Lewisham
Safeguarding Adults Board

A working partnership to prevent abuse

Annual Report 2021-22

1 April 2021 to 31 March 2022

Message from the Independent Chair

"Relationships between the Board's partners, and agency engagement with the Board, remain strong, collegiate and collaborative, and challenging when appropriate."

Once again it is my pleasure to provide the introduction to this year's annual report. The ongoing pandemic has continued to shape *how* the Lewisham Safeguarding Adults Board has approached its work, but the focus on its three statutory duties has remained: publication of an annual report; focused work based on a strategic plan; and the commissioning and completion of Safeguarding Adults reviews (SARs).

This annual report includes details of SARs that have been completed, commissioned or have continued during the year in focus. The Board has followed through on learning from previously completed SARs, including seeking assurance regarding fire safety in care settings. Events have been held to disseminate learning from completed SARs, and assurances have been provided to address these findings, and from reviews completed elsewhere.

This annual report contains the Board's refreshed Business Plan which was revised at an event that also assessed the delivery of the Board's objectives.

Work continues on raising awareness amongst the diverse faith and other communities in Lewisham, and there has been a continued emphasis on the importance of performance reporting in order to seek assurance about the effectiveness of partnership working.

This annual report contains a summary of analysis of trends. One trend reported nationally, is an increase in the number of adult safeguarding concerns relating to self-neglect, including hoarding.

Learning and development has been a key component of the Board's work in this reporting year, including a focus on domestic abuse and the dissemination of resources through an ever-growing web platform.

Adult Social Care departments will be inspected by the Care Quality Commission from next year as a result of the Health and Care Act 2022 coming into force, which will include a focus on adult safeguarding. The same legislation will see Clinical Commissioning Groups replaced by Integrated Care Boards. Safeguarding will continue to feature prominently in these new arrangements across South East London.

The Board has plans in place to support partners with the introduction of the new Liberty Protection Safeguards (expected in 2023) and a new Code of Practice that accompanies the Mental Capacity Act 2005.

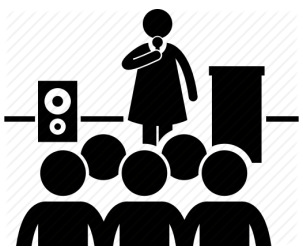
Relationships between the Board's partners, and agency engagement with the Board, remain strong, collegiate and collaborative, and challenging when appropriate.

Finally, I would like to appreciate the contributions of Martin Crow, Vicki Williams and Tiana Mathurine who manage the business and administrative tasks of the Board efficiently and effectively. I would also like to acknowledge the work of practitioners and managers who are committed to keeping people safe in Lewisham.

Professor Michael Preston-Shoot

Our Impact in 2021-22

PREVENTION



A total of 846 people attended 23 **learning and development events** during the last 12 months, which is the highest volume of training ever delivered by the Board (see page **5** for more details).

A total of 77 people attended a series of 4 Cultural Humility Workshops commissioned by the Board and delivered by Mabadiliko (local Community Interest Company specialising in anti-racism work). The Board also delivered a Networking and Safeguarding Champions event at the Lewisham Islamic Centre attended by 40 people, invited Lewisham Refugee and Migrant Network to become Board members, and built a **focus on racial disparity and disproportionality** into all relevant projects, audits and other pieces of work. This was a key prevention objective for the Board in 2021-22 which continues into 2022-23 (see page **12**).

Awareness raising campaigns were delivered throughout the year, including during the national Adult Safeguarding Awareness Week in November 2021. 172 delegates attended events delivered by the Board during that week, and 22,000 impressions were achieved on social media in 5 days, which is the highest volume of activity the Board has achieved online in a single week (see page **6** for more details).

ACCOUNTABILITY

The Board launched the **Lewisham Adult Safeguarding Pathway** on the 1 April 2021. This is the first time the Board has had a consolidated set of local and detailed guidelines to support the London Multi-Agency Adult Safeguarding Policy and Procedures. There were 14,450 hits on the Pathway webpages on the Board's website during the first 12 months, and numerous local agencies have now accessed this guidance.

The Board also continued to have a significant case load in relation to statutory Safeguarding Adults Reviews (see pages **9 &10**), and agreed to work with other strategic partnerships to create a **joint learning and development project** for 2022-23.

PARTNERSHIP

The Board hosted a launch event for the Borough wide **Domestic Abuse and Violence Against Women and Girls Strategy** in December 2021. This was attended by over 100 delegates and the opening address was given by Nicole Jacobs (Domestic Abuse Commissioner). The Board also continued to expand its networks and reach into local communities throughout the year, including with the use of regular e-Bulletins which were read by over 12,000 people during 2021-22 (see page **6** for more engagement information).

Case Studies

James was referred into the Hospital Adult Social Work Team (HAST) at the University Hospital of Lewisham (as a Lewisham resident) by Social Work colleagues at the Kings College Hospital (KCH), who in turn had passed on a Safeguarding Concern from the London Ambulance Service (LAS).

A neighbour of James had made an emergency call to LAS due to him being cold and having trouble breathing. He was taken and admitted into KCH.

Before the pandemic James had been fairly independent, but due to the Covid-19 restrictions had become more isolated, which had resulted in a deterioration in his health to the extent he had become quite frail.

There were some signs of ‘self-neglect’, including the refusal of help and services.

After James was admitted to Hospital consent was given for a Social Worker in the HAST Team to contact the neighbour and gain access to the property, and for the Council’s Special Duty Team to attend and to help de-clutter and clean the property.

The Social Worker found the property to be in a severe state of disrepair with no heating or working boiler (no hot water).

When the HAST Team started to make the arrangements for James to be discharged from Hospital they contacted the social landlord to arrange for repairs to be made to the property as it was not safe for him to return home.

Action was taken to install some new electrics and make the home safe and warm, and a homecare package was also established.

The London Ambulance Service attended Ellie's home in response to a medical emergency (heart condition), but raised Safeguarding Concerns linked to the very poor state of repair at the home address.

A number of different professionals attempted to engage Ellie, who is elderly and has physical health and mobility problems, to gain entry to the property, including a Care Co-Ordinator and an Occupational Therapist. Access was eventually gained and evidence captured of the property being in very bad state of repair including hoarding, flooding and 'dents' in the walls, which might have been an indicator of possible violent behaviour.

Ellie lives with two other relatives who are the registered tenants, and Ellie had sold a previous property before moving in with them. Safeguarding Enquiries revealed that Ellie had borrowed one of relatives some money after selling the previous property, which also highlighted concerns about possible financial abuse, and suspicions that Ellie may be suffering from coercive and controlling behaviour.

Ellie did have the mental capacity to make her own informed decisions about her health, wellbeing and housing at the time in question, although further assessments of mental capacity may be needed. The Safeguarding Adults Manager (SAM) continues to carefully monitor this case and has escalated this to senior managers and the Council's legal team, as this may need to be escalated to the Court of Protection. The Safeguarding Enquiry Officer would like to see Ellie re-housed into suitable supported accommodation as an adult at risk of abuse and neglect.

A neighbour found Winston unconscious at home after a fall and contacted the emergency services. Winston was admitted to hospital due to the injuries he sustained, and although a plan was formulated to discharge him to a local care home, he refused this and returned home after treatment.

A Safeguarding Enquiry was initiated due to concerns about self-neglect, and Winston also has a diagnosis of Parkinson's disease, alcohol misuse and a history of psychiatric problems.

Winston's home was in a very dilapidated state with mice and pigeon infestations, and hoarding rated at level 6 on the Clutter Rating Scale. Winston also had a dog that was not in good health.

A multi-agency approach was taken to try and improve the situation for Winston involving animal welfare, the London Fire Brigade, social work input and other services from within the Council.

Winston instructed a solicitor to contact the local authority to tell them to leave him alone as he was not receptive to any further support. However, the SAM continues to monitor the case and has wrote back to the solicitors outlining the local authorities duty of care to help protect Winston.

Read here for more Information:
Self-Neglect & Hoarding Multi-Agency Policy, Practice Guidance and Hoarding Toolkit

Learning, Training and Development

The Board delivered a new **Foundation Level Introduction to Adult Safeguarding** training course throughout the year to 234 people, which has been supported by the publication of a Workbook (same name). This is particularly useful for volunteers who may not be able to readily access I.T or training, but who have colleagues who can help to print this off for them.

This can be accessed here: Introduction to Adult Safeguarding Workbook

The Board also delivered a two-day **Multi-Agency Safeguarding Adults Manager** training course for the first time in November 2021 in conjunction with the Safeguarding Adults Boards (SABs) in Greenwich and Bexley. This joint working allowed colleagues in the Metropolitan Police Service, who cover all three Boroughs, to participate in this training alongside Council and NHS staff.

The Board also collaborated with the City of London Police, who are the lead agency for conducting **Fraud and Financial Abuse Investigations**, to deliver a workshop on this subject during the National Adult Safeguarding Awareness Week.

A **Sexual Abuse Awareness Session** was also delivered during this week in conjunction with the Violence Against Women & Girls (VAWG) Forum, and the Board Chair delivered a **Learning from Safeguarding Adults Reviews** session which was attended by delegates from across the country.

During this week of activity the Board developed and shared a learning programme along with five other SABs in South East London: Bexley, Bromley, Greenwich, Lambeth and Southwark.

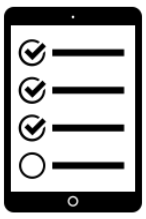
Communication and Engagement

Use of the Board's **website** is up again with 76,245 'hits' in 12 months. ✓

Social media activity is also up with 62,000 impressions on Twitter and 500+ followers. ✓

Links to new groups and communities continues, partly facilitated by the ongoing delivery of **networking events**, which have now re-started face to face. 145 people attended these in the last year. ✓

The Board ran several **surveys for professionals** throughout the year which helped with the development of safeguarding practice.



Key Questions:

- My organisation is effectively using the Lewisham Adult Safeguarding Pathway: 50% said yes
- Online and or remote working has meant we are missing opportunities to identify abuse or neglect: 51% said yes
- Workload pressures mean we are not as effective as we should be in protecting those most at risk in the Borough: 33% said yes

Comments included:

"Because our clients are very vulnerable due to their immigration status, more work needs to be done to break down barriers to reporting abuse, as they are fearful this will lead to re-percussions if they approach statutory services for help".

"We have found that when we submit a Safeguarding Concern there is no feedback and we don't know how effective our reporting is".

The Board has also worked in conjunction with the Norfolk SAB and Lewisham Speaking Up (local self-advocacy group) to produce an animated video **'Tricky Friends'.** This helps adults living with a learning disability to understand the risks linked to their social networks and friendships. **See the video here:** Tricky Friends

Safeguarding Information 2021-22

Table 1: Performance Dashboard 2012-22

Green = above benchmark Orange = near miss Red = way below benchmark

	Strategic Objective	Performance Criteria	Q1	Q2	Q3	Q4	RAG Rating
1	**Prevention 2:** Help to break down barriers to reporting abuse and improve access to supportive and protective services	There are a minimum of 160 concluded safeguarding enquiries each quarter (includes other enquiry)	104	79	83	70	Average was 84
2		At least 10% of Police MERLIN/Adult Come to Notice Reports lead to a Section 42 Enquiry	2%	10%	8%	9%	Average was 7.25%
3		At least 50% of Section 42 Enquiries are concluded within the target timescale (40 days)	56%	60%	69%	46%	Average was 58%
4		At least 85% of all Section 42 Enquiries result in the risk to the adult being reduced or removed	93%	64%	64%	74%	Average was 74%
5	**Prevention 3:** Listening to the 'Voice of the Adult'	At least 75% of adults involved in a Section 42 Enquiry were asked their desired outcomes	56%	79%	100%	93%	Average was 82%
6		At least 75% of those involved with a Section 42 Enquiry were satisfied with their outcomes	42%	61%	73%	71%	Average was 62%
7	**Partnership 2:** Fully support the delivery of the Domestic Abuse Strategy	There should be an increasing number of Safeguarding Enquiries by the Local Authority for this subject. The average for each quarter in the last two years has been (5)	3	2	2	5	Average was 3

These benchmarks have been established based on national outcomes (averages) or local reporting patterns and trends over the last 2-3years.

The adult Multi-Agency Safeguarding Hub (MaSH) was launched in June 2021, which is the single biggest procedural change to the way in which safeguarding enquiries are managed in the Borough since the Care Act 2014 came into force.

This new way of working has created some uncertainty, which in turn has affected some of the outcomes highlighted above. A further review of local processes and systems was instigated in early 2022, which is leading to improvements to the way in which safeguarding procedures are delivered, and how performance information is captured. Further audits and policy developments are also planned during 2022 to help improve the delivery of these strategic objectives, and in particular no. 4.

Table 2: Types of Abuse - Concluded Section 42 Enquiries 2021-22

51% of all concluded Enquiries were linked to Neglect & Acts of Omission which is a very high proportion, and not something we have seen in recent years. Although the overall number of concluded s.42 Enquiries has reduced from the previous year, the number for this subject has still increased by 20% from 2020-21. This might be a reflection of the pressure on services and unpaid informal carers post pandemic, which has resulted in this increase.

30% of all abuse types combined was linked to the Adult's Own Home, and 23% in Residential Care Homes.

The trend in the adult's own home may also be linked to the post pandemic period, as more issues have been identified or reported as services have started to re-open and re-engage face to face with adults at risk.

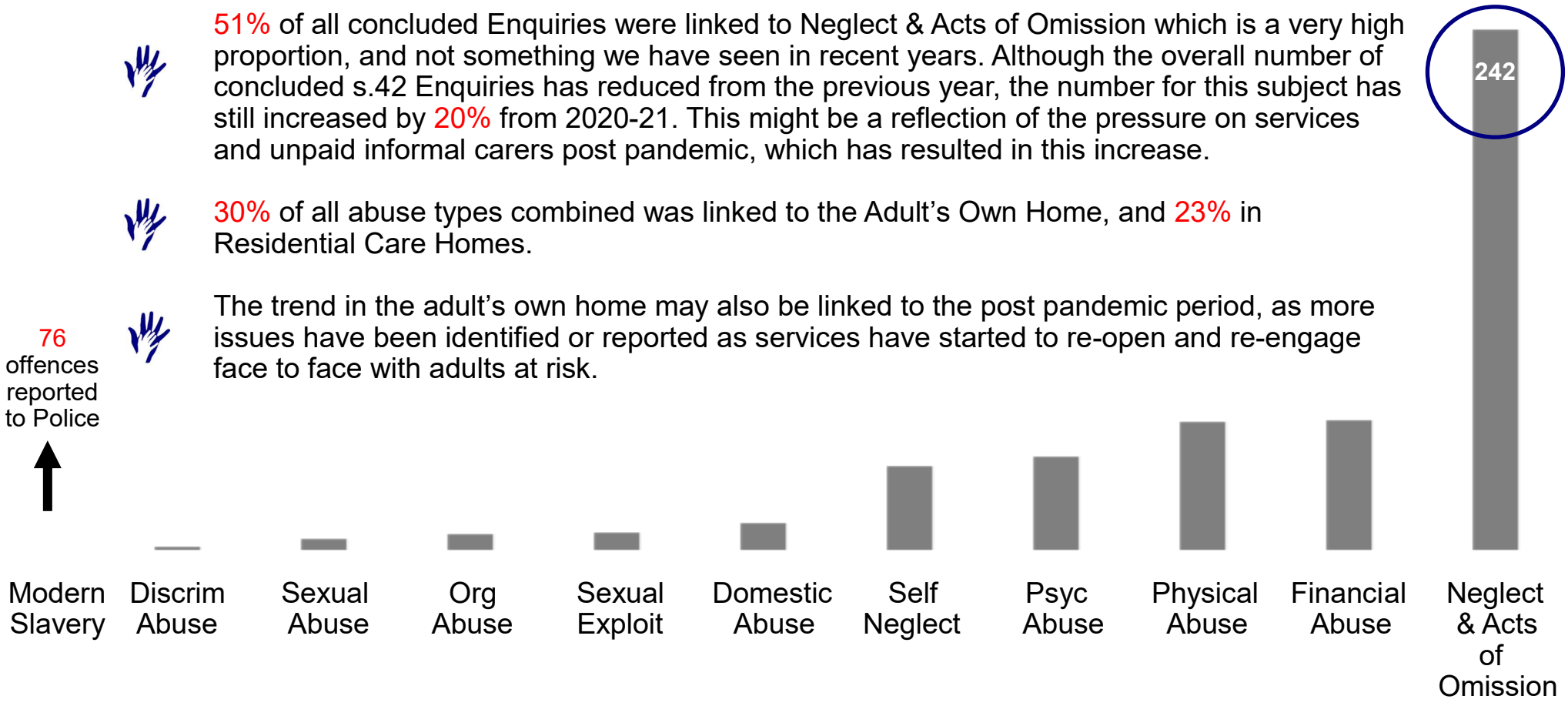


Table 3: Local Trends for Safeguarding Concern Reporting 2016 to 2022

The long-term national trend also continues to increase for Safeguarding Concerns, although this fluctuated during the pandemic period in some areas.

The key question is: does this table illustrate an increase in abuse or neglect, or does it depict increasing awareness and better reporting? It is likely to be both, but more strongly linked to the increasing volume of education and training being delivered locally by the Board and partner agencies, resulting in better awareness.

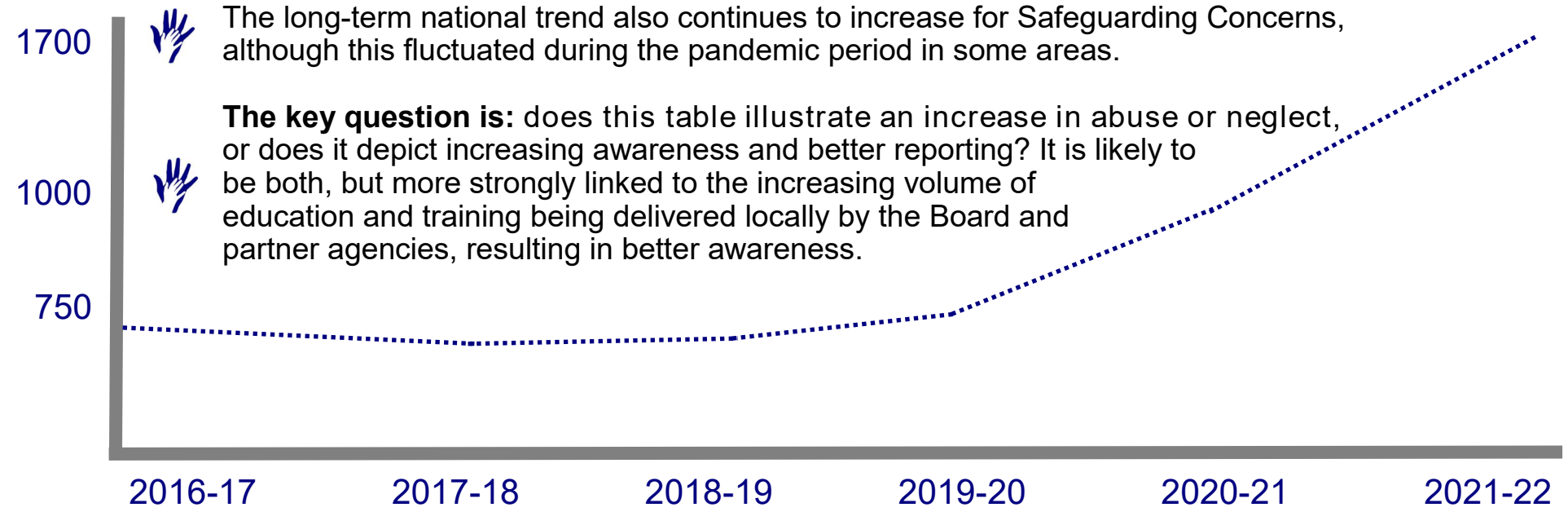


Table 4: Who Reported the Abuse - Concluded Section 42 Enquiries 2021-22

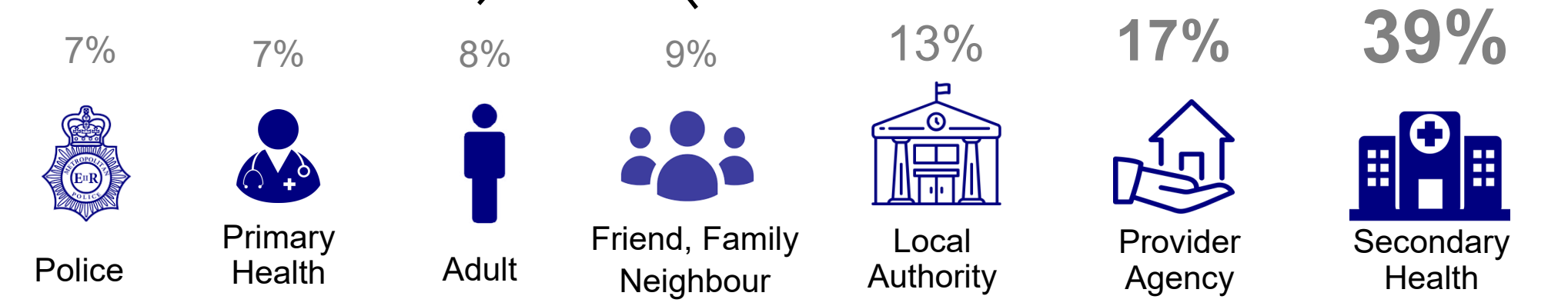
Linked to Table 1 more Merlin Adult Come to Notice reports are now resulting in s.42 Enquiries

This % has more than doubled from 2020-21 which is positive

In 2020-21 the combined total across these two areas was 6%. Post pandemic this increase is a positive indicator

8% Adult Social Care

⇒ Ambulance Service
⇒ Mental Health Services
⇒ Acute NHS Trusts
⇒ Brain Injury Units



Safeguarding Adults Reviews

The Board received 4 SAR notifications during 2021-22, two of which were approved and are still active and ongoing reviews. The other two did not meet the criteria for review.

Two other reviews were concluded during the last year and the key details of these are presented below and on the following page.

Further details on the work of the Board's Case Review Sub-Group is outlined on page **11**.

SAR Adult Z (published 19 July 2021)

Background

In the spring of 2018 Adult Z's daughter identified signs of deterioration in the mental and physical health of their relative. This continued to deteriorate until the adult became dehydrated and emaciated, telling paramedics when they were called, that they were committing suicide by starving themselves.

Paramedics initially assessed Adult Z to have capacity and concluded that they had no powers to convey Adult Z to hospital, despite the high risk they presented to themself. A Mental Health Act (MHA) assessment was arranged for the following day, and an Approved Mental Health Professional and psychiatrist attended with paramedics and police. The paramedics then assessed Adult Z as lacking capacity to make decisions for their care, and Adult Z was then taken to hospital under the authority of Sections 5 and 6 of the Mental Capacity Act (MCA) 2005.

Key Learning Points

- Mental capacity training for staff should include practical elements including complex and borderline decisions where there is doubt over the person's ability to 'use or weigh' the information.

- A capacity assessor is required to hold a 'reasonable belief' that a person does or does not have capacity to make a particular decision at a particular time. The standard of proof is "on the balance of probabilities".

- It is widely acknowledged that the interface between the MCA and the MHA is particularly complex and challenging, which means practitioners must work closely in utilising their respective legal powers and duties.

Read here: **7 Minute Briefing - Adult Z** - for Professionals.

SAR Mia (published 29 September 2021)

Background

Mia (pseudonym) was a 41-year-old woman and European Union National who lived in various squats and temporary accommodation, as well as presenting as homeless and intermittingly rough sleeping in Lewisham.

Homelessness and rough sleeping were a contributing factor to her death, together with being subjected to coercive and manipulative control as a victim of domestic abuse at the hands of her male partner. Mia was also drug dependent which contributed to wider issues she endured in relation to self-neglect.

Eleven different agencies were involved in providing care and support to Mia. However, the review found that there were problems in relation to information sharing and effective communication between the different professionals and agencies who tried to help Mia to resolve the many concerns she had her in life.

In Mia's case there were also missed opportunities from some agencies and organisations to submit safeguarding referrals for her, and although there were also several submitted that did meet the criteria for a statutory Safeguarding Enquiry, one was never conducted.

Key Learning Points

- Where concerns persist in a domestic abuse or an adult at risk case, a multi-agency safeguarding planning meeting should be convened to consider the wider impact on the health and wellbeing of the person.

- Professionals should thoroughly explore the circumstances of homelessness and accompanying health and social complexities, ensuring all available actions and initiatives including Care Act 2014 needs assessments and Safeguarding Enquiries are conducted, and that no high-risk case is closed without managerial oversight.

- Make yourself aware of Appendix Seven: Adult Safeguarding and Homelessness - London Multi-Agency Adult Safeguarding Policy and Procedures.

Work of the Sub-Groups

Case Review Sub-Group

The Sub-Group oversees Safeguarding Adults Review (SAR) processes locally, and is led by the Board's Independent Chair Professor Michael Preston-Shoot.

The group met 7 times during 2021-22 and considered or monitored 11 cases throughout the year. In the two cases where the SAR Notification did not progress to a review in 2021-22, it resulted in links with training or audits.

The group also reflects on the learning from previous SARs, which included re-examining fire safety in care settings linked to the Cedric Skyers review (2017).

The Board also updated its SAR Policy and Procedure in October 2021.

The last three years of SAR activity have informed us what the **key trends and themes** are in relation to notifications:

1.	Lack of Inter-Agency Working	13
2.	Pressure Area Care	4
3.	Mental ill-Health (including death by suicide)	4
4.	Multi-Agency or Single Agency Response to Urgent	3
5.	Substance Misuse	3
6.	Self-Neglect	3

This information helps the Board to develop its strategic priorities and objectives.

Lewisham Modern Slavery and Human Trafficking Network

The Board continues to support the development of this multi-agency group which is helping to improve the profile of this subject by creating a local Modern Slavery Victim Care Pathway, closely analysing local data, and improving the delivery of training.

Performance, Audit and Quality Sub-Group

This group continued to meet quarterly throughout the year to analyse and monitor the Board's performance indicators and other relevant information, which is summarised on page 7.

This activity also plays a significant part in informing the ongoing development of the Board's strategic objectives which are set out on page 12.

The group delivers the Board's audit and practice development programme by setting up time limited working groups to oversee these tasks. Four strands of this work are outlined below.

Reporting Medication Incidents as Safeguarding Concerns - Task and Finish Group

This multi-agency working group developed the local Guidance of the same name, which is embedded into the Lewisham Adult Safeguarding Pathway. All relevant agencies should now be using this.

Housing Related Safeguarding Audit and Hospital Discharge Audit - Steering Committees

These two groups were set up during the last 12 months and will report on their respective work later in 2022.

Liberty Protection Safeguards (LPS) Task and Finish Group

This group was re-started again during the last year despite further delays with the consultation on the Mental Capacity (Amendment) Act 2019 Code of Practice.

Is it still unclear when the new legislation will come into force in 2023, but the Board has now set up 5 LPS Training sessions for professionals to support transition planning.

Business Plan 2022-23 on a Page

Strategic Vision

Ensure adults are safeguarded by empowering and supporting them to make informed choices and decisions (Making Safeguarding Personal)

Prevent adult exploitation, abuse and neglect	Develop intelligence led, evidence based practice	Strengthen partnership working
Prevention Aim Develop preventative strategies by working with those most at risk of abuse and neglect	**Accountability Aim** Ensure safeguarding policies are fully embedded into practice	**Partnership Aim** Support 'the whole family approach' to protecting those most at risk of abuse in Lewisham
Prevention Objectives 1. Ensure the focus on equality, narrowing inequality and racial disparity is built into all relevant Board activities. 2. Continue to break down barriers to reporting abuse by ensuring the Lewisham Adult Safeguarding Pathway is used effectively. 3. Listen to the voices of adults, ensuring their experiences shape how services are delivered.	**Accountability Objectives** 1. Deliver further audits to test how well current safeguarding policies, procedures and guidance are embedded into practice. 2. Continue to support the delivery of the Domestic Abuse Strategy in Lewisham by rolling out new guidance and training. 3. Further develop guidance to improve the effectiveness of the safeguarding system.	**Partnership Objectives** 1. Continue to focus on mental ill-health support and recovery, which is one of the most significant risk factors linked to adult abuse and neglect locally. 2. Strengthen the focus on Transitional Safeguarding. 3. Support health and wellbeing initiatives, and further improve connections with other relevant and local strategic boards.

What LSAB partners will all do to help deliver this Plan:

1. Build the LSAB Strategic Aims into individual organisational plans.
2. Support multi-agency training, including the Awareness Week in Nov 2022.
3. Promote the use of the Lewisham Adult Safeguarding Pathway.
4. Proactively support LSAB awareness building campaigns.

Lewisham
Safeguarding Adults Board
A working partnership to prevent abuse

www.safeguardinglewisham.org.uk/lsab