Redbridge Safeguarding Adults Board

October 2018

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 fifteenth 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 a strategic plan, reviewed and updated annually, 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 SAB must arrange a SAR when an adult in its area dies as a result of abuse or neglect, whether known or suspected, or experiences serious abuse or neglect, and there is concern that partner agencies could have worked more effectively to protect him or her. The purpose of a SAR is to identify and apply lessons for future practice from the review, in order to improve the effectiveness of adult safeguarding in the future. However, the SAB may also conduct a review of any case which does not meet the criteria set out above, if it believes that there are lessons to be learned. Redbridge SAB completed two SARs in the period covered by this report.

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 which is reflected on the Redbridge Board.

The membership of Redbridge Safeguarding Adults Board at 31 March 2018 was as follows:

Mark Benbow	Community Safety Transformation & Enforcement Lead, LBR
Andrea Crisp (for Kathryn Halford, Chief Nurse)	Safeguarding Adult Lead, BHRUT
Ross Diamond	Chief Officer, Redbridge CVS
Glynis Donovan	Service Manager, Redbridge Carers Association
Bob Edwards	Integrated Care Director, NELFT
Mark Gilbey-Cross	Safeguarding Adult Lead, Redbridge CCG
Natalie Gourgaud	Regional Director, Care Quality Commission
Stewart Grant	Housing Area Manager, LBR
Andrew Hardwick	Commissioning Manager, LBR
Gita Hargun	Service Manager, Families Together Hub, LBR
Jacqui Himbury	Director of Nursing, Redbridge CCG
Will Hodgkinson	DCI, Safeguarding, MPS East Area BCU
Leila Hussain	Head of Service/Principal Social Worker (PSW), LBR
Jamie Jenkins	Borough Commander, London Fire Brigade
Ian Maxey	Service Manager, Voiceability
James Monger	Associate Director, Age UK Redbridge, Barking & Havering
Samira Natafgi-Roberts	Head of Safeguarding Adults & Protection Service, LBR
Samantha Spillane	Adult Safeguarding Lead, Bart's Health Trust
Margaret Summers	Chief Officer, One Place East
Cathy Turland	Chief Executive Officer, Healthwatch Redbridge

At its inception, the Board was chaired by the Council's Director of Adult Services. In April 2017, following his retirement, partners agreed to appoint an independent chair. John Goldup, who has chaired the Redbridge Local Safeguarding Children Board (LSCB) since 2014, took up the role in June 2017. 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. Until mid-2017, the Board had no Business Manager. Support to the Board was part of the wide ranging responsibilities of the Council's Head of Adult Safeguarding and Protection. However, in June 2017 it was agreed that Lesley Perry, Business Manager for the LSCB, would become Manager for both Boards.

Unlike the LSCB, 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 LSCB. This inevitably limits the range of work that can be undertaken under the auspices of the Board.

2. The Annual Report

2017/2018 was a transitional year for the Board. The Board had published a 'broad brush' Strategic Plan 2015 -2018 in 2015, which included a commitment to an annual action plan which would set out the detailed actions which the Board would be taking. However, at the point at which the independent chair assumed the role, there was no annual plan for 2017/2018 in place, and neither had there been a plan produced in 2016/2017, due to lack of capacity to develop one.

The Chair's first priority, therefore, was to develop and agree an annual plan for 2017/2018, to set the Board's priorities and to focus its work. The plan was agreed by the Board at its meeting in September 2017. It effectively therefore only covered six months of the financial year, and some of the key activities to which it committed the Board were only completed for presentation to the Board in June 2018. In the light of these exceptional circumstances, this Annual Report covers where appropriate an extended period, from April 2017 to June 2018. Activity data, however, relates to the twelve month period, 1 April 2017 to 31 March 2018. Published benchmarking data, however, where quoted, relates to 2016/2017, as comparative data for 2017/2018 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 (SARs) completed during the year, the findings and lessons learned, and what has been done to act on them. This report is primarily structured around those two requirements.

However, to set the context, it is important to ask first: what do we know about safeguarding activity in Redbridge and the outcomes achieved in 2017/2018?

3. Safeguarding activity, outcomes and performance

Overview

All partner agencies represented on the Board continue to demonstrate a strong commitment to the safeguarding of vulnerable adults, across both statutory and voluntary sectors. Voluntary sector organisations continue to play a leading role in a number of important and innovative partnership projects – for example, Age UK, Victim Support, and the Old Protectors are all active in the Bogus Callers Partnership, chaired and hosted by the London Fire Brigade. They maintain their commitment to ensuring that all staff and volunteers are appropriately trained on safeguarding issues. Importantly, the voluntary sector also plays a critical role in ensuring that the voices of vulnerable people, who might have difficulty in making their voices heard, are represented and engaged. Both Healthwatch and One Place East, for example, were active in raising the concerns of residents and families during the consultation carried out by the Clinical Commissioning Group in 2017/2018 on the proposed closure of a nursing home providing dementia care.

In December 2017 the Board agreed the final version for publication of its Multi-Agency Self-Neglect and Hoarding Protocol, developed by a working group led by Samira Natfagi-Roberts, Head of Redbridge Safeguarding Adults and Protection Service, and including the Borough Commander, London Fire Brigade (LFB), and the LBR Housing Service. The Protocol gives staff in all agencies detailed and practical guidance on recognising, assessing and acting on self neglect, including hoarding. One of the Safeguarding Adults Reviews completed during the period of this report, discussed in more detail later in this report, focused on the extreme complexity of decision making on self-neglect within the adult safeguarding framework, and the need for the most effective possible support and guidance in making such decisions. The Board agreed an implementation plan to accompany publication of the protocol, and agreed that an evaluation of its impact and effectiveness should be completed in 2018/2019. This evaluation will be led by the LFB Borough Commander.

There were a number of significant developments in 2017/2018 in the delivery and support of safeguarding activity in statutory sector organisations. In Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT), following the submission of a successful business case, a substantial investment to expand the Trust's Safeguarding Team was agreed. A number of posts were recruited to including a Safeguarding Advisor, Harmful Practice; two whole time equivalent Safeguarding Advisors in the Emergency Department, and a Safeguarding Adult Advisor to support the work of the Named Nurse, Safeguarding Adults. This has strengthened the support which the team can provide at both an operational and strategic level. There was a focus throughout the year on safeguarding training compliance: compliance with the requirements for Safeguarding Adults Level 1 and 2 training has been consistently above 95% since April 2017. A revised Mental Capacity Act e-Learning module was launched in October 2017 as "essential" training for all clinical staff, achieving 85% compliance by year end. A Deprivation of Liberty Safeguards (DoLS) patient/carer information leaflet was developed to explain the DoLS process as required by the Mental Capacity Code of Practice. This information was also developed in easy read format.

Within adult social care services, there was a successful pilot of 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 – 'People Matter'. 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 model was piloted between November 2017 and February 2018 on two sites: the First Contact Team (as the name suggests, is the first point of contact for all referrals and potential referrals) and one of the four health and social care locality 'clusters'. The initial data analysis from the pilot suggested that the model, while time intensive in the early stages of a contact, delivered significant reductions both in the volume of work passing from the First Contact team to a locality and in the need for long term care and support arrangements. In the pilot phase, referrals identified at the outset as "safeguarding referrals" were excluded from the application of the model. However, as the model is rolled out across adult social care, it could have a significant impact in reducing unnecessary safeguarding referrals, with its focus on fuller engagement at the point of first contact. Although there would clearly be risks that would need controlling in extending the scope of People Matter to safeguarding, this might be the area with the greatest return in terms of reducing unnecessary referrals to teams.

The central Adult Safeguarding and Protection Team within the Council's People Directorate carried several vacancies throughout 2017/2018, severely impacting on its capacity. However, by the end of the year it was fully staffed. This has been achieved through the employment of a stable group of agency staff. Budgetary pressures mean that agency staff contracts are subject to review and renewal on a three-monthly basis.

In February 2018 the Council launched on their Intranet a comprehensive set of Standard Operating Procedures, to ensure for the first time that adult social care staff have access to a consistent set of policy and procedural guidance in one place, regularly updated, as a basis for their work. The procedures include discrete sections on safeguarding, mental capacity and deprivation of liberty. The review of safeguarding arrangements described in Section 5 recommends that the next stage of this development should be the integration of the existing Safeguarding Adults Local Protocol with the Standard Operating Procedures to avoid unnecessary cross-referencing and duplication.

Other developments during the year reported by member agencies include:

- NELFT have introduced quarterly reporting by the Safeguarding Team to the Trust's Quality and Safety Committee. A range of safeguarding policies have been written or updated. The Trust safeguarding intranet page has been fully redesigned. To further strengthen the 'Think Family' approach the first joint Safeguarding Adults and Children Link Practitioners workshop was held in December 2017. This was attended by 39 staff and was positively evaluated. The Link Practitioners were updated on harmful sexual behaviours; professional curiosity; trafficking and modern day slavery; homelessness; and the NELFT safeguarding team's work to implement the learning disability mortality review project. Mental Capacity Act and Deprivation of Liberty Safeguards training has been placed into the 'mandatory' category and NELFT maintains training compliance at 95%+. The NELFT Safeguarding Team completed and published a range of audits in 2017/2018. Good practice identified included the timeliness and quality of advice given by the safeguarding advice service; 100% compliance with making safeguarding personal objectives and an increase in the appropriate use of safeguarding alerts in patient electronic records. Areas for improvement identified include the need to embed the use of safeguarding risk assessment tools such as those for child sexual exploitation, female genital mutilation and Safe Lives (domestic violence).
- The Clinical Commissioning Group (CCG) has further embedded the Designated Adult Safeguarding Manager role which has now been in place for two years, within the local health economy. During 2017/2018 there has been a higher level of scrutiny around the National Health Service's role within local safeguarding practices, including the monitoring of health-related actions resulting from Safeguarding Adult and Domestic Homicide Reviews. Additionally, there has been a greater level of assurance seeking from two large NHS providers, four independent sector providers and twelve care homes with nursing.
- The Council's Housing Service visited around 700 vulnerable residents in 2017/2018, signposting as necessary to appropriate agencies. They have continued to work closely with the London Fire Brigade to identify and address specific issues around fire safety, both within individual homes and communal areas. Work to reduce fire risk in the homes of vulnerable residents. A £30,000 grant from the London Fire Brigade enabled the development of a free online training tool for carers, care providers and housing providers to help protect vulnerable people from fire, which was launched in October 2017.
- The Metropolitan Police Service East Area Basic Command Unit (BCU) have agreed a performance framework for the BCU in which safeguarding issues, including modern slavery, human trafficking, domestic abuse, serious sexual offences, and hate crime, are central. The BCU has established a small qualitative review team which has undertaken a range of quality assurance work on both children's and adults' safeguarding issues.

Safeguarding activity, outcomes and performance

The volume of safeguarding activity continues to increase. In terms of the local authority's responsibilities for adult safeguarding under the Care Act, the number of safeguarding concerns raised in 2017/2018 was 964, compared to 846 in 2016/2017 – a 14% increase. This follows on from a 32% increase in concerns raised in 2016/2017, compared to the year before. In both years approximately 72% of concerns were judged to require a formal safeguarding enquiry under Section 42 of the Care Act. The number of enquiries undertaken increased from 610 in 2016/2017 to 695 in 2017/2018 – similarly, a 14%

increase. This continuing increase in the safeguarding workload for localities and other social care teams makes it particularly important that the authority can be confident that the thresholds for identifying an adult safeguarding issue are being correctly and consistently applied. This issue was thoroughly explored in the review of the effectiveness of the current arrangements for discharging the local authority's adult safeguarding responsibilities described in Section 5 of this report.

There were some significant shifts in both the age and gender profile of individuals in relation to whom safeguarding enquiries were raised or started in each year. In 2016/2017 59% of those individuals were female; in 2017/18 this increased to 65%. This change is probably linked to an increase in the number of people aged over 85. Those aged 85+ were the subject of 28% of the enquiries begun in 2016/2017; in 2017/2018 people aged 85 and over accounted for 34% of enquiries. In 2016/2017 safeguarding enquiries involved 18 individuals aged 95+; in 2017/2018 there were 43 such enquiries.

In other respects the profile of those subject to safeguarding enquiries remained broadly consistent. For example:

- In terms of ethnicity, 66% of subjects in 2016/2017 were white, compared to 70% in 2017/2018.
- In both years, risk related to neglect or acts of omission were the biggest form of risk identified, identified as the main risk in 38% of cases.

In both years, care provider services were identified as the source of risk in around 50% of enquiries completed: these enquiries related to enquiries across domiciliary, nursing home and residential care. The percentage of completed enquiries, considering potential risk from all sources and in all settings, which resulted in risk being identified and action taken fell in 2017/2018, from 78% in 2016/2017 to 68% in the year under review. Nevertheless, if in 68% of all enquiries the existence of some level of risk is substantiated, and 50% of those enquiries are triggered by a concern arising in care provider services, it follows that a large number of those concerns are found to be justified at least at some level. It is essential to have assurance that the processes in place for addressing those concerns, not just as they may affect the individual who is the subject of the specific enquiry but also as they might affect all service users receiving care from that provider, are robust. The Chair's review (Section 5) could not establish this assurance. It concluded that much greater clarity is needed about the arrangements in these matters for working together and sharing information between the Contracts and Procurement Team, the Safeguarding Adults and Protection Team, and operational teams who hold responsibility for individual service users.

One of the key principles of adult safeguarding work under the Care Act is personalisation – Making Safeguarding Personal (MSP). 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. The Annual Report for 2016/2017 reported that 67% of those subject to enquiries had been asked what they wanted the outcome of the enquiry to be and had expressed one or more desired outcome. The Report commented:

> *It is highly likely that front line staff are not always asking the views of service users or their representatives and involving them in the decision making process.*

Unfortunately, it is not possible to report on whether performance in this regard improved or not in 2017/2018, as the data has not been consistently recorded or collated. While the requirement to engage service users in this way is clearly set out in the relevant policies,

procedures and documentation, the Board cannot currently be assured that this requirement is being delivered in practice. This is a serious gap in our ability to evaluate the quality of safeguarding practice.

The volume of safeguarding referrals within BHRUT is more stable on a year to year basis. In 2017/2018, across all Trust sites in the three boroughs, there were 660 referrals to the Safeguarding Adults team, compared to 648 in 2016/2017. As in the previous year, the great majority, 90%, related to referrals raised by Trust staff concerning risks arising in the community. These included a significant rise in the number of referrals related to concerns about self neglect, from 93 to 163. However, 65 referrals were raised by external agencies reporting concerns within the Trust. Ten of these on investigation were found to be fully substantiated. Notably, they all related to failings in effective discharge practice.

There were 477 safeguarding alerts raised by NELFT in 2017, across all services and geographical areas of operation, compared to 606 in 2016 and 668 in 2015. There was however an increase in enquiries to the internal safeguarding advice service at an earlier stage which may prevent issues escalating to safeguarding concerns.

All the main NHS Trusts providing services to Redbridge patients were subject to CQC inspection activity in 2017/2018. BHRUT continued to be rated as 'requires improvement' overall following unannounced inspection in January and February 2018. However, inspectors were positive about safeguarding standards:

> *Nursing staff demonstrated an awareness of safeguarding procedures and how to recognise if someone was at risk or had been exposed to abuse…There were reliable systems and training to protect people from abuse. Staff were knowledgeable about safeguarding.*

However, inspectors remained concerned about the response to patients presenting with mental health problems at King George Hospital. They reported that staff did not understand their roles under the Mental Health Act, and did not record incidents relating to restraint or rapid tranquilisation consistently, with result that *'there was no way to audit the frequency of safety of those procedures'.*

Following inspection in October/November 2017, the overall rating of NELFT services improved, from 'requires improvement' to 'good'. CQC inspectors commented that 'robust safeguarding procedures were in place across all services and staff understood their safeguarding responsibilities'. Whipps Cross Hospital also improved its rating, from 'inadequate' to 'requires improvement', following unannounced inspection in May 2017.

Deprivation of Liberty Safeguards (DoLS)

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.

Having increased by 48% between 2015/2016 and 2016/2017 (from 541 applications to 799), the rate of increase in the number of DoLS applications made to the local authority slowed in 2017/2018. 842 applications were received – an increase of just under 5.4%. In

2016/2017 Redbridge received slightly more applications per 100,000 population than London as a whole – 430 compared to 412 per 100,000. However, for England as a whole the rate was significantly higher, at 492 per 100,000.

The balance between 'standard' and 'urgent' applications shifted significantly, with fewer urgent applications. In 2016/2017, 57% of all applications were 'urgent'. In 2017/18 this dropped to 44.5%. This appears to reflect an improved understanding among care home providers of the criteria for an urgent application, through the work of the Best Interest Assessors Forum in which assessors and providers meet regularly.

There was an even bigger shift in the balance between the number of completed applications granted and those not granted. In 2016/2017 49% of applications were granted, and 48% not granted, with a small number withdrawn. In 2017/2018 only 35% were granted, and 62% not granted. On the face of it, this would appear to suggest that a large number of applications made were inappropriate or unnecessary. However, this would be misleading. The great majority of 'not granted' applications come from hospitals, and relate to circumstances in which the subject is discharged or dies before assessment or before consideration of the application is completed. In these circumstances national procedures require that the application is categorised as 'not granted'. What is not clear is why Redbridge is such an outlier in this regard. While comparative data for 2017/2018 is not yet available, in 2016/2017, 56% of applications were granted in England as a whole, and only 32% refused. In 2016/2017 there were only two London boroughs who granted a lower percentage of applications received than Redbridge.

Performance on the timeliness of dealing with DoLS applications is discussed further in Section 4.5 of this report. DoLS applications made by BHRUT, across all sites, increased by 43% in 2017/2018 - from 699 to 996. This figure includes applications to all boroughs from which patients are admitted, and is not specific to Redbridge. In contrast, there were 73 DoLS applications across the whole of the NELFT area, compared to 136 in 2016/2017.

Transitional Safeguarding

Some concerns have been raised at the Board during the year about vulnerable young people becoming vulnerable adults and potentially falling through the gaps between two safeguarding systems – the concept of 'transitional safeguarding'. Clearly, children's and adults' safeguarding systems are based on different legislative requirements and responsibilities; there are significant conceptual differences; and the eligibility criteria, duties, and powers under which adult services operate are very different from those for children's services. Equally clearly, however, for many young people who have experienced or are at risk of harm – for example, from coercion into sexual activity, or gang affiliation, or who have been trafficked – that risk, and their need for support in a safeguarding context, does not evaporate on their 18th (or 21st, or 25th) birthday. Research in Practice for Adults (RiPFA) suggest in their Strategic Briefing, Mind the Gap: Transitional Safeguarding (August 2018), that vulnerable young people entering adulthood often 'fall over a cliff edge' in terms of support. This is a potential focus for some joint work between the Boards in the future.

4. Safeguarding Adults Board Action Plan 2017/18: actions, progress, and outcomes

The SAB Action Plan 2017/2018 was agreed at the Board on 20 September 2017. Progress against the headline actions is reported below.

4.1 Complete outstanding Safeguarding Adults Reviews (SARs) and identify action required to act on learning

Two Safeguarding Adults Reviews were outstanding at the beginning of 2017/2018. Progress on completing both of them was very slow at the outset, for a range of different reasons. However, final reports on both reviews were presented to the Board on 26 June 2018. The circumstances of each review, the findings, learning identified, and recommendations, are reported in more detail in a later chapter of this report.

4.2 Review of the effectiveness of arrangements, structures and practices for discharging the responsibilities of LB Redbridge for the safeguarding of vulnerable adults

This review was completed by the independent chair and presented to the Board on 26 June 2018. It particularly focused on an evaluation of the delivery of the local authority's responsibilities for adult safeguarding within the integrated Health and Adult Social Services (HASS) structure implemented in Redbridge in April 2016. In addition to desktop research, the review was based on over 40 interviews with a wide range of people – senior managers, middle managers, front line practitioners, commissioning and contracting staff, learning and development staff, and others. Perspectives were also sought from partner agencies. The review was also able to take account of the findings of the two SARs referred to above. The findings and recommendations from the review are discussed in more detail in Section 5 below.

4.2 Update safeguarding policies and procedures across HASS and integrate with Standard Operating Procedures.

Progress against this action is summarised in the Chair's review described above:

> *In February 2018 the Council launched on the Intranet a comprehensive set of Standard Operating Procedures, to ensure for the first time that adult social care staff have access to a consistent set of policy and procedural guidance, regularly updated, as a basis for their work. This is a very positive initiative. The section on safeguarding is extremely clear, comprehensive and easy to follow. However, it continues to suggest cross-reference to the Redbridge Multi-Agency Safeguarding Adults Local Protocol. This is cumbersome, and the contents of one are largely duplicated in the other. Practitioners consistently report that they do not find the Protocol in its existing format particularly user-friendly. I think it would take relatively little work to ensure that the Standard Operating Procedures fully replaced the existing Protocol. All guidance would then be in one place, in a consistent form, and always up to date. This would be a massive gain. While the existing Protocol is described as a multi-agency protocol, it is almost entirely guidance and procedure for the use of local authority staff. If all this guidance is contained within the Standard Operating Procedures, there will certainly be a need for a multi-agency protocol setting out roles and expectations of all agencies.*

However, this would be a much shorter document and could be developed under the auspices of the Safeguarding Adults Board very quickly.

If this recommendation is followed, the opportunity should be taken to review the existing suite of forms and procedural requirements that are currently set out in the Protocol. Practitioners consistently complain that the safeguarding process is too dominated by procedures, that there are too many forms, and that the forms are too long and too time consuming for there to be a realistic expectation that they will be fully completed. This is not to say that the process can properly be streamlined, and it may be that all the existing procedures and documentation remain essential. But the opportunity should be taken to ask the question.

4.4 Undertake scoping and preparatory work for a multi-agency approach to the prevention of adult abuse and neglect.

As a first stage, a literature review was undertaken by Public Health staff, and work begun on the scoping exercise. The Board agreed that the work on prevention of adult abuse and neglect should be taken forward in a wider Prevention Strategy for health and social care.

4.5 Continue to improve timeliness of decision making on Deprivation of Liberty Standards (DoLS) applications.

It was not possible to make progress against this action in 2017/2018. Out of 842 applications for authorisation received in 2017/2018, 235 (28%) remained outstanding on 31 March 18. This was almost identical to performance in 2016/2017 – 225 outstanding at the end of the year out of 799 received. Urgent authorisations should be completed within 7 days of application, and standard authorisations within 7 days. A review by the Council's Internal Audit service carried out in January 2018 found delays of six months or more in authorising standard applications, and up to three months in authorising urgent applications.

There are complex factors which give rise to this position. There is a clear question about whether adequate resources have been made available for this work; there are difficulties in recruiting and retaining the skilled assessors required for this work; and, as the Internal Audit report highlighted, there is a systemic issue in that currently only one officer, the Head of Safeguarding Adults and Protection, is authorised to grant or otherwise DoLS applications. It should also be noted that the volume of DoLS applications has increased enormously since 2014 as a result of a landmark Supreme Court judgement expanding the scope of the regulations – from 29 in 2013/2014 to 842 in 2017/2018. It should be emphasised that there is probably no local authority in the country which does not have large backlogs of applications and substantial delays in authorisations. Data published by NHS Digital estimates that the average time it would take local authorities in England to deal with their 2016/2017 end of year backlog, if no new applications were received at all, would be 7.3 months. The estimate for Redbridge was 8.4 months – the fifth highest figure in London. While this estimate has not yet been published for 2017/2018, it is unlikely, given the data above, to have materially changed.

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 2016/2017 we reported a backlog of 19 cases waiting to be progressed to the Court of Protection. At 31 March 2018 this had increased to 25 cases.

4.6 Review and strengthen arrangements for dealing with allegations of abuse within care provider services ensuring local procedures are in line with the London Safeguarding Adult Procedures.

Progress against this action is summarised in the chair's review outlined under Action 4.2 above:

> *At the outset of the review, I was shown a Provider Failure policy which had been in draft form since May 2017 but was still not completed or signed off. I was told that one of the reasons for lack of progress had been the difficulty of agreeing lead roles at various points in the process. The policy has now been completed and will be presented to the Council's Cabinet in June 2018. This is very positive, and the proposed policy is clear and easy to follow. However, the key question of who is responsible for what at key stages does not seem to be entirely resolved and there remains scope for ambiguity and potentially friction about the respective roles of, for example, the Head of Safeguarding and the Head of Contracts and Procurement.*
>
> *A range of documents available on the intranet cover aspects of safeguarding practice and procedure in the event of concerns relating to providers, including cross boundary issues. These include the Pan London Multi-Agency Adult Safeguarding Procedures, ADASS guidance on Out of Area Safeguarding Adults Arrangements, and a short section in the Redbridge Local Protocol on a protocol for the suspension of placements or contracts with providers when there are serious adult safeguarding concerns (although this does not clarify such practically key critical issues as who is responsible for convening and chairing meetings). Staff should not have though to cross reference to a number of different documents for guidance. There is an urgent need for a single, coherent and clear procedure which is explicit about roles and responsibilities. The Pan London Multi-Agency Safeguarding Policy and Procedures set out a clear six stage Provider Concerns process. This does not seem to be reflected in any documented local procedure in Redbridge, with lead responsibilities allocated.*

4.7 Establish a framework to quality assure safeguarding adults training and implement a process to evidence and monitor impact.

In March 2018, the Board agreed both a proposed 'tiered' structure for safeguarding adults, Mental Capacity Act and Deprivation of Liberty Safeguards training, and an associated Quality Assurance Framework. The agreed training structure provides for training at different levels and depth, from basic awareness training for all staff to a new programme to be developed on Safeguarding Leadership. It includes training for specific roles within adult safeguarding procedures, and specialist training in areas such as Mental Capacity Act assessments and Best Interests assessments.

The Quality Assurance Framework 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 recognised that obtaining firm evidence of the impact of training is a perennial challenge in all organisations. However, it warmly welcomed both the proposed training structure and the Quality Assurance and Evaluation Framework. Progress and impact will be reviewed by the Board in 2018/2019.

4.8 Jointly develop and implement a CCG/LBR quality assurance monitoring and improvement strategy for commissioned care services.

No specific progress was made with this recommendation. The Board considered that future work should link with action on 4.6 above.

4.9 Agree protocol with LSCB defining responsibilities of staff working with children for the identification and protection of vulnerable adults.

This action followed on the agreement between the SAB and the LSCB in March 2017 of a protocol to ensure that professionals working primarily with vulnerable adults or adults at risk understand and deliver on their responsibilities in relation to the protection of children within those households. A complementary protocol, setting out the equivalent responsibilities of professionals working primarily with children in relation to the protection of vulnerable adults, was agreed by both Boards in December 2017/January 2018.

4.10 Identification of evidence of the impact of the Multi-Agency Self-Neglect and Hoarding Protocol.

As the final Protocol was only agreed for publication in December 2017, the Board agreed that evaluation of impact should be deferred to 2018/2019.

Overall, this is perhaps best described as a mixed picture. A lot of work was completed which surfaced a number of issues which need to be robustly addressed over the next period if the Board is to be assured that the safeguarding of vulnerable adults is on a consistently secure footing in Redbridge. The ability and capacity of partner agencies to respond to and progress the learning from the Safeguarding Adults Reviews and the independent review of safeguarding arrangements will be critical in delivering improvements. The development of Standard Operating Procedures within the Council, the agreement of a much clearer framework for safeguarding training within adult social care, and the agreement of complementary protocols to encourage joint working and sharing of information between children's and adults' services staff where professional responsibilities overlap, as well as the development of a new protocol and guidance on self neglect and hoarding, are all important achievements. However, the lack of progress on timely progressing of DoLs applications is not simply a bureaucratic challenge: it means that large numbers of individuals are having their liberty unlawfully restricted for extended periods. Finally, while it is clear that serious concerns about provider services are pursued with some vigour, the lack of coordination and effective information sharing within the system means that full assurance of the appropriate protection of individuals in receipt of commissioned services cannot be given.

A copy of the Action Plan for 2018 – 2019 is an Appendix of this Report.

5. Review of the effectiveness of arrangements, structures and practices for discharging the responsibilities of LB Redbridge for the safeguarding of vulnerable adults

This review is briefly described under Section 4.2 above, as a key commitment embedded in the SAB Action Plan for 2017/2018. It was undertaken between November 2017 and June 2018 by the Independent Chair. The review found a strong commitment throughout the service to safeguarding vulnerable adults, with staff across the system working very hard and sometimes very effectively and creatively to do so. Perhaps inevitably however, a review of this kind tended to focus on areas for improvement.

Staff in the HASS localities expressed a powerful sense of being 'deluged' with safeguarding referrals, which, once badged in that way, automatically take priority over other work and in the words of one respondent, 'take on a life of their own'. All the operational staff interviewed agreed that once work has been identified as 'safeguarding', it will be prioritised above and at the expense of other work – for example, assessments of need or care and support plan reviews – which may in fact be more urgent. According to one manager:

"The only thing that gets allocated is safeguarding."

This must be a factor in the performance of adult social care in Redbridge on waiting times for assessment and the review of care and support plans. In mid-February 2018, 47% of service users had not had a care and support review in the past 12 months. The statutory requirement is for a minimum of annual review, although it should be noted that this is a requirement most local authorities fall well short of meeting. It was difficult to quantify the number of people waiting for a care and support needs assessment, or how long they have been waiting, due to data cleansing issues, but managers reported that there are substantial waiting lists. If assessments are overdue, or reviews are not being carried out, there is a risk that genuine safeguarding issues will not be identified or addressed in the situations of those service users.

Crucially, the review found that there is very wide variation in the thresholds being applied to define what is and is not an adult safeguarding issue, and as a generalisation the threshold is too low – in other words, a significant amount of work goes into adult safeguarding processes and procedures which does not meet the appropriate threshold. This is a significant factor in the obvious struggle that operational social care teams face in managing their workload. The procedures to be followed, and the recording required, once a service user's situation is defined as a safeguarding issue - and this can sometimes be a relatively routinised, 'err on the side of caution', decision - are complex and time-consuming. 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. 72% of safeguarding concerns in Redbridge progress into formal Section 42 enquiries. In London as a whole the conversion rate is 34%, and in England 37%. Redbridge is a conspicuous outlier in the proportion of referrals that are judged to require investigation under formal safeguarding procedures. It has the highest conversion rate in London, and the eleventh highest out of 152 local authorities in England.

There are a number of systemic factors which contribute to this. The variation in duty systems for dealing with referrals may influence conversion rates. Where there is a different worker on duty every day or every couple of days, the amount of information that can be gathered before the changeover of duty worker is limited. This may lead to

premature decision making on that limited information which is more likely to lead to progression to a Section 42 enquiry, if only to allow further information to be gathered. There was evidence that the difference between the way safeguarding is defined in the NHS, where any form of risk or harm to individuals whether or not it involves actual or potential abuse or neglect will be reported as a safeguarding concern, and the narrower Care Act definition, has become blurred in the minds of some staff. The systems for dealing with initial referrals in place in the First Contact Team do not facilitate sufficient filtering before, in the words of one interviewee, *"the safeguarding box gets ticked"*. However, over and above these systemic factors, there is clearly a cultural issue in social care teams evidenced in a number of comments from interviewees across the service:

> *"People think that the policy is that anything badged as safeguarding needs to go on to a safeguarding enquiry"*
>
> *"People don't feel confident to say they don't feel confident in dealing with safeguarding so they err on the side of caution"*
>
> *"There's no shared understanding of thresholds"*
>
> *"It's a really grey area what is safeguarding and what isn't"*
>
> *"It really depends on who you talk to"*

The review also considered the relationship between the strategic centre (the Safeguarding Adults and Protection Team) and operational services. There are enormous workload pressures on both sides. In particular, the central team takes almost exclusive responsibility for all the work related to the Deprivation of Liberty Safeguards (DoLS). The number of DoLS applications to be considered has expanded massively since 2014 as a result of landmark Supreme Court judgement expanding the scope of the regulations – from 29 in 2013/2014 to 799 in 2016/2017. This pressure makes it difficult for the Team to play the significant strategic, consultative, developmental or quality assurance role that one would normally expect of such a function. An Internal Audit report in January 2018 recommended that management review the resources and workloads around DoLS authorisations and the SAB Chair's review also concluded that the Council needs to urgently review the way in which DoLS work is resourced and managed. The review found that the relationship between the strategic centre and operational services needs to be significantly strengthened and developed. Fundamentally, the Council needs to determine what it wants a specialist safeguarding service to deliver, within the resources it can make available, and how those resources should be best configured.

Social care staff are positive about the quality of the safeguarding training on offer, but raised many issues about its availably and waiting times. Several managers and front line practitioners commented that the biggest gap in the training offer was in skills development for practitioners – a gap between basic awareness training and training for managers taking on the Safeguarding Adults Manager role.

Concerns and allegations about providers are taken seriously and the Contracts Team in particular appear vigorous in following them up. However, it was consistently reported in the review that when issues are identified with a particular provider, potentially affecting

numbers of service users across several localities or service areas, there are no clear arrangements for co-ordinating the gathering and analysis of information or the planning of action. Greater clarity is needed about the respective roles of the Contracts and Procurement Team, the Safeguarding Adults and Protection Team, and operational teams who hold responsibility for individual service users.

There is an urgent need for a single, coherent and clear procedure which is explicit about those roles and responsibilities.

In the course of examining safeguarding arrangements, the review identified a number of wider issues. In particular, the quality assurance of social work practice in the HASS needs to be strengthened. Consideration should be given to introducing a peer auditing programme. Safeguarding practice, including the application of thresholds, should be an early focus of such a programme. There is a need within adult social care for clearer expectations and guidance on supervision, and about the management oversight that should be evidenced on individual care records.

Next steps

The final report of the Chair's review of the effectiveness of local authority arrangements for safeguarding adults in the London Borough of Redbridge was considered at the Section 75 Executive Steering Group on 29 June, following its consideration at the Safeguarding Adults Board. This is the senior officer group which manages and monitors the Partnership Agreement under which the integrated health and social care service is provided. The Group endorsed the review report and accepted all its findings and recommendations in principle. An action plan is now being developed to address those findings and recommendations.

6. Safeguarding Adult Reviews (SARs): findings, learning and recommendations

As this report has already noted, two SARs were completed in June 2018.

Safeguarding Adults Review: Ms A

Brief summary of circumstances and findings

Ms A was a woman with severe learning disabilities, aged 54 at the time of her death in January 2014. From November 2011 until her death she lived in a Supported Living flat. However, her care and support needs were met, not by the accommodation provider, but through a Direct Payment which funded a 24 hour package of live-in support. This arrangement was agreed in a crisis, following the breakdown of previous care arrangements. This was fully funded by the Redbridge Clinical Commissioning Group (CCG) under Continuing Health Care arrangements. Ms A had exhibited very challenging behaviour from an early age. She also had a number of physical health issues and conditions.

The care plan at the point of placement in November 2011 was that care would be provided on a shift basis by five different workers. However, within three months four of the workers had left, and all care at that point was being provided by a single worker, who had previously been Ms A's key worker in the care home in which she lived from August 2008 to April 2011. This care worker persuaded Ms A's sister, who was responsible for the management of the Direct Payments budget, that a colleague from this care home should be employed to join her. After a short period of time, they were the only two care workers employed to work with Ms A. It is clear from social care review records that there were only two care workers providing 24 hour, seven day a week care for Ms A, and that they each worked alone. However the risks to Ms A's welfare created by this arrangement were never identified or addressed. Although Ms A's care was fully funded by the CCG, professional ownership sat with the Learning Disability Team, a multi-agency service provided through a Section 75 partnership agreement between LB Redbridge and NELFT, and managed by NELFT. (Since April 2016, these services have been provided as part of the integrated health and social services (HASS) partnership between LBR and NELFT, and delivered through the four HASS localities rather than as a single borough-wide service.) A number of professionals from different disciplines were involved with Ms A. However, it does not appear that these different roles and interventions were co-ordinated as part of an overall plan, or were clear to or understood by Ms A's sister. Crucially, there does not appear to have been any individual whose role was to coordinate the provision and oversight of Ms A's care, or with the primary responsibility for understanding her daily lived experience. As a result, neither the inadequate nature of the care being provided, nor the increasing stress on Ms A's sister, were understood or addressed.

Tragically, Ms A died in January 2014, after being found unconscious in her bath. There was a lengthy investigation into Ms A's death and a number of pathology reports were produced. However, pathologists were unable to determine the cause of death or to attribute it to any actions on the part of the carer present in the flat at the time. However, due to what the Crown Prosecution Service (CPS) described as the 'deliberate failure' of the carer to call an ambulance between 9.15pm, when she discovered Ms A in the bath, and 10.06pm, when her colleague, who she had contacted by phone, called one, the carer present at the scene was charged with criminal neglect. She pleaded guilty to the charge and in February 2016 was sentenced to a short term of imprisonment.

Having considered a detailed report on the case in June 2018, the Board agreed without reservation that Ms A had suffered from serious failings in both the quality of care and the quality of professional oversight. It did however confirm that it was not possible to identify any evidence that those failings contributed to her death, the cause of which remained uncertain. The Board also expressed its sincerest condolences to Ms A's family. In particular, it recorded its appreciation of her sister's willingness to contribute to the review of the death of the sister whose interests and welfare she had fought so long and hard to protect, in spite of her own distress and grief.

Learning identified from the review

- Most fundamentally, the review highlights the absolute importance of effective co-ordination and review of the care arrangements in place for people with the most complex needs and vulnerabilities. This is true, not only for those receiving self-directed support (although as this case shows there are potentially specific risks and vulnerabilities in such situations), but in all care settings.
- Specifically, where care is funded by NHS Continuing Care, it is vital that arrangements for care co-ordination are explicit, recorded, and very clearly communicated to service users and families; and that robust arrangements are in place for meeting the primary health care need(s) which are the basis for Continuing Care eligibility in the first place.
- Reviews must not become simple checklists. They must concentrate on understanding the lived experience of the service user, and be conducted in a way that facilitates and supports both service users and families to express their concerns and worries.
- Where there are complexities of funding and different professional responsibilities, clarity between professionals, and between professionals and service users and families, is essential. Professionals must not assume that simply informing service users and families is sufficient to ensure understanding.
- There are risks to making long term care arrangements in a crisis and / or in response to pressure, which must be carefully considered and balanced before decisions are made. The welfare and needs of the service user must be the first consideration at all times.
- There was at the time of these events (2011) a shortage of appropriate care provision for people with the most complex needs and challenging behaviour, able to respond effectively at points of crisis, and Safeguarding Adults Review Panel members reported that this continues to be the case.
- For service users with the most complex needs and vulnerabilities, there are significant risks and challenges as well as substantial benefits in the use of Direct Payments.

Recommendations agreed by the Safeguarding Adults Board 26 June 2018

1 NELFT and LBR should jointly review the arrangements in place to identify those service users with the most complex needs 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.

2 The CCG should review all current cases of Redbridge residents whose care is funded by NHS Continuing Health Care, to ensure that effective and explicit care co-ordination and robust arrangements for meeting primary health needs are in place.

3 LB Redbridge should review its guidance and procedures on care reviews to ensure that the review focuses on the lived experience of the service user and is conducted in a way that facilitates and supports both service users and families to express their concerns and worries.

4 The Health and Adult Social Services Management Team should consider how most effectively to disseminate learning from this review through all multi-disciplinary teams.

5 LBR and the CCG should ensure that they address the issue of shortage of appropriate care provision for people with the most complex needs and challenging behaviour, able to respond effectively at points of crisis, in the development of joint commissioning strategies, in particular the draft Strategic Commissioning Framework for People 2018-2023 considered by the Council's Cabinet on 6 March 2018.

6 LB Redbridge should consider whether the completion of enhanced DBS checks on people employed by Direct Payment service users should be a condition of such payment; whether there should be more specific guidance on the limited circumstances in which the local authority might consider that a Direct Payment is not an appropriate way to meet a person's needs; and whether there is sufficient guidance and support available to enable service users with the most complex needs and vulnerabilities (or authorised/nominated persons acting on their behalf) to manage their care effectively.

7 The relevant agencies identified should report back to the Board at its next meeting on the outcomes of their considerations and any actions taken.

Safeguarding Adults Review: Mr B

Brief summary of circumstances and findings

Mr B was 72 years old at the time of his death. He lived alone. On 1 September 2016, following a report from a neighbour who heard him calling for help, he was found in his bath, in which he had been stuck for three days, by the police and the London Fire Brigade. He was taken to King George Hospital by the London Ambulance Service and was admitted to hospital. He was discharged from hospital on 22 September 2016. On 8 November 2016, following a report of a fire in his home, he was found dead in his bedroom of a heart attack. During this attack, he had fallen into an electric fire which had caused a fire in the property. However, no smoke was found in his lungs, suggesting that he was dead before the fire started. The cause of death was determined to be heart disease.

From December 2009 onwards, Mr B had a number of hospital admissions or attendances, for a variety of reasons including leg ulcers, congestive cardiac failure, atrial fibrillation, and kidney injury. On one admission in April 2015, his home was described as 'unkempt'. A later admission in July 2016 was triggered by a fall in public after self-reported consumption of six beers. On this occasion he was again described in the hospital record as 'unkempt'. No safeguarding referrals or other referrals to social care were made on any of these occasions, and he was not known to social care services before his admission on 1 September 2016.

On his admission, the hospital ward raised a safeguarding alert because they were concerned about self neglect. The police also submitted a notification to the adults.alert mailbox, expressing extreme and graphic concern about the conditions of Mr B's flat – 'extremely bad and not a fit environment for somebody to live in'. The management of the hospital social work team, having considered the available information, decided that Mr B's needs should be considered, not through safeguarding procedures, but through an assessment of his needs for care and support under care management procedures.

While in hospital, Mr B was seen on numerous occasions by hospital Occupational Therapy and physiotherapy staff for observation and assessment. A hospital social worker visited Mr B on the ward to begin an assessment of his needs for care and support. The assessment was not completed at that point, pending the conclusions of the OT and physiotherapy assessments. On 20 September 2016 the team received a completed OT Discharge report. The social worker went to see Mr B to undertake a care management assessment on 23 September 2016. However, she discovered that Mr B had been discharged from hospital the previous day. The hospital social work team had not received advance notice of his discharge, as required by the BHRUT Discharge Policy. The Trust acknowledges that this was an oversight. The hospital social work team referred the case to the Seven Kings Health and Adult Social Services locality. District Nurses from Seven Kings visited Mr B at home on numerous occasions between 24 September 2016 and 6 November 2016. From the first visit, the District Nurses were recording that Mr B was in need of social care assistance. An urgent referral was made to social services on 30 September 2016, and again on 28 October 2016. On 24 October 2016 and 28 October 2016, the duty social worker requested that a social worker be allocated. The case was not allocated, and social services had no contact with Mr B between his discharge from hospital and his death.

The review focused on two significant aspects of this: firstly, the decision made by the management of the hospital social work team, on receipt of the safeguarding referral from

the ward, that no further action should be taken under safeguarding procedures, but that Mr B's needs for care and support should be considered through care management; and secondly, the lack of action by social services within Seven Kings on the referral from the hospital team, in spite of the increasingly urgent requests from the District Nursing service for social care involvement. On the first matter, neither the SAR Review Panel nor the Board reached a consensus. However, all recognised that an alternative decision, to pursue through safeguarding procedures, would not have conferred on social services any additional powers to override Mr B's choices, and would not have guaranteed any change in the circumstances to which he was discharged. It was suggested, however, that if it had been defined as an adult safeguarding issue, it would have focused more urgent attention while Mr B was still in hospital on working with him to persuade him to recognise the risks to which he was exposing himself and to accept some support to mitigate those risks, and that it would have secured a more urgent response on discharge from the Seven Kings Duty Service.

Whatever the different views on the appropriateness of the decision on the safeguarding referral, all agreed that what the case highlighted, and the most important learning to come out of this review, was the extreme complexity of decision making on self-neglect within the adult safeguarding framework, and the need for the most effective possible support and guidance in making such decisions. Everybody recognised that the first principle was 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, everybody also recognised that there is 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, as in this case, there will not often be a clear cut 'right or wrong' answer.

On the second question, the Board accepted the review's conclusion that in November 2016 the social services duty system at Seven Kings was inadequate, unsafe, unfocused and lacking in sound practice, supervision and management. Members were therefore very pleased to receive a very detailed report, with appendices, from the current permanent Team Manager at Seven Kings, in post since January 2018, describing the current duty arrangements in the cluster, and describing the improvements made against all of the failings identified in the review. After considerable discussion, the Panel and the Board felt assured that, while the accepted failings in the autumn of 2016 are deeply regrettable, the system and the arrangements now in place have satisfactorily addressed those failings. The Panel was also aware, however, that there are a variety of duty systems operating in the different clusters, and felt reassurance should be sought that the arrangements in all clusters are as robust as those in Seven Kings appear to be. The case of Mr B had highlighted significant issues at the time about communication and responsiveness between different elements of the service, the District Nursing Service and the social care duty service. The Panel were pleased to learn, for example, that there are now twice weekly meetings between service leads in the cluster, to ensure that any issues are shared and resolved promptly, and that joint visits between social care and health professionals are now established as common practice.

It was clear that the fire in Mr B's property was not the cause of his death. However, there were points during the course of events where a more robust response to fire risk would have been appropriate. Although the London Fire Brigade did fit smoke alarms to the

property after the incident of 1 September 2016, they did not raise a safeguarding concern, which in the words of the review carried out by the LFB 'did not entirely comply with LFB policy standards'. Although on two occasions District Nursing staff alerted Mr B about the dangers of using his electric fire, they did not make a referral to the fire service. Representatives of the LFB at the Panel were extremely keen to emphasise that they welcomed and wanted referrals on any individuals that health or social care services identified as potentially at any level of fire risk, and that the great majority of fire deaths were of individuals who were vulnerable as a result of mobility, frailty, mental health, self-neglect, and other care and support issues.

Recommendations agreed by the Safeguarding Adults Board 26 June 2018

1 The complexity of decision making on self-neglect within the adult safeguarding framework, and the need for the most effective possible support and guidance in making such decisions, must be acknowledged.
2 The Board must ensure that this is fully considered and reflected in the review of the Self-Neglect and Hoarding Protocol which is programmed in the Board's Action Plan for 2018/2019.
3 The Health and Adult Social Services Management Team should assure itself of the robustness of social care duty systems throughout the service and report the outcomes of such an assurance programme to a future meeting of the Board.
4 The Board will work with the London Fire Brigade to promote to all agencies and providers the importance of referring to the LFB any vulnerable individual who they identify as potentially at any level of fire risk.
5 The Board will develop for consideration at its next meeting a multi-agency escalation and dispute resolution protocol, 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.
6 In the light of the length of time that this and the SAR on Ms A have taken, and a number of process issues that have arisen, the Board will develop for consideration at its next meeting a revised version of the Safeguarding Adults Review Protocol.

Appendix

Redbridge Safeguarding Adults Board (RSAB) Action Plan 2018 – 2019

Action	Lead Officer	Target Timescale
1. Presentation of findings and recommendations from SARs and implementation of learning.	Independent Chair	• Presentation of findings and recommendations by June 2018. • Agreement of actions by June 2018. • Incorporation of actions into Action Plan from Independent Review
2. Review of the effectiveness of arrangements, structures and practices for discharging the responsibilities of LB Redbridge for the safeguarding of vulnerable adults.	Independent Chair	• Complete review and report to Board June 2018 • Agreement of recommendations • Development of Action Plan • Implementation of Action Plan July 2018 – March 2019
3. Safeguarding Adults at Risk Audit 2018 – 2019.	Business Manager	• Individual single agency audits using London SAB Audit Tool by December 2018. • Development of a multi-agency action plan from findings by March 2019. • Implementation of the Action Plan January – March 2019.
4. Implementation of the Safeguarding Adults Training Framework and evaluation of the impact of training.	Learning & Development Co-ordinator, LBR	• Implementation of the Framework from April – June 2018. • First report on evaluation of impact of training – December 2018.
5. SAB Annual Report 2018 – 2019 highlighting impact and outcomes from safeguarding work.	Independent Chair	• Publication of Annual Report 2017 – 2018 by 31 October 2018.
6. Evaluation of impact of Multi-Agency Self-Neglect and Hoarding Protocol.	Borough Commander, London Fire Brigade	• Report to Board in September 2018.
7. Consideration of learning and application of recommendations from Redbridge Domestic Homicide Reviews (DHRs) and those of neighbouring Boroughs, and neighbouring Safeguarding Adult Board (SAB) Safeguarding Adult Reviews (SARs).	Business Manager	• Establish a process for sharing learning and recommendations with neighbouring Boards/Boroughs by 30 June 2018. • Development of a template for the provision of summary learning by 30 June 2018. • Routine sharing of summaries with Board partners and schedule of discussions as appropriate on Board Agenda.