Lewisham Safeguarding Adults Board

A working partnership to prevent abuse

Annual Report 2020-21

1 April 2020 to 31 March 2021

Image courtesy of
Lewisham & Greenwich NHS Trust

Message from the Independent Chair

"I want to pay tribute to all those who have contributed to safeguarding adults at risk of, or experiencing abuse and neglect. You have shown real leadership"

We have all had to adjust our lives this year due to the Covid -19 pandemic. Our patterns of daily life have been significantly disrupted; our liberties curtailed by the Coronavirus Act 2020. Throughout this period, however, the adult safeguarding duties within the Care Act 2014 have remained in place. Consequently the Lewisham Safeguarding Adults Board has continued to seek assurance that adult safeguarding has remained "everyone's business" and that statutory, voluntary and community services have worked together effectively to prevent and/or protect individuals from abuse and neglect. The Board has also continued to deliver its Business Plan and to commission and complete Safeguarding Adult Reviews, as required by the Care Act 2014. This Annual Report summarises what the Board has achieved during the year.

Throughout the pandemic the Board has sought assurance that services have worked effectively together when responding to this unprecedented situation. The response of local services has been commendable, with enhanced levels of collaboration to ensure the resilience of health and social care provision for people at risk. Going forward the Board will be concerned to ensure that this degree of cooperation and collaboration, working together, is maintained. We already have seen increased demand for care and support, and rising referrals of adult safeguarding concerns, whether occasioned by mental distress and social isolation, domestic abuse or self-neglect.

As the country emerges from lockdown, we expect to see a rising number of concerns, as families, friends and practitioners begin to meet adults who may be at risk in person again. The resilience of all our services will be needed as never before.

As the Board's Independent Chair, I am especially proud of the web pages that carry important information for practitioners and for Lewisham's residents and communities. I am especially proud of the outreach into Lewisham's local neighbourhoods, community and faith groups. The Board has made good progress with its data collection and analysis, an essential part of gaining assurance about the effectiveness of adult safeguarding provision and of setting new priorities.

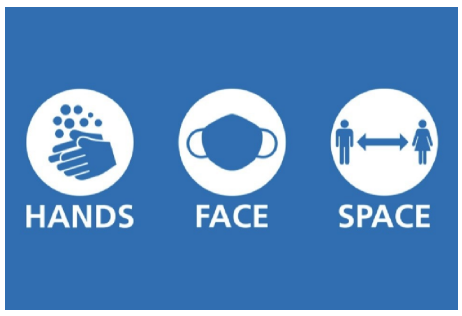
We are learning and disseminating lessons too from the Safeguarding Adult Reviews that have been completed, and from other reviews already underway, ensuring service improvement and enhancement where necessary. This report shines a light on that work.

Finally, I want to pay tribute to all those who have contributed to safeguarding adults at risk of, or experiencing abuse and neglect. You have shown real leadership.

I want to thank Martin Crow, Vicki Williams and Tiana Mathurine, the Board's business team, without whom we would not have made the progress summarised in this annual report.

Professor Michael Preston-Shoot

Key Outcomes in 2020-21



1. Covid 19 - Pandemic Response:

In addition to the Board's normal schedule of meetings partners met more regularly to discuss the response to the pandemic and local risk factors. Focus was given to:

- Domestic Abuse and the delivery of local services
- Adult mental health services
- The voice of the adult - the Board worked with and supported Lewisham Speaking Up to stay engaged with adults living with a learning disability who have been disproportionately affected by Covid-19
- Rough sleepers
- Hospital discharges
- Out of borough placements.

The Board also supported the work on the 'shielding' programme, and with the development of a national data set analysing safeguarding trends, as well as publishing monthly e-Bulletins and a dedicated webpage. See pages 3 & 4 for further information in relation to the impact of the pandemic.

2. Self-Neglect & Hoarding Multi-Agency Policy, Practice Guidance and Toolkit:

This was revised based on consultation with key practitioners and clinicians working in the borough, taking into account training that had been delivered on this subject and the feedback from delegates that had been received on the previous policy. Read the policy, guidance and toolkit HERE

3. Launch of the Lewisham Adult Safeguarding Pathway:

This included the publication of a revised Single Agency Adult Safeguarding Policy and Procedures Template, and the launch of a series of new leaflets and posters (see the back cover). Specific details are on page 5.

4. Communication and Engagement Work: See page 6 for more detail.

5. Learning, Training and Development Programme: Also page 6 for the detail.

6. Publication of three Safeguarding Adult Reviews: See pages 9 & 10.

7. Supported the launch of the Lewisham Modern Slavery and Human Trafficking Network: See page 11 for more detail.

8. Review of Statutory Advocacy Services:

This review commenced in March 2021 and will be completed in September.

From the Board's nine Strategic Objectives eight were either fully completed or are ongoing as outlined above, with the training programme and leadership project linked to adopting a 'Trauma Informed Approach' delayed due to the pandemic.

Covid - 19 Pandemic Response: Highlighting Inequalities

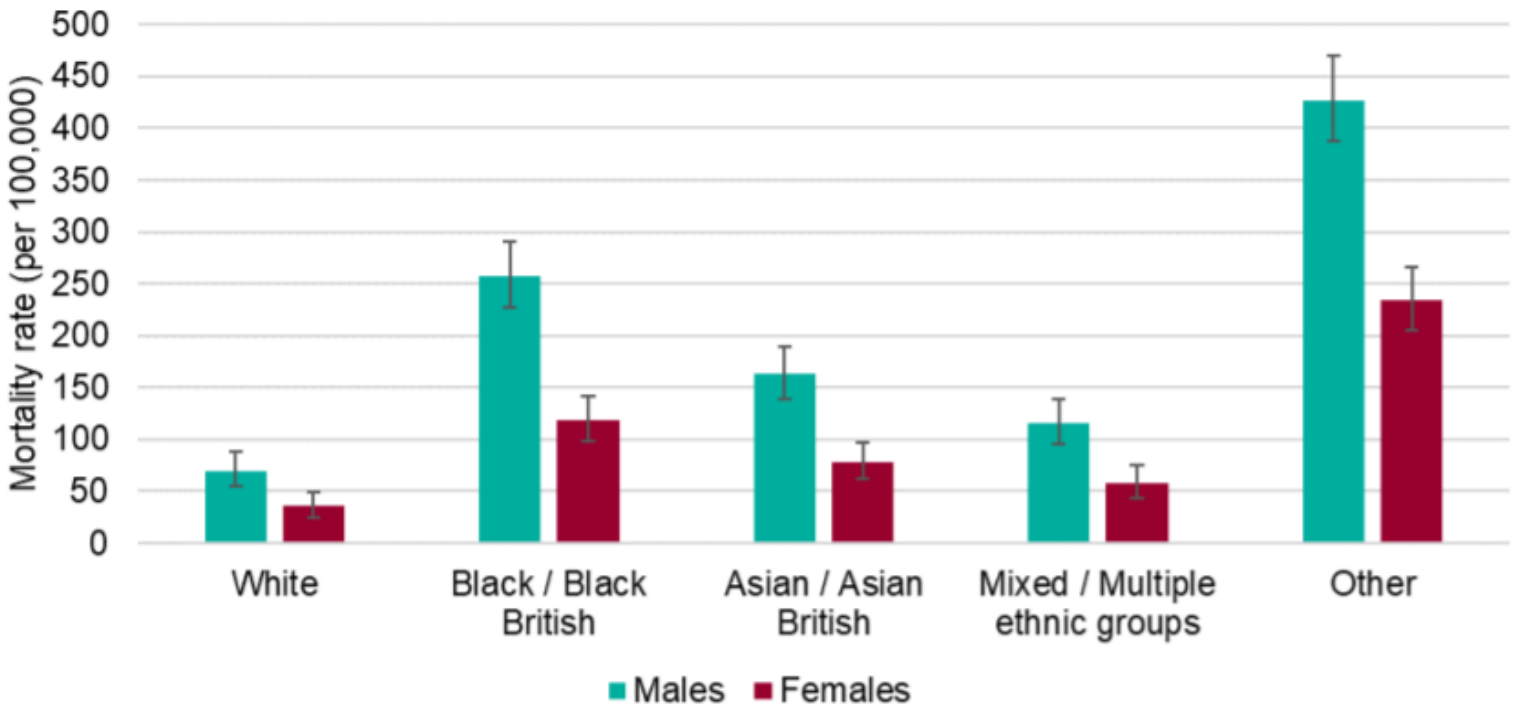
Nationally

Public Health England (PHE) described health inequalities in the following way:

"*Some groups have an increased risk of adverse outcomes from COVID-19 including some ethnic groups, males, those with certain pre-existing conditions such as obesity, those in deprived communities, older people, some occupations, people living in care homes, and other vulnerable groups.*

(PHE Beyond the Data: Understanding the Impact of COVID-19 on BAME Groups - June 2020)

- ⇒ People aged 80+ are seventy times more likely to die than those under 40
- ⇒ Mortality rates are double in the most deprived areas compared to the least
- ⇒ Rates are also Higher for Black, Asian and Minority Ethnic (BAME) groups
- ⇒ Death rates in London are 3+ times higher than in the South West (lowest area).



(PHE Disparities in the Risk and Outcomes of COVID-19 - Aug 2020)

Locally

"As well as the tragic toll of the disease, the lockdown has affected both mental health and wider determinants of health and wellbeing, including access to vital services, our local economy, and the education of our children and young people. The full extent of this impact and the inequalities that are created or exacerbated will only begin to emerge over the coming months and years".

- ⇒ Lewisham residents born in the Americas, the Caribbean, Middle East or Asia have a significantly higher death rate than people born in either the UK or Europe
- ⇒ 22% of deaths from COVID-19 were residents who normally lived in care homes
- ⇒ The analysis shows no significant difference in the rate of death between those living in the most and least deprived areas of Lewisham
- ⇒ Almost 10,000 people were shielding in Lewisham, and a wider cohort of approx. 3,000 vulnerable people (not known to services) were identified, and prioritised for a welfare call/ referral to other support if required.

Birmingham City and Lewisham Councils are launching ground-breaking work into the health inequalities of African and Caribbean communities. The aim is to find approaches to break decades of inequality that will lead to better futures for citizens.

(COVID-19: Lewisham System Recovery Plan - September 2020)

Case Studies

The following case studies provide an insight into the pressures and challenges that were faced by professionals in relation to safeguarding adults across Lewisham.

An 81year old man lived in a residential care home due to a progressive dementia diagnosis and his inability to remain safely in his own home. At this time the care home was closed to all visitors, and outside professionals where communicating virtually with the care home staff. The residents were being encouraged to remain in their own rooms to reduce the risk of transmission of infection, and staffing were also affected due to positive COVID tests, which all contributed to increasing the carers workload.

Although appropriate care was being provided, due to the pressures across the system, there was a delay in a pressure relieving mattress being provided and the man developed an unstageable pressure ulcer. The case was investigated by the Community Pressure Ulcer Panel and an action plan was jointly developed.

This was an unprecedented time for all of the services involved, but lessons were still identified and systems improved. The pressure ulcer is now completely healed and the gentleman remains happy living in the care home.

Local police worked with a man living with a learning disability who was a victim of several robberies, assaults and anti-social behaviour. He also felt intimidated going out in his local community because of these incidents, as well other problems, some of which extended from Adverse Childhood Experiences (ACE's).

His basic living conditions were very poor including mould and mildew on the walls, bare and rotting floorboards, no fridge and no lock on his front door. Police instigated a multi-agency meeting bringing together his sister, a new social worker and the relevant housing association's property manager.

Following on from this the property was cleaned, painted, repaired and updated, and carers are now giving the man appropriate support. Despite having felt let down by services previously, this man is feeling a lot more positive and now starting to interact more in his local community. (Case refers to periods in between lockdown periods).

Staff managing mental ill-health related safeguarding enquiries faced a number of challenges because of Covid-19, including an increase in the severity of symptoms being experienced in the community, and a shift to remote working, which was not always conducive to engaging the adult at risk.

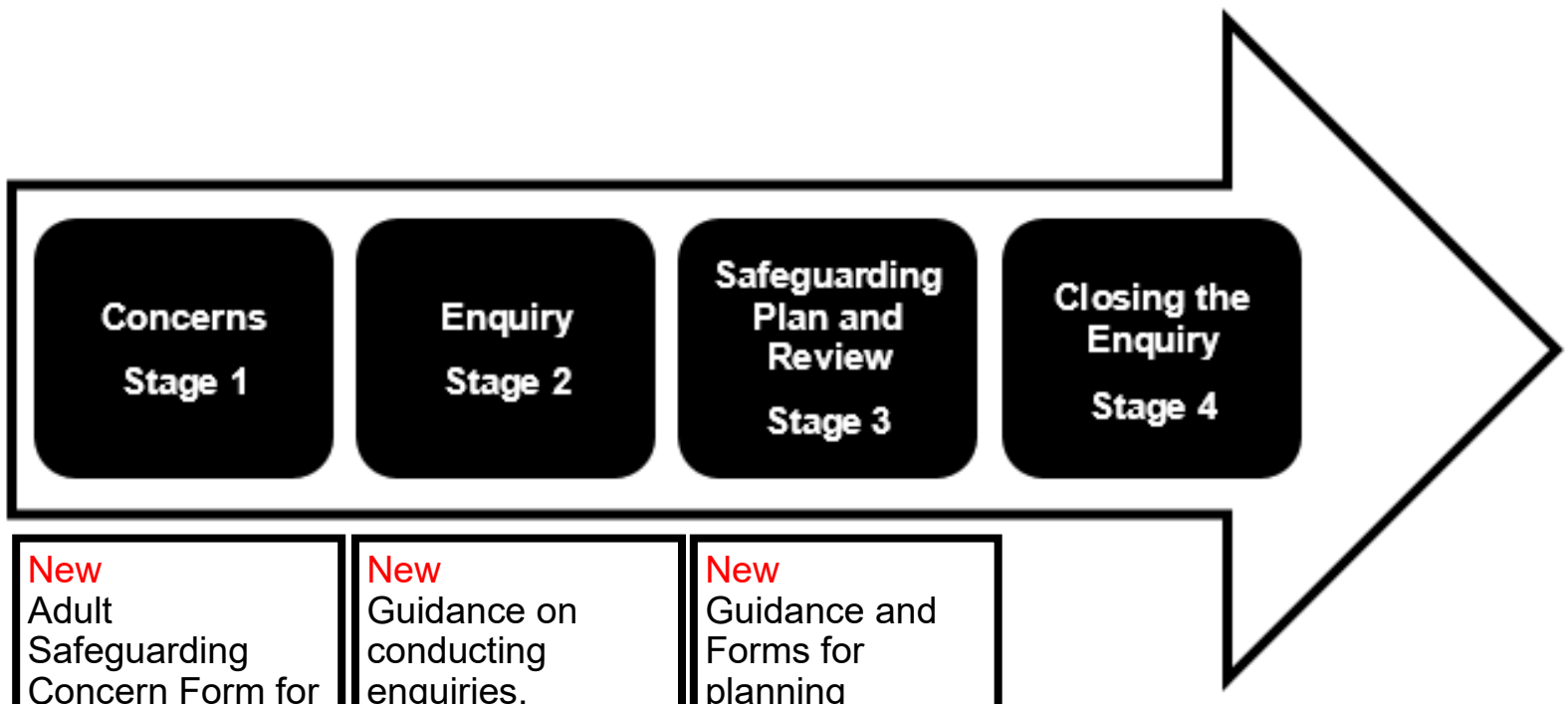
A positive example was the case of an adult who was initially identified by the London Ambulance Service as suffering from acute self-neglect, having attended their home due to the distressed state of the person. The Safeguarding Enquiry Officer worked with the Care Co-ordinator online, who then co-produced a care plan with the adult (Making Safeguarding Personal). Supportive outcomes and actions were generated in a very prompt manner as part of a wider harm minimisation plan.

What is this?
Comprehensive set of web pages providing local guidance, tools, forms and resources to support the London Multi-Agency Adult Safeguarding Policy and Procedures, as well as a platform to share good practice and build a local network of connected agencies all working to help prevent abuse and neglect.

Why do we need it?
To make it easier for professionals to understand and digest the pan London Policy and Procedures, and to create a step by step guide (Stages 1-4) which is embedded into local agencies ways of working (practice) and systems.

Who is it for?
All professionals working with adults at risk of abuse and neglect in Lewisham, as well as members of the public, including carers.

Who developed this Pathway?
A range of professionals from across partner agencies were involved in developing the work, as well as the public who helped to co-produce the leaflets and posters.



Access the Pathway HERE

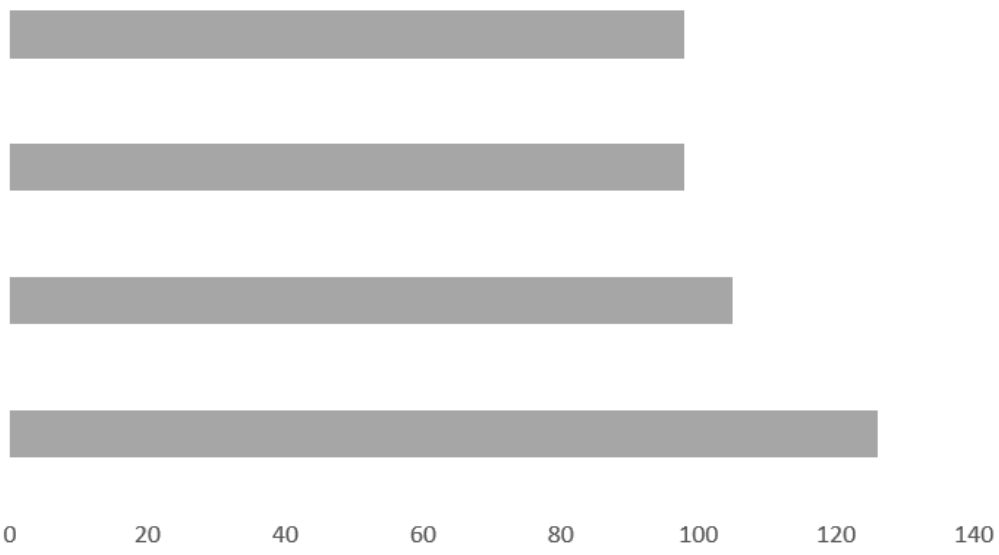
What do I need to do?
1. Use the New Adult Safeguarding Concern Form if you make a referral to the Local Authority.
2. Read and use all of the guidance throughout the four stages as outlined, and as applicable.
3. Embed this Pathway into your agency's way of working and systems if you are the lead professional responsible for safeguarding.
4. Use the template Policy and Procedures if you work in a non-statutory agency.
5. Use the leaflets and posters.

Contact: LSAB@Lewisham.gov.uk when you have completed number three above.

Communication and Engagement Work

"evidence of community awareness of adult abuse and neglect and how to respond"
(Care Act Statutory Guidance 14.157)

Fig 1:Annual Survey 2020-21: What should the Board's priorities be in 2021-22?

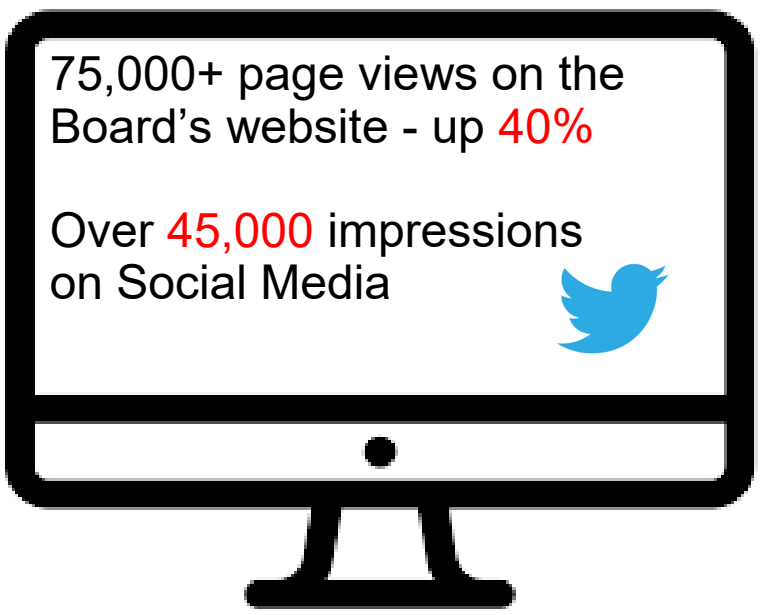


Over 200 professionals and members of the public engaged with the survey, which helped to inform the development of the Board's strategic objectives (see page 12).

Fig 2: I think LSAB is effective?

- **70% Strongly Agree/ Agree**
- **23% Couldn't answer the question/ Don't know**
- **7% Disagree**

"I feel that we are further down the road in terms of achieving this (vision) than we have ever been"



Over 6,000 reads of e-Bulletins

Learning, Training and Development Delivery

10 Learning and training events were cancelled/ postponed between March - June 2020 due to Covid -19.

A transition to entirely online delivery was then made after this which wasn't easy, although targets were still achieved within a condensed six month period. This demonstrates the positive effect that online delivery can have in increasing the numbers who can engage with learning interventions
(annual average has been 320 places since 2018).

"increase the SAB's understanding of prevalence of abuse and neglect locally that builds up a picture over time"
(Care Act Statutory Guidance 14.139)

Table 1: Safeguarding Concerns and Concluded Section 42 Enquiries

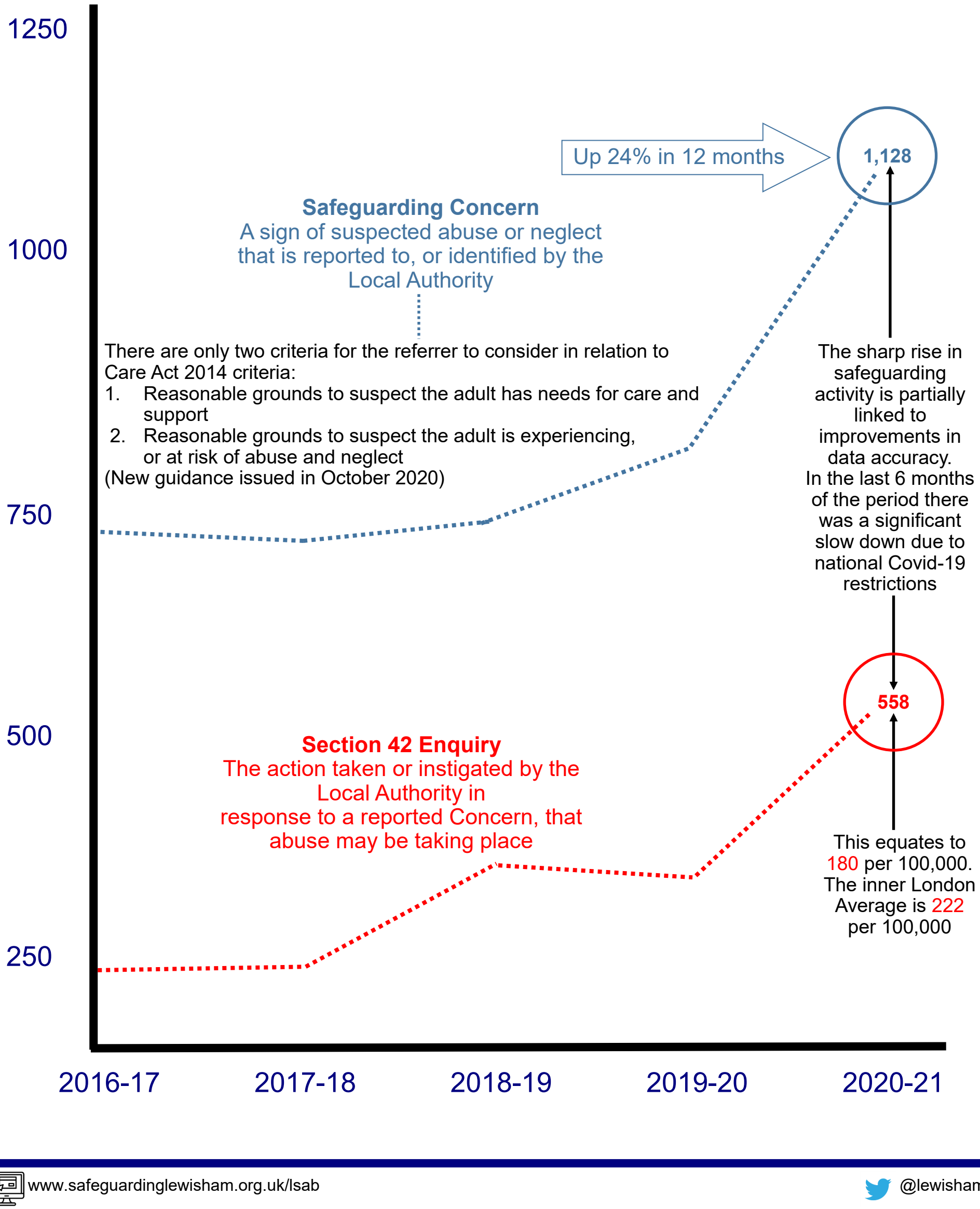


Table 2: Types of Abuse: Concluded Section 42 Enquiries

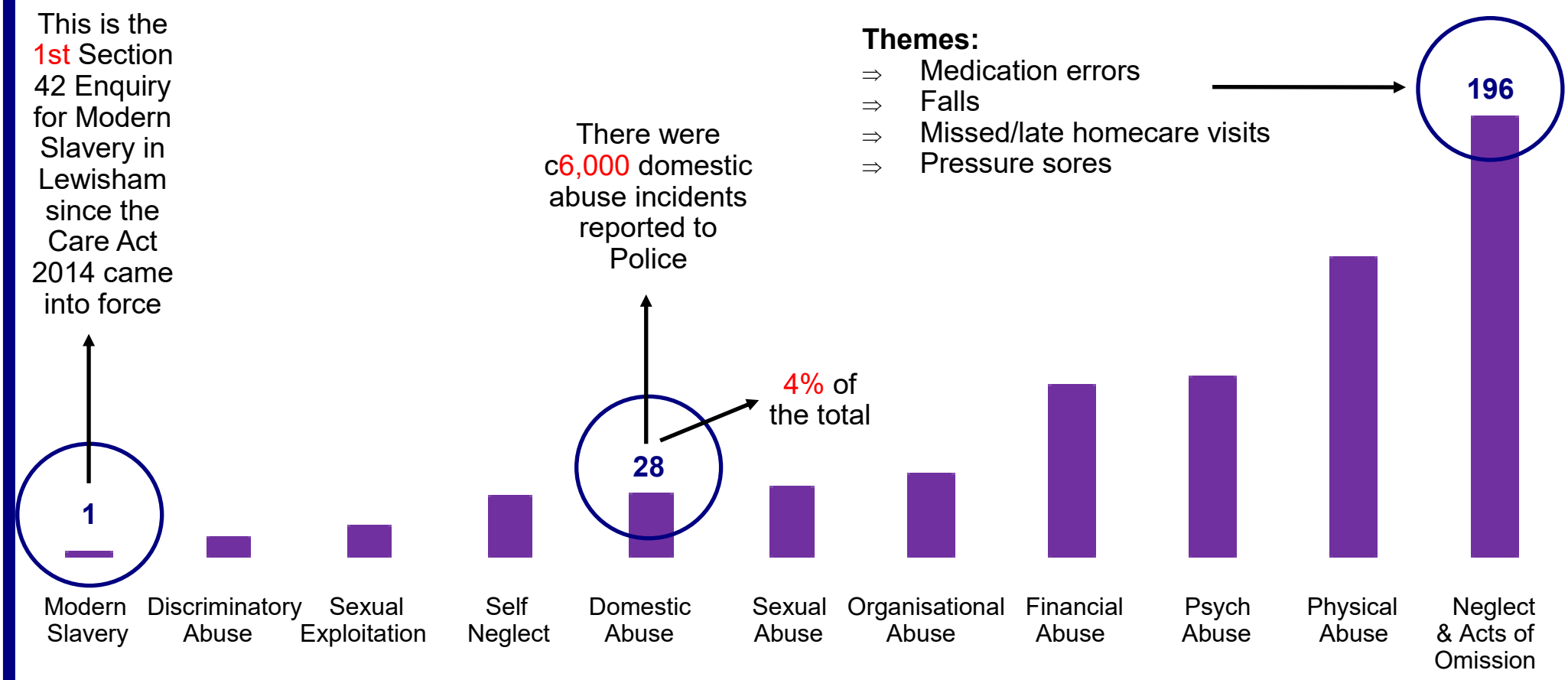
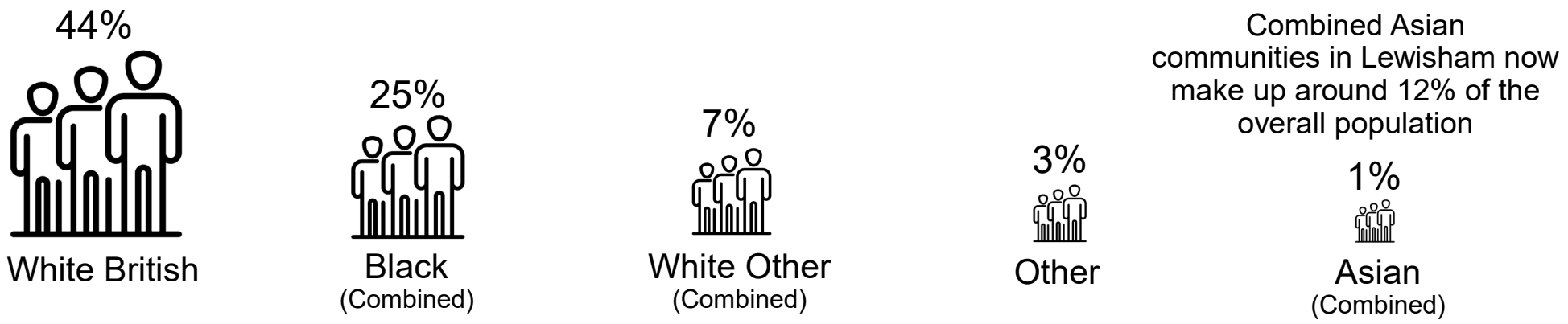


Table 3: Concluded Section 42 Enquiries By Ethnic Code Group

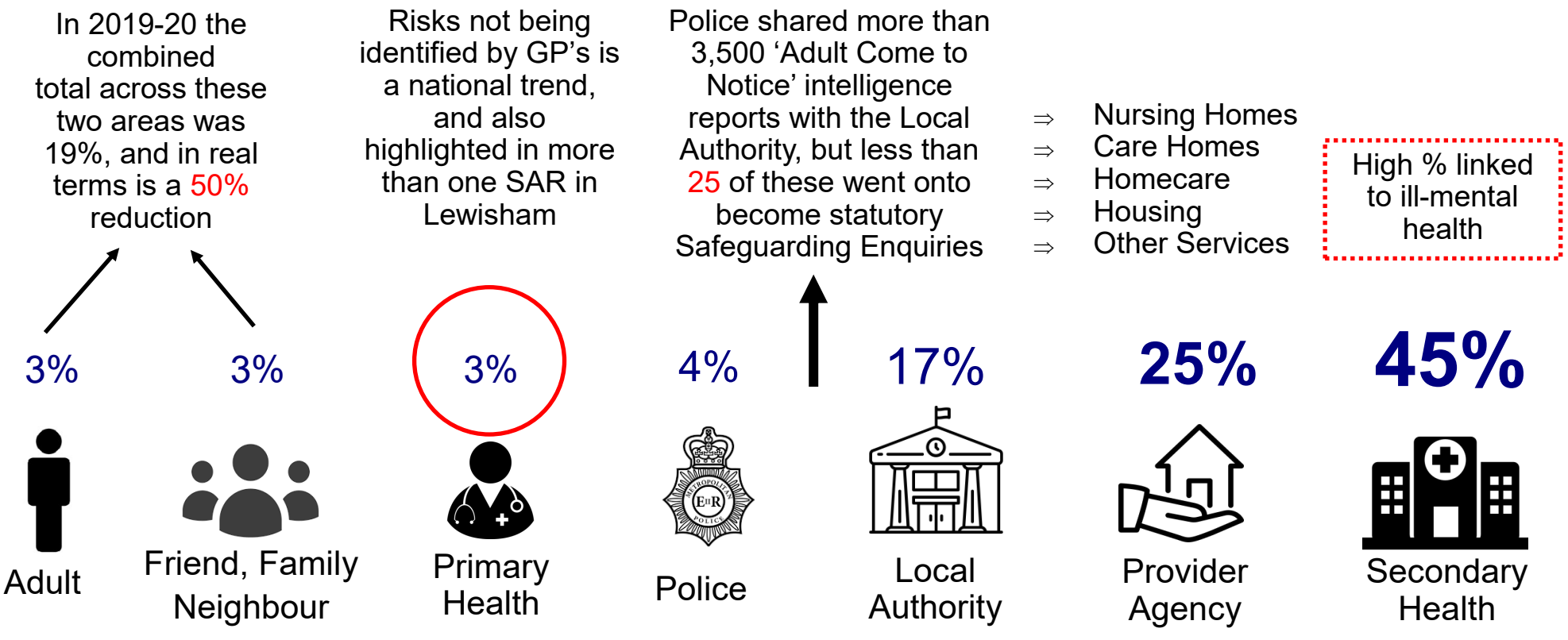


⇒ 36% of concluded s.42 Enquiries involved adults from Black, Asian and Minority Ethnic backgrounds (BAME)

⇒ Most up to date data projections are that the BAME population is around 48% in Lewisham (and rising)

⇒ This data indicates that there are still barriers to reporting abuse, which in turn suggests there is racial disparity and disproportionality in accessing protective services

Table 4: Source of Concern Leading to Section 42 Enquiry (Who reported the abuse)



Safeguarding Adult Reviews

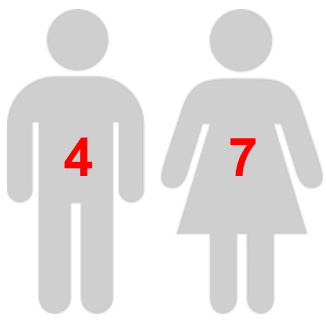
"Safeguarding Adults Boards must arrange a Safeguarding Adult Review (SAR) when an adult dies either as a result of abuse or neglect, known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult".
(Care Act Statutory Guidance 14.162)

The Case Review Sub-Group

In total 11 cases were considered and or monitored by the Sub-Group, which is made up from the Board's statutory partners, throughout the year (see page 9).

A National Analysis of SARs was also published in October 2020: Read HERE

SAR Demographics and Themes (11 cases considered)



Age

18 - 44:	3
45 - 59:	3
60 - 74:	2
75+	3

Most Common Types of Abuse
- ⇒ Organisational Abuse
- ⇒ Neglect & Acts of Omission

	Themes: All Cases
1	Lack of inter-agency working
2	Mental ill-health (including death by suicide)
3	Response to urgent care and support needs
4	Mental Capacity
5	Substance misuse
6	Self-Neglect
7	Physical assault/ Domestic Abuse

SAR Lee (5 June 2020)

Read the 7 Minute Briefing HERE

Background
On 11 January 2016 Lee walked out of a hospital where he had been an in-patient, and was found dead in the street eight miles away three days later. Lee was 46 years old and had a history of alcohol related illnesses, depression and anxiety.

Key Learning Points
1. No formal assessment of risk was completed when Lee left the hospital that drew on previous knowledge of him. It took three days before Lee was formally recorded as missing by police. NHS Procedures should have been used to conclude that Lee was high risk of going missing from hospital.
2. There was miscommunication involving the police, family and hospital with respect to whether Lee was missing, and then whether a missing person enquiry should be raised.
3. No formal Mental Capacity Act assessment was ever conducted.

SAR Tyrone Goodyear (12 June 2020) ➡ Read the 7 Minute Briefing HERE

Background

Mr Goodyear had been in irregular contact with mental health services since he was 15 years old and had been assessed to have Autism Spectrum Disorder (ASD), learning difficulties and Obsessive-Compulsive Disorder.

Tyrone lived with his mother and five of his siblings in four-bedroom temporary accommodation. This was causing friction between the family members. Tyrone left home after trying to secure alternative accommodation and his mother reported him missing. He was later found dead in a hotel room on 21 February 2019 having taken his own life via an overdose. He was 24 years old.

Key Learning Points

1. People with ASD are more likely to commit suicide than the general population, and the factors that predict this can also be different from the wider general public.
2. People with ASD may 'camouflage' their needs in order to fit in. They may not be accessing any services but this does not mean that they do not have unmet needs.
3. Services need to be made more accessible for people living with ASD.

Extract: Statement from the family of Tyrone to accompany the SAR

"We hope that the changes recommended in this report can be put into place as soon as possible, to ensure that when someone with Autism Spectrum, learning and communications difficulties, and suspected mental health issues, will be treated with the correct priority that they need and deserve".

SAR Mrs A and Miss G (26 June 2020) ➡ Read the 7 Minute Briefing HERE

Background

Mrs A (102 years old) and Miss G (73 years old) both lived on their own at home and were receiving Homecare Services linked to mobility and other health conditions. They both also had periods where they were admitted to hospital and discharged, which led to complications in relation to the care they subsequently then received.

Key Learning Points

1. Problems arose in the reassessment of needs during admission to hospital.
2. After mobility had decreased this should have informed a full reassessment.
3. Discharge from hospital resulted in the 'restart' of previous levels of care which were no longer appropriate to meet an increase in care needs.
4. Discharge planning was not undertaken in line with the good practice standards.
5. Carers continued to attempt to meet clients' needs rather than escalate either difficulties with the delivery of effective care, or the impact on the clients' health where needs were not met.
6. Community Nursing did not always respond appropriately or in a timely manner to referrals made by hospital or community services.
7. Equipment that was required at home was not ordered, delivered or set up.
8. Other delays in practical aspects of setting up changes to care caused needs to remain unmet, which led to serious health consequences for the adults.
9. Decision making was not assessed even though poor physical health can lead to a deterioration in mental capacity linked to associated risks in the community.

Work of the Sub-Groups

Case Review Sub-Group

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

The group met 7 times and considered 3 new SAR Notifications during 2020-21. 4 SARs commenced during the year (which includes 2 that were pending from 2019-20), with a further 2 on hold due to 'parallel processes'. The SARs that were published during the year are outlined on pages 9&10.

Lewisham Modern Slavery and Human Trafficking Network

This group was newly launched and involves a range of Board partners across all age domains, but has been initially guided by the Board's business team, supported by the Human Trafficking Foundation.

The Network is developing a new local strategy and guidance for, and with practitioners, which will include a Victim Care Pathway. This subject does not have a high profile in relation to adult safeguarding locally, and is evolving all of the time with new approaches and guidance being created nationally.

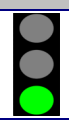
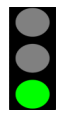
Mission Statement

"We will robustly tackle all forms of modern slavery and human trafficking in Lewisham through effective and collaborative partnership working, and by identifying, protecting and supporting potential victims of modern slavery and human trafficking.
We will empower people to move on safely and successfully from exploitation, and proactively target and pursue criminals".

The Governance for the Network has not been decided yet, but this is likely to come from the Safer Lewisham Partnership Board.

Performance, Audit and Quality Sub-Group

This group continued to meet quarterly throughout the year to monitor the Performance Indicators below:

Pi	Performance Indicators (Pi)	Pi Criteria	Risk is
1	Percentage of Concerns leading to Section 42 Enquiries	> 40%	
2	Percentage of Section 42 Enquiries that involved an adult with a previous enquiry in a rolling 12 month period	< 25%	
3	Percentage of those who were asked their desired outcomes	> 75%	
4	Percentage of those who were satisfied with their outcome	> 75%	
5	Percentage of those where risk has been reduced or been removed	> 89%	

Risks have increased since the end of 2019-20 due to the pressures and challenges the Council and the NHS have faced during the last 12 months.

The group also monitors other pieces of relevant data some of which is outlined on pages 7&8. This informs the groups work programme of audits and reviews, and has played a significant part in informing the development of the Board's current strategic objectives (page 12).

SAR Mrs A and Miss G Task and Finish Group

This group was established to support and track the delivery of the Action Plan linked to this SAR. This was paused to allow Lewisham & Greenwich NHS Trust to focus on the pandemic response, but has now re-commenced.

Lewisham Safeguarding Housing Forum

The group continued to meet quarterly throughout the year, bringing a wider range of agencies and providers together. The Forum has now been stood down having achieved its stated objectives.

Business Plan 2021-22 on a Page

Lewisham Safeguarding Adults Board

A working partnership to prevent abuse

All of the elements outlined below have been developed based on feedback from members of the public and practitioners, performance and other relevant data, audits, and by Board partners providing specific input. This plan is designed to give relevant agencies and professionals a generic template to use in conjunction with the Board.

Vision

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

Priority One

Prevent adult exploitation, abuse and neglect

Priority Two

Develop intelligence led, evidence based practice

Priority Three

Strengthen partnership working

Prevention Aim

Develop preventative strategies by working with those most at risk of abuse and neglect

Accountability Aim

Use monitoring information and data to help develop evidence based practice

Partnership Aim

Support 'the whole family approach' to protecting those most at risk of abuse in Lewisham

Prevention Objectives

1. Focus on equality and narrowing inequality, particularly in relation to racial disparity and disproportionality.
2. Help to break down barriers to reporting abuse and improving access to supportive and protective services.
3. Listen to the voices of adults, ensuring their experiences shape how services are designed and delivered.

Accountability Objectives

1. Support the roll out of the new Lewisham Adult Safeguarding Pathway which includes comprehensive guidance, tools, forms and resources for use across the borough.
2. Combine the findings from higher level reviews to create a joined up and more strategic approach to learning and improvement.

Partnership Objectives

1. Focus on ill-mental health support and recovery, which is one of the most significant risk factors linked to adult abuse and neglect locally.
2. Fully support the delivery of the new Domestic Abuse Strategy in Lewisham and the implementation of the Domestic Abuse Act 2021.

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www.safeguardinglewisham.org.uk/lsab