



A working partnership to prevent abuse

Annual Report 2018-19

Period: 1 April 2018 to 31 March 2019



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Any words used in the report that are included in the Jargon Buster are highlighted using *

Message from the Independent Chair

This is the third occasion I have had the pleasure to welcome you as Independent Chair to the Annual Report of the Lewisham Safeguarding Adults Board (SAB). It is a statutory requirement for each SAB to publish this report and include the details of what it has done to deliver its strategic plan (pages 6 & 7). The report must also provide information about Safeguarding Adult Reviews (SARs) that are ongoing or have been completed, including what has been done to ensure that the lessons from these SARs are translated into the development of policy and practice (pages 8 & 9).

These are challenging times for public and voluntary sector agencies. Organisations are having to manage the ongoing impact of financial austerity alongside not just rising demand for care and support, but also the increasing complexity of needs being presented to the Local Authority and to NHS staff in primary and secondary care. Almost inevitably, it appears, the need to find further savings leads agencies into structural re-organisation, which inevitably has an impact on the strategic and operational relationships that are essential for effective adult safeguarding.

Nonetheless, partners have remained committed to the SAB and to adult safeguarding, as their contributions to this annual report demonstrate. The SAB has held these partners to account for how they ensure that people with care, health and support needs are protected from abuse and neglect, for example by close scrutiny of performance data, inquiry into how the wellbeing of people in residential and nursing care is promoted, and focus on ensuring that the lessons from Lewisham SARs, and from those conducted elsewhere, result in improved practice locally.

The SAB has also been proactive in providing learning workshops, ensuring that those involved in adult safeguarding have the best possible foundations for their practice. I have been really pleased with the take-up of the events for making safeguarding personal, mental capacity act assessments and working with people who self-neglect.

Healthwatch Lewisham and Voluntary Action Lewisham supported the delivery of a conference for voluntary and community sector organisations. This helped to continue the work in raising awareness of key issues, and in promoting practice that seeks to prevent as well as protect people from abuse and neglect.

The annual report gives an account of these and other initiatives that partner agencies have delivered, and what the SAB and its partners plan to deliver in 2019-20 to ‘ensure adults are safeguarded by empowering and supporting them to make informed decisions’. (The Strategic Business Plan for 2019-20 is on page 21).

During the year we said goodbye to Philip Byron the SAB Business Manager, who did much to establish the effectiveness of the Board. We welcome Martin Crow as his successor, working alongside Vicki Williams and Tiana Mathurine. Together they have ensured the smooth running of the SAB. I am grateful to them for their work and to all those who have worked hard to provide effective adult safeguarding services in the Borough.

I hope that you find the annual report informative and helpful.

**Professor Michael Preston-Shoot
Independent Chair**



Board Membership

The Board is made up from the following organisations, which includes the statutory partners that must be involved in leading local adult safeguarding arrangements, as well as the other important agencies listed below:

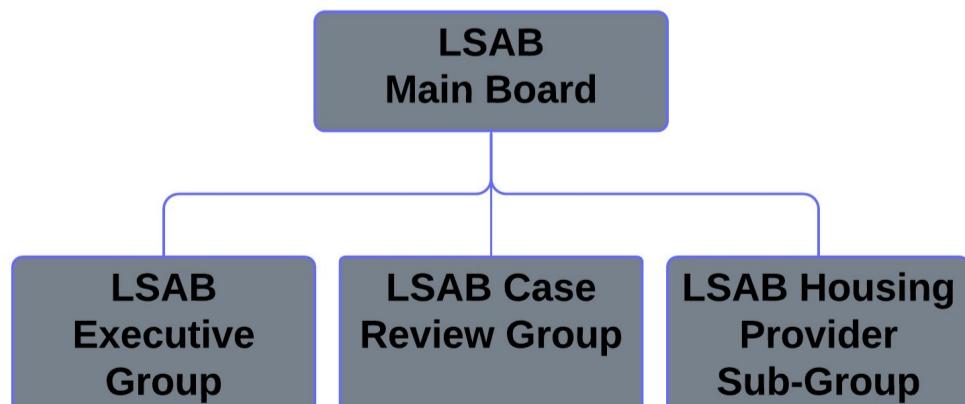
- Healthwatch Lewisham
- Lewisham & Greenwich NHS Trust
- Lewisham Adult Social Care
- Lewisham Children & Young People's Services
- Lewisham Safeguarding Children's Partnership Board
- Lewisham Homes
- Lewisham Joint Commissioning Group
- Lewisham Public Health
- Lewisham Public Protection and Safety
- Lewisham Strategic Housing Services
- London Ambulance Service
- London Community Rehabilitation Company
- London Fire Brigade
- Metropolitan Police Lewisham
- National Probation Service, Lewisham and Southwark
- NHS England
- NHS Lewisham Clinical Commissioning Group
- South London & Maudsley NHS Foundation trust
- Voluntary Action Lewisham

Board Structure

The Executive Group was made up from the statutory and funding partners who met to discuss resourcing and other key strategic issues. However, the group did not meet regularly throughout 2018-19 and a decision was made to stand this group down.

The Case Review Group became a formal Sub-Group towards the end of the reporting period, which is linked to the review of the structure in line with the objectives outlined in the Strategic Business Plan for 2019-20.

Lewisham Safeguarding Adults Board Structure



Lewisham: Key Facts and Figures



There were 125 Safeguarding *Section 42 Enquiries per 100,000 of population recorded in Lewisham in 2018-19 (the London average is approximately 270).

See more detailed safeguarding data on page 17.

The data on this page has been taken from the *Joint Strategic Needs Assessment (JSNA) for Lewisham, Local Authority statistics, NHS, and Metropolitan Police reporting data.

Strategic Business Plan 2018-19 Outcomes

The Board had the following Aims during 2018-19:

1. Stop abuse and neglect

This is a critical feature of the work of the Board. The examples and stories that are outlined on pages 11 to 16 help to illustrate what the partner agencies are doing to help stop adult abuse.

2. Improve the health and wellbeing of people

This is also a core part of the work of many of the Board's partner agencies, which includes the public health and trauma informed approach to violence reduction. These strategies are helping to prevent adult abuse and tackle some of the most significant issues in the Borough.

3. Promote people making choices and having control of their lives

During the last 12 months the Board has conducted a Making Safeguarding Personal (*MSP) 'Temperature Check' in conjunction with the London SAB, which was designed to test how well agencies have embedded person-centred approaches to supporting adults at risk of abuse and neglect. This was supported by a training session being delivered to professionals on this subject in January 2019, which followed on from a previous Seminar on Autonomy vs Duty of Care in June 2018.

4. Raise public awareness of abuse and neglect and what to do

The Board delivered a Voluntary and Community Sector Safeguarding Conference on the 8 November 2018 in conjunction with Healthwatch Lewisham and Voluntary Action Lewisham.

This event was very well received and attended by 83 delegates, helping to improve the profile of adult safeguarding related work in the local community by placing an emphasis on self-neglect and hoarding, disability hate crime, domestic abuse and SCAMS prevention.

The Business Unit continues to distribute Newsletters and Bulletins centrally, and partners are involved in numerous projects across Lewisham to help raise public awareness, which forms part of their commitment to this subject as part of their membership of the Board.

5. Promote prevention of abuse and neglect

Between November 2018 and March 2019 the Board delivered 12 learning events:

Self-Neglect and Hoarding Masterclass x 4

Making Safeguarding Personal x 2

Mental Capacity Act & Deprivation of Liberty Safeguards (DoLs) x 2

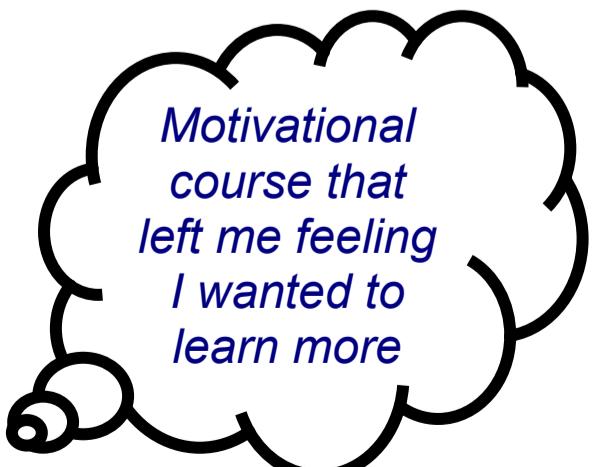
Information Sharing x 2

Provider Managers x 1

Basic Awareness x 1



This resulted in a total of 248 delegates accessing these training activities.



"Excellent training. It came strongly recommended and lived up to expectations"

"I am grateful to have such good training"

The Board conducted and published two Safeguarding Adults Reviews (SARs) in 2018-19, which are designed to generate lessons that can be learned to prevent similar instances from occurring again.

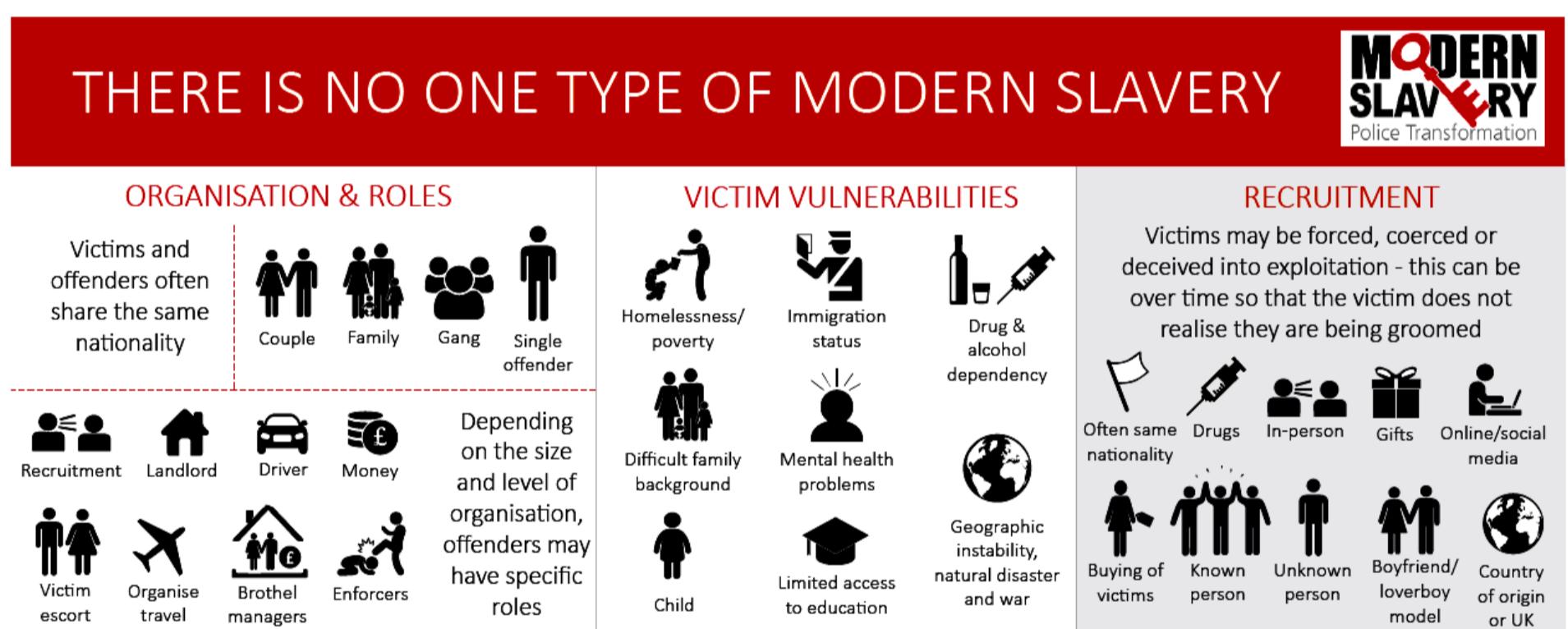
The recommendations and actions that have been developed as a result of these reviews are still being delivered, helping to inform practice developments in the Borough and further afield. These reviews are summarised on pages 8 & 9.

The Board has also been developing a comprehensive Self-Neglect and Hoarding Policy and Procedures in the last year, which will help to underpin changes to local systems when the adult *Multi-Agency Safeguarding Hub (MaSH) becomes operational in the near future.

The Board also supported Lewisham Borough Council in the development of the Modern Slavery and Human Trafficking Protocol (published February 2019), and will help to further promote and establish the approaches needed to prevent this type of abuse in the coming year and beyond.

These Policies and Protocols can be accessed here:

<https://www.safeguardinglewisham.org.uk/lsab/lsab/publications/policy-and-procedures>



6. Support people to protect themselves and stay safe

The final evaluation of the Faith Group Champions training delivered to 223 people in 2017-18 was completed in October 2018. This has been used to help the planning of a broader Safeguarding Champions' role to be established, which will encourage professionals, volunteers and community members to support people to stay safe.

7. Improve the quality of care

The Board co-ordinated a significant amount of activity that was designed to examine the quality of care being provided in the Borough. This included oversight of the:

- Lewisham Clinical Commissioning Groups Audit Report
- Joint Commissioning Provider Audits and Annual Safeguarding Assurance Report
- Deprivation of Liberty Safeguards Audit by Lewisham and Greenwich NHS Trust
- Deprivation of Liberty Safeguards Audit by Lewisham Borough Council.

This focus on quality will continue and be expanded in line with the Board's Strategic Business Plan for 2019-20.

Work of the Case Review Sub-Group

Safeguarding Adult Review (SAR) Definition

Safeguarding Adults Boards (SABs) must arrange a SAR when an adult dies either as a result of abuse or neglect, known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult; or if an adult has not died, but the SAB knows or suspects that the adult has experienced serious abuse.

The Case Review Sub-Group manages and oversees the SAR process locally and is led by the Board's Independent Chair Professor Michael Preston-Shoot.

The group met six times throughout the year and included membership from Lewisham Borough Council, the Metropolitan Police, Lewisham Clinical Commissioning Group, and Lewisham & Greenwich NHS Trust. A significant amount of work was overseen by the group, and in addition to the cases outlined below, other non-statutory reviews and reports were also considered and monitored. This included the local annual reports for the *Learning Disability Mortality Review Programme (LeDeR), and Drug & Alcohol Related Deaths. This report also specifically examined the subject of homelessness, which links to Government advice for SARs to be used to examine the deaths of rough sleepers where appropriate.

SAR Notifications

The Board received and considered **5** new SAR Notifications during 2018-19. One of these cases was approved as a statutory SAR and has commenced; one didn't meet the criteria; and the other three were still pending a decision at the end of March 2019 due to the need for parallel processes (such as court cases) to conclude, or for more information to be collected.

Ongoing SARs

One review continued throughout all of 2018-19 but has been delayed due to unforeseen circumstances, and two further SARs were concluded and are outlined below.

SAR Mr. Michael Thompson (published in July 2018)

Mr. Thompson was a 60-year-old Black British man of Jamaican origin who had been living on his own in Lewisham for the previous five years. The review concerns the death of Michael on 3 March 2016.

On that morning a call was made to the London Fire Brigade (LFB) as smoke had been seen coming out of the window of Michael's flat by a person driving past. LFB found Michael unconscious and called the London Ambulance Service who attended and administered emergency treatment. Michael was taken to Hospital, placed on cardiac support and ventilation, but he was declared dead the following day. A post mortem later gave a provisional cause of death due to inhalation of fumes.

During the 2 and 3 March 2016 emergency services had been called to Michael's flat by family members and neighbours on three separate occasions because of concerns about his behaviour. It is the circumstances surrounding these contacts with services and the subsequent decisions and actions that were taken that are central to this review.

Key actions that were delivered as a result of this SAR:

1. Considering Mental Capacity

All clinicians attended training on Mental Capacity Act assessments facilitated by a Consultant Psychiatrist. This subject also featured in a weekly bulletin to clinicians, and the consideration and use of Mental Capacity Act assessments is now regularly audited.

2. Inter-agency referrals to out of hours mental health services

Protocols and agreements have been implemented to improve the information and assistance available to emergency services working out of hours (evenings, nights and weekends).

3. Nearest relative & their right to ask for assessment under the Mental Health Act 1983

A leaflet on the rights of the nearest relative to a person in mental health crisis has been created and distributed by mental health and social care services. The wishes of the nearest relatives are also now recorded in all contacts with the mental health service.

SAR Mr. Cedric Skyers (published in July 2018)

Mr. Skyers was a 69-year-old man who was born in Jamaica but had lived in England from being a teenager.

Cedric died on the 13 March 2016 in Hospital after he was transported there by ambulance, after having been discovered engulfed in flames in the smoking shelter located in the garden of the Nursing Home where he had lived for the previous 10 years.

Earlier he had been taken to the shelter in his wheelchair so that he could smoke. The cause of death was recorded as extensive burning. The review examined the wider considerations, circumstances and context of Cedric's death, in respect of policy, procedure and practice to aid future prevention and learning.

Key actions that were delivered as a result of this SAR:

1. Smoking and risk assessment guidance in care homes

Guidance is being written which will set out what a good risk assessment should look like. This will include: Consideration of the Mental Capacity Act 2005, documenting any unwise decisions; the use of equipment, including alarms and fire retardant clothing; levels of dexterity/mobility and physical impairment; need for regular review; and the right to privacy versus supervision.

2. Smoking cessation

Residents are offered the chance to stop smoking with the assistance of smoking cessation services, and this offer is repeated on an annual basis by the care home provider.

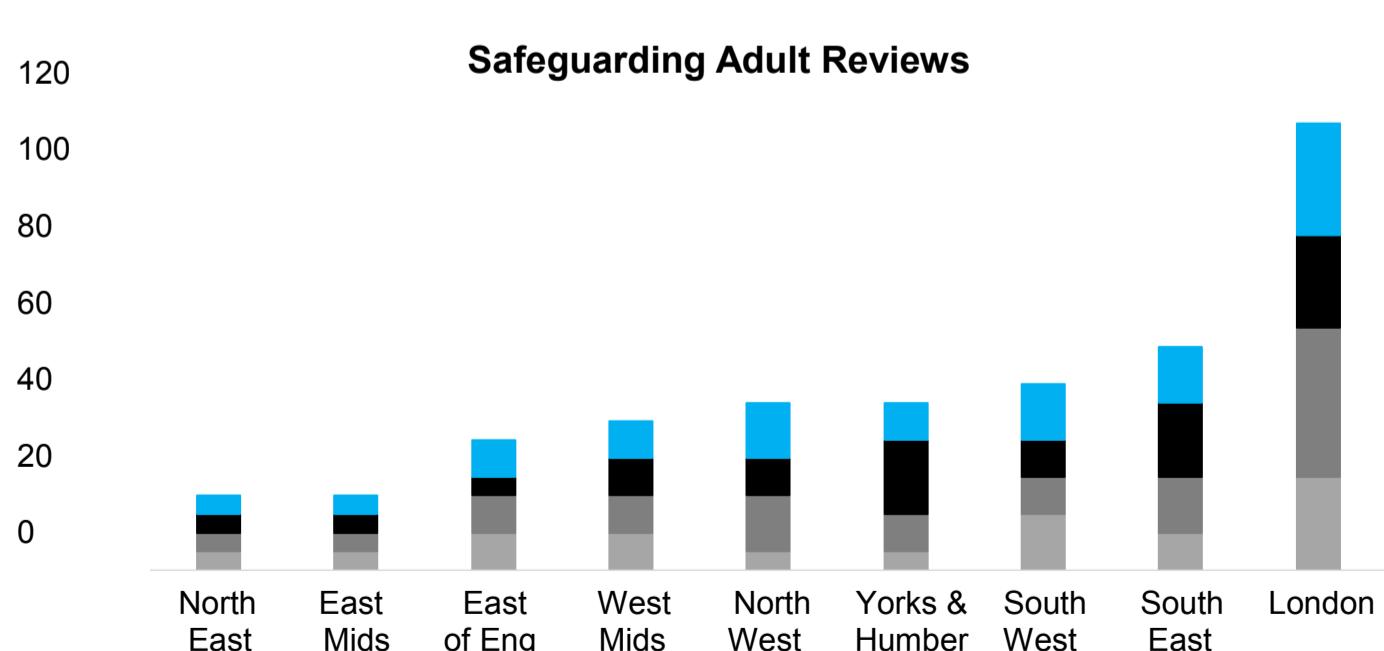
3. Risk assessments for the adult

All residents who smoke now have a fully completed risk assessment that is regularly updated.

Both reviews can be read in full here:

<https://www.safeguardinglewisham.org.uk/lstab/lstab/publications/safeguarding-adult-reviews>

National Picture



Since 2015 when the Care Act came into force there have been around **420** SARs conducted nationally. Approximately **25%** of these have been conducted in London.
(Data for 2018-19 is based on the previous averages).

Work of the Housing Providers Sub-Group

The group met three times during the reporting period and included regular contributions from ten local housing providers, as well as from a range of other organisations.

Throughout the year there were very useful presentations from:

- Age UK - Scams Prevention and Victim Support Project
- London Fire Brigade - Support for Hoarders and Fire Safety Visits
- Lewisham and Greenwich NHS Trust - Community Falls Service
- Lewisham Borough Council:
 - ⇒ Adult Social Care (Multi-Agency Safeguarding Hub)
 - ⇒ Violence Reduction Team ([Cuckooing and County Lines](#)).

The group have shared case studies and good news stories, and used the forum to improve understanding around relevant policy and practice guidelines; including information sharing and self-neglect (hoarding).

Members have also completed a self-audit process based on the London Safeguarding Adults Board model, which will help to further inform practice and improve the focus on preventing adult abuse and neglect.

The Board would like to formally thank Sebastian Taylor (Phoenix Housing) for being the Chair of this group throughout 2018-19, and welcome Clare Hopkins (Lewisham Homes) who has now taken on this role.

Cuckooing and County Lines

Cuckooing is a form of home invasion crime in which drug dealers take over the home (like a nest) of a vulnerable person in order to use it as a base for drug dealing.

County Lines is a term used when drug gangs from cities start operating in smaller towns, exploiting children and adults at risk of abuse (including human trafficking) to sell drugs. These dealers use dedicated mobile phone **lines**, known as 'deal **lines**', to take orders from drug users. **This is a growing and significant problem across London and in Lewisham.**

Vulnerabilities	Methods	Venues
Certain circumstances in a persons life place at them at greater risk of grooming for County Lines involvement, and gangs look to exploit this:	The gang lifestyle is glorified on social media, promises of cash and clothes are made, and other grooming methods are reported:	These venue types are commonly used, but there is a lack of detailed intelligence on this:
Exclusion from school, or part-time attendance is seen by exploiters positively as the young person has more time to work on a County Line and will not trigger Council action through truancy.	Hook: Young people are used to recruit others, with the recruiter being the 'Hook'. Honey Trap: A young woman is used to entice young men as part of 'grooming'.	Pupil Referral Units & Schools Social Media & Gaming Platforms
Family breakdown can be a risk factor. More attention should be given to young people at these times of crisis.	Broadcasts: These are put out on social media offering young people the opportunity to make a lot of money.	Youth Clubs
Young people on the verge of going into care are at risk, before attracting the attention of Local Authorities and Police during missing periods.	Food: This is bought for young people in 'chicken shops' as an early step in the grooming process.	Chicken Shops & Other Fast Food Outlets
People with drug habits, learning difficulties or who may be naïve are exploited, and especially those not known to Police as 'clean skins'.	Drugs: Exploited are offered 'freebies' to gain control of them leading to regular drug use or debt bondage.	Bus Stops, Parks & Skate Parks

Work of the Board's Partner Agencies

Healthwatch Lewisham



Key achievements in 2018-2019

1. Enter and View

In accordance with the Health and Social Care Act 2012, Healthwatch Lewisham conducted Enter and View visits to gain insight from service users into how services are experienced, highlight good practice and make recommendations for improvement.

Linked to LSAB Aim 7



2. Community Adult Safeguarding Conference

Healthwatch supported the planning and organisation of this event where the Chief Executive (Folake Segun) outlined the role of the organisation in relation to adult safeguarding.

Linked to LSAB Aim 4

3. BAME Mental Health Summit

Healthwatch helped to deliver this Summit in response to the Health and Wellbeing Board's review of health inequalities and the treatment of mental ill health within the BAME community.

Linked to LSAB Aim 4

4. Seldom Heard Engagement

This includes engagement with numerous support groups across the Borough to hear about how people experience health and care services.

Linked to LSAB Aim 7

Lewisham Clinical Commissioning Group (LCCG)



Lewisham

Clinical Commissioning Group

Key achievements in 2018-2019

1. Work within nursing and residential homes

The Safeguarding Nurse Advisor (SNA) continued to offer significant support to nursing and residential homes in relation to improving quality standards and safeguarding.

Linked to LSAB Aim 2, 3 & 7

2. The Multi-Disciplinary Community Pressure Ulcer Panel

This is chaired by the SNA to investigate the causes of community acquired pressure ulcers, and to ensure lessons are learned and that recommendations are taken forward. Care homes are supported through the process by the SNA who also delivers 'reflection on practice' groups and unannounced follow up visits to ensure changes of practice are being embedded.

Linked to LSAB Aims 1, 2 & 7

3. Partnership working

The SNA is a member of the following groups and is involved in development work linked to these forums:

- Catford Falls Project
- The South London Health Innovation Group for Community Pressure Ulcers
- Weekly Multi Agency Safeguarding Conferences (MASCC) chaired by the Local Authority
- Multi-Agency Quality Assurance and Information Group (MAQUAIG)
- Catheter Care Project Group.

Linked to LSAB Aims 1, 2 & 6

Work of the Board's Partner Agencies

Lewisham and Greenwich NHS Trust



Key achievements in 2018-2019

1. Improving the reporting to LeDeR (Learning Disability Mortality Reviews)

The Adult Safeguarding Team conduct reviews for patients who have died within the Trust, and now report to the newly established internal Mortality Review Committee. The Trust also participates in the South East London steering group and divisional governance meetings.

Linked to LSAB Aims 2 & 7

2. Preparation for adult safeguarding records to go live electronically across the Trust

The Adult Safeguarding Team has worked in conjunction with the 'iCare project Team' to plan and prepare for adult safeguarding documentation to be implemented within electronic patient records. This includes Safeguarding Alerts, Mental Capacity Act Assessments, and all clinical documentation related to adult safeguarding. These changes will also enhance the efficiency of onward referrals to the Local Authority safeguarding team.

Linked to LSAB Aim 7

3. Introduction of a Level 2 training App for adult safeguarding - Improving access to training

The Adult Safeguarding Team devised a training programme via an App which is available to clinical staff. The programme contains a self-assessment that consists of twenty questions covering all of the content in the App including Making Safeguarding Personal, Safeguarding Adult Reviews, Modern Slavery, Domestic Violence and the Mental Capacity Act 2005.

Linked to LSAB Aim 7



South London and Maudsley NHS Foundation Trust (SLaM)



South London
and Maudsley
NHS Foundation Trust

Key achievements in 2018-2019

1. Quality Indicator Dashboard

The Adult Safeguarding Leads in the Boroughs that SLaM operates within now have access to the Quality Indicator Dashboard. This allows them to view and analyse relevant information linked to adult safeguarding, which in turn supports them in identifying themes and gaps in practice, to be used in creating learning and development objectives.

Linked to LSAB Aim 7

2. Domestic Abuse

The Trust now has Domestic Abuse and MARAC Steering Groups involving staff from all of the areas SLaM delivers services in. The Trust also conducted a domestic abuse audit during the reporting period that focussed on practitioner's awareness and documentation.

Linked to LSAB Aims 5 & 7

3. Training delivery

SLaM continues to exceed training targets for Prevent and Safeguarding Adults Level 1 & 2.

Linked to LSAB Aim 5

Radicalisation

Prevent is part of the Government's counter-terrorism strategy (Contest). This aims to safeguard and provide support to divert vulnerable individuals at risk from being radicalised or groomed into supporting terrorist activity, before any crimes are committed.

Work of the Board's Partner Agencies

London Borough of Lewisham - Adult Social Care (ASC)



Key achievements in 2018-2019

1. Development of 'call over' meetings

These monthly meetings help to improve the quality and consistency of safeguarding practice and performance across ASC. They examine information and case work records, and involve discussions with Safeguarding Adult Managers to explore these issues in greater detail.

This resulted in **32%** more enquiries being conducted on time and also led to the development of a 10 day safeguarding case file self-audit tool; an agreed escalation process when there are delays in receiving reports from other agencies; and changes being proposed to the Council's Case Management System.

Linked to LSAB Aims 2 & 7

2. Implementation of routine internal audits of Safeguarding Casework

A working group led by the Principle Social Worker were involved in the development of a casework/ safeguarding audit tool for *ADASS, which was then used to develop a local version. The results of these audits help to support practice, identify training needs and to address any gaps in competency levels.

Linked to LSAB Aim 7

3. Hoarding and Self-Neglect Policy Development Officer

This post was funded and created (currently being recruited) to enable the post holder to help implement and embed the new LSAB policy across all partner agencies, ensuring that effective local arrangements are in place to support adults in relation to self-neglect.

Linked to LSAB Aims 2, 3, 4, 6 & 8

Metropolitan Police Service – South East Basic Command Unit (BCU)



Key achievements in 2018-2019

1. Safeguarding under the SE BCU

Staff investigating Domestic Abuse (DA), Child Abuse and Rape offences have been brought together into one Safeguarding team. Bringing these teams together enables us to provide a more joined up approach, providing victims with earlier, improved contact and reassurance.

Linked to LSAB Aim 6

2. Prevent & Change Panel

This project aims to increase the safety of DA survivors and their children by working directly and indirectly with prolific domestic violence perpetrators. Police work with partner agencies to disrupt and deter perpetrators from offending, and also conduct specific 1-2-1 work with victims.

Linked to LSAB Aims 1 & 6

3. *Domestic Violence Prevention Notices/Orders (DVPN/O)

The BCU has obtained the **2nd** highest rate of DVPN/O's across the Metropolitan Police Service (**37** applied/issued).

This has been achieved by having a dedicated DVPN/O Officer who works alongside Independent Advocates to support victims during the 28 day enforcement period, with further funding also used to support those most at risk.

Linked to LSAB Aim 6



Work of the Board's Partner Agencies

London Fire Brigade (LFB) - Lewisham



Key achievements in 2018-2019

1. Home Fire Safety Visits (HFSV's)

The LFB in Lewisham completed 2077 HFSV's which was above the annual target, with 92% of those people involved (1716) being described as vulnerable or in 'priority places'. Work has also been conducted in conjunction with the police in regard to the threat of arson linked to domestic violence cases, resulting in 12 arson letterboxes being installed and 6 sets of fire retardant bedding being issued.

Linked to LSAB Aim 6

2. Welfare Concern reporting

A total of 70 safeguarding/welfare concerns were referred to LFB Lewisham, with hoarding being a prominent factor involving 23 (33%) of cases, which were also commonly linked to mental and or physical impairment, and poor living conditions.

Linked to LSAB Aims 4 & 6

3. Fire Safety Sprinklers

£20,000 was given to Lewisham Homes from LFB's Community Safety Investment Fund to contribute to sprinklers in a local housing development. This links to a worrying trend in the increase in non domestic fires in Regulatory Reform Order (RRO) properties. These are properties such as Care homes, Houses of Multiple Occupation (HMO), commercial properties or shops with dwellings above, that can commonly involve adults most at risk of abuse and neglect.



Work continues between LFB and trading standards to identify rogue landlords or premises which do not have the required level of fire precautions. As a result 3 enforcement notices were issued to registered care homes in the Borough, who were compliant upon re-inspection. (This links to the Cedric Skyers SAR).

Linked to LSAB Aim 6

Lewisham Homes



Key achievements in 2018-2019

1. Improved the response to hoarding and self-neglect



Hoarding UK were commissioned to deliver training and policy and procedures were reviewed in line with the LSAB guidance. An internal safeguarding panel was also established to review cases, increase accountability, share decision making and improve consistency.

Linked to LSAB Aim 6

2. Implemented a system of tenancy risk rating and sustainment

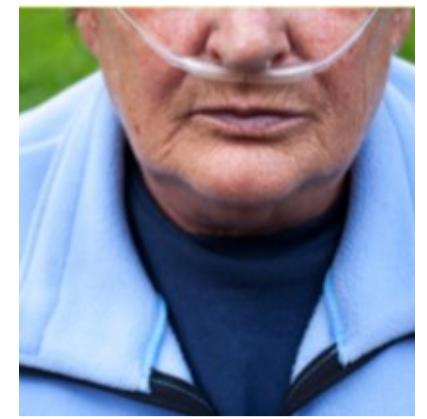
Safeguarding concerns are identified earlier, and more preventative work is being conducted.

Linked to LSAB Aim 5

Adults Stories

Eileen

The Safeguarding Team within Lewisham and Greenwich NHS Trust (LGT) were approached by the Consultant Respiratory Nurse for support and advice regarding Eileen.



This patient was receiving oxygen therapy at home and it had been noticed on a recent home visit that there was evidence of smoking cigarettes in the home, which could be posing risks to others in the household as well as neighbours. It was not clear whether Eileen had the mental capacity to make decisions regarding these risks.

A home visit was arranged along with London Fire Brigade Officers and it was found that Eileen did have the mental capacity to make informed decisions and that she had stopped smoking, although other family members had been smoking around her.

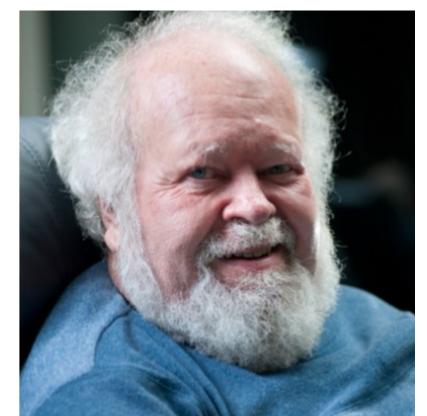
Eileen and her son worked with the Fire Brigade and the Nurses, and together they formulated a risk management plan.

Eileen and her son were able to explain the risks of smoking while using oxygen therapy and said they would discuss this with other extended family members.

Smoking cessation information was offered, and as a result of the interventions the Respiratory Nurse Team felt that the risk of a smoking and oxygen related clinical incident had been significantly reduced. The team also felt more confident in conducting a Mental Capacity Assessment and in working with other partners to protect adults from abuse and neglect.

David

A neighbour alerted Optivo Housing (member of the LSAB Housing Sub-Group) about their concerns regarding David after going inside his property. He was dirty, had been wearing the same clothing for a long time, and there was a strong smell coming from around his home.



A Housing Officer arranged a visit to meet David following these concerns, where it became apparent that he had health issues affecting his breathing, linked to a heart condition which made him exhausted quickly.

During the visit David stated that he was struggling to contain the mess in his home as he had allowed it to get so bad, and the Housing Officer noticed there was no cooker or fridge in the property, and only a small amount of food in the cupboard.

Following a discussion with David and liaison with the Local Authority, the Tenancy Sustainment Officer arranged to deep clean the property, which David agreed he would be able to maintain. A cooker and fridge freezer were also installed following an application to the Helping Hands Fund (Optivo budget).

This support has helped to improve David 's health due to living in a cleaner environment and now having the ability to store and cook food.

This has also meant that he has been able to maintain his tenancy and improve the relationship with his neighbour. This help has prevented the risk of self-neglect from escalating and needing a statutory safeguarding response.

Adults Stories

Anna

Anna is an 81 year old living in a residential care home for people with Dementia.



Lewisham Council (Adult Social Care) received a report from the out of hours Doctors service to say they had been called to review Anna following an incident with another resident. The Police were contacted and they made a decision based on the needs of both clients that they would not pursue the matter. Adult Social Care conducted a safeguarding enquiry and initiated closer supervision of the other resident, who was later admitted to hospital following a mental health review. Anna was monitored closely by staff and supported by her family, and a multi-agency safeguarding case conference was held with family members, the care provider, and health services.

Although Anna was assessed and found to lack the mental capacity to be directly involved in the safeguarding investigation, her family acted as advocates and were involved throughout. Clear outcomes were established based on the views and wishes of the family, which ensured that the 'adult's voice' was very clearly present, and that Making Safeguarding Personal (MSP) principles were used to guide the enquiry process.

The multi-agency response ensured that therapeutic support was provided for Anna and her family, and that measures were identified to help prevent further instances from reoccurring. Despite the negative impact the incident had on Anna's family, they felt that the action that had **been taken, and the way that this had been delivered, was positive.**

James

James threatens to jump from heights and walks on train tracks, sometimes both, and is often highly intoxicated during these incidents and therefore at high risk of accidental suicide. Interventions from Police, London Ambulance Service and mental health services had not worked, and he was not open to support from drug and alcohol services due to his previous behaviour. The financial impact of James's presentation was around £2,200 per month, on top of an estimated cost of £100,000 per incident in delays to the rail network.



A multi-agency *Serenity Integrated Mentoring (SIM) plan was created involving more intensive mental health support, police liaison, diversion into other activities, as well as enrolment into the Recovery College (mental health support service) as a precursor to alcohol rehabilitation.

These interventions resulted in James spending his first Christmas in ten years outside of a mental health hospital, and providing safer crisis management choices for him.

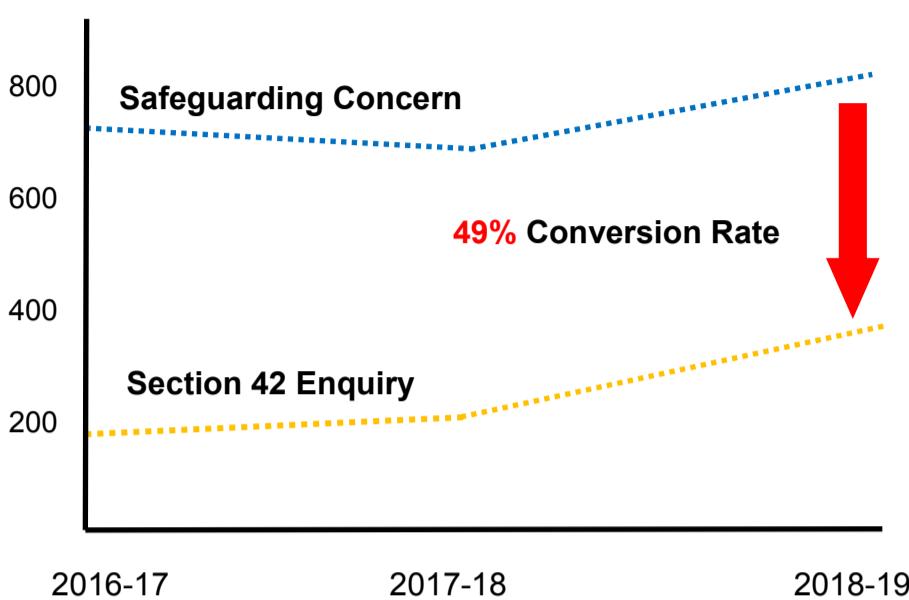
All of the agencies involved in the SIM plan are using it effectively whilst continuing to seek support and advice, which is improving the professional response from each agency, and the overall multi-agency effect in protecting James and preventing adult abuse and neglect.

James is positively engaging with the SIM programme and taking steps towards his recovery, including possibly entry back into employment.

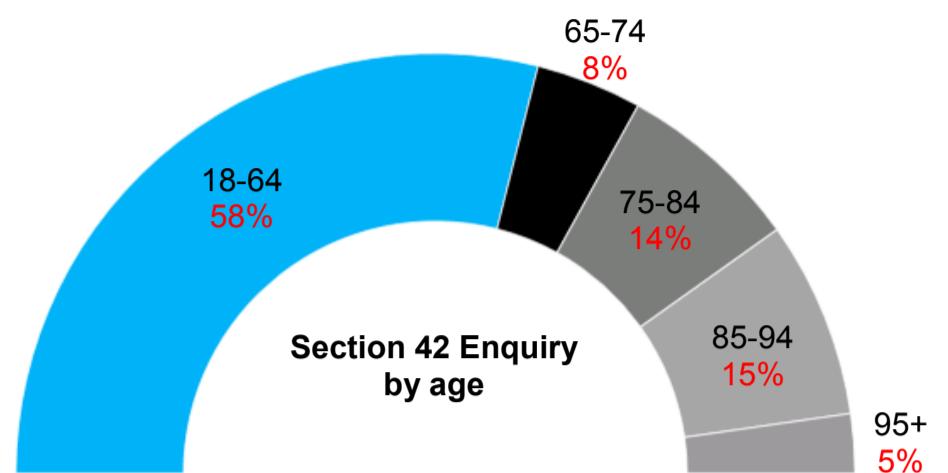
Safeguarding Data 2018-19

This is Local Authority Data regarding concluded Section 42 Enquiries (unless stated)

How much adult abuse was reported?

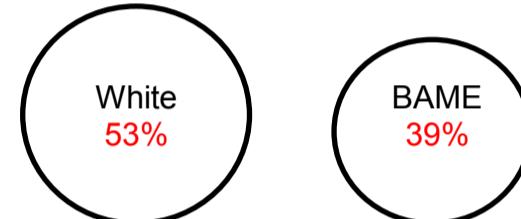


What is the age and ethnicity of victims?



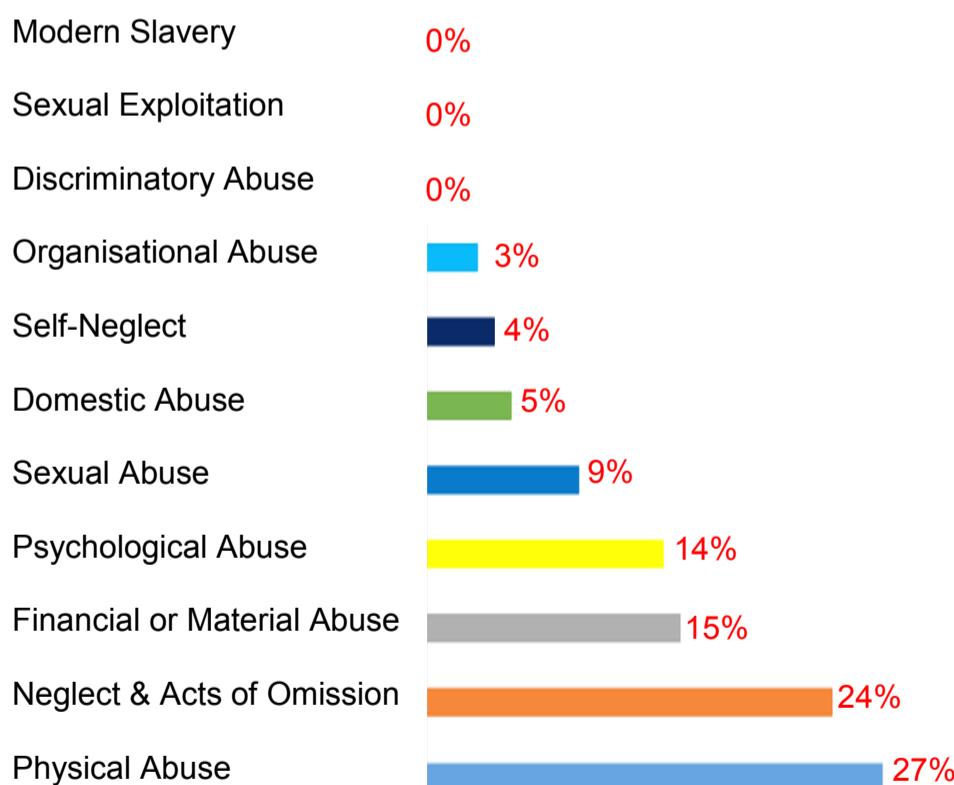
The average age of victims is lower than across England, which reflects the demographics in the Borough and also links to where abuse occurred, with only a relatively small % in care homes.

Section 42 Enquiry by ethnicity



The number for BAME is higher than the national average, but still below the demographics for Lewisham, which may highlight some barriers to reporting abuse.

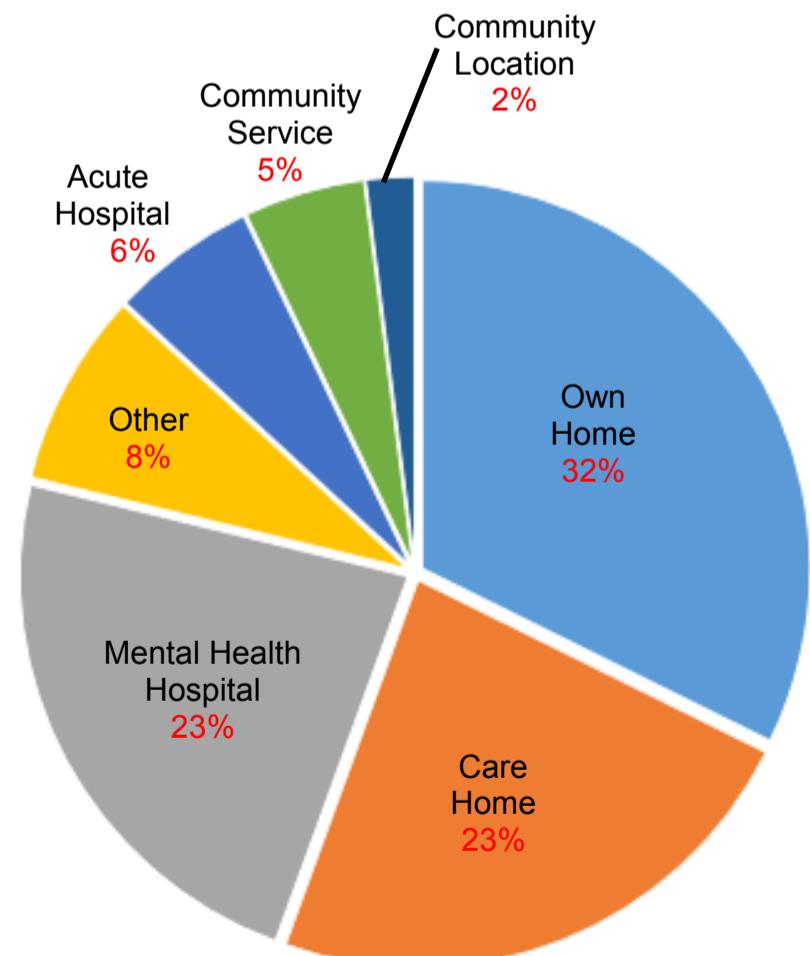
What types of adult abuse were reported?



Sexual Abuse is higher than the national average, although this probably reflects the actual picture more accurately as 1 in 5 adults have been sexually assaulted in their lifetime (ONS 2017).

Self-Neglect numbers may start to increase due to the priority given to this subject, which accounts for almost 50% of all SARs nationally.

Where did adult abuse occur?



Mental Health Hospital is high compared to national trends, and 4 times higher than the University Hospital of Lewisham. A large number of these cases are linked to incidents between patients at the Ladywell Unit.

Strategic Business Plan 2019-2020

The Board has created a new one-year Strategic Business Plan for 2019-20 in consultation with partner agencies and utilising community feedback. This is summarised below.

This not only reflects local issues in Lewisham, but seeks to address some of the most prominent national challenges that are currently being faced in relation to preventing adult abuse and neglect.

The objectives will form the basis of the collective work programme for partner agencies to contribute to through the work of the Board over the next 12 months, and will be delivered through planned activities, whilst also building on existing good practice and local networks.

The priorities and aims will also influence each separate partner agency, who are committed to embedding this overall strategy into their broader organisational approach to safeguarding adults.

Vision: To ensure adults are safeguarded by empowering and supporting them to make informed decisions	
Priorities:	<ul style="list-style-type: none">• Prevent adult exploitation, abuse and neglect.• Develop intelligence led, evidence based practice.• Strengthen partnership working.
Prevention Aim: By April 2020 we will have made further progress in developing preventative strategies.	Objectives: <ul style="list-style-type: none">• Develop and implement a Learning, Training & Development Strategy.• Conduct an audit of prevention focussed work.• Implement local policies and protocols, and support initiatives to help prevent abuse.
Accountability Aim: By April 2020 we will have established methods to effectively measure how well adults at risk of abuse and neglect are being protected, which will be used to develop evidence based practice.	Objectives: <ul style="list-style-type: none">• Establish a Performance, Audit & Quality Sub-Group to measure how well local agencies collectively protect adults at risk of abuse and neglect.• Conduct self and peer audits to help agencies better protect adults at risk of abuse and neglect.• Facilitate the development of system wide, inter-agency guidance that will establish best practice in protecting adults at risk of abuse and neglect.
Partnerships Aim: By April 2020 we will have demonstrated our commitment to supporting the 'whole family' approach to safeguarding those most at risk of abuse and neglect in Lewisham.	Objectives: <ul style="list-style-type: none">• Develop a Communication and Engagement Strategy that supports involvement of service users.• Create a protocol that better links the work of children and adult safeguarding partnerships.• Continue to work with partners in building a safer community, expanding the number of Safeguarding Champions, and developing a Safe Place Scheme in the Borough.

Appendix One: Jargon Buster

ADASS (The Association of Directors of Adult Social Services)

A charity and association that aims to further the interests of people in need of social care by promoting high standards of social care services and influencing legislation and policy.

BAME (Black, Asian & Minority Ethic)

A term used to described the ethnicity of a wider group of individual ethnic minority groups.

Conversion Rate (Safeguarding Concern to s.42 Enquiry)

This describes when a Safeguarding Concern (see below) becomes a statutory Section 42 Safeguarding Enquiry (also see below). This can help to ascertain the level or quality at which Concerns are being submitted, with a high conversion rate being seen as positive indicator.

Domestic Violence Prevention Notices/Orders (DVPN/O)

A DVPN is an emergency eviction notice which can be issued by the police to a perpetrator when attending to a domestic abuse incident. This allows the victim a degree of breathing space to consider their options with the help of a support agency.

Joint Strategic Needs Assessment (JSNA)

JSNAs are the means by which leaders work together to understand the health and wellbeing needs of people in the local area, and to decide on the priorities in delivering services.

Learning Disability Mortality Review Programme (LeDeR)

The LeDeR programme was established in May 2015 to support local areas across England to review the deaths of people living with a learning disability, so that the learning from those deaths can be used to help prevent further occurrences.

Multi-Agency Safeguarding Hub (MaSH)

The main aim of the adult MaSH in Lewisham will be to improve the quality of information sharing and decision making between the statutory agencies, so that a more co-ordinated response to Safeguarding Concerns can be delivered and achieved.

Pressure Ulcer Pathway

This is the set of processes and procedures that practitioners will follow in providing the most appropriate care and treatment for preventing and managing pressure ulcers.

Safeguarding Concern

A sign of suspected abuse or neglect that is reported to, or identified by the Local Authority.

s.42 Enquiry (Section 42)

The action taken or instigated by the Local Authority in response to a reported concern that abuse may be taking place.

Safe and Independent Living (SAIL)

This is a service that is ran by Age UK in partnership with a range of local agencies, providing a quick and simple way to access local services to support older people (60+ in Lewisham) in maintaining their independence, safety and wellbeing.

[https://www.ageuk.org.uk/leishamandsouthwark/services/sail/](https://www.ageuk.org.uk/lewishamandsouthwark/services/sail/)

Serenity Integrated Mentoring (SIM)

This is a model of care where specialist Police Officers work alongside community mental health professionals to support people struggling with complex mental ill-health problems.

Making Safeguarding Personal (MSP)

MSP is an initiative which aims to develop a person-centred and outcomes focus to safeguarding work in supporting people to improve or resolve their circumstances.

If you see or hear something that concerns you, or you suspect somebody is being abused, or someone tells you they are being abused. **Report it without delay:**

See it, report it!

If you suspect a neighbour, friend or family member is being neglected or abused, or you need help yourself

Call the Police on **101** or **999** in an emergency

Contact the Adult Social Care Team Monday to Friday 9am - 5pm:

Tel: **020 8314 7777** (select option 1)
Email: **SCAIT@lewisham.gov.uk**
Out of hours service: **020 8314 6000**

Contact details for the deaf / impaired hearing community

Minicom: **020 8314 3309**
Text Message: **07730 637 194**
Glide: **07730 637 194**

If you are unsure, talk to adult social care team, they will listen to you and give you good advice. You can talk to them without giving your name.

What not to do

- Don't promise to keep abuse a secret
- Don't alert the abuser, this might make matters worse and make it more difficult to help the person at risk
- Don't delay reporting abuse, report this straight away.

Think Family

Consider risks to others which may include children or other adults with care and support needs. Should there be a concern that a parent may be neglecting children in their care, concerns should be reported to Children's Social Care.

Contact the Children's Multi-Agency Safeguarding Hub Monday to Friday 9am - 5pm:

Tel: **020 8314 6660**
Out of hours service: **020 8314 6000**