



Safeguarding Adults Board

Making Safeguarding Personal



Annual Report 2019-20

Safeguarding is everyone's responsibility



Safeguarding Adults Summary for 2019-20



Concern and enquiries

- 1,115 people had one or more safeguarding concern raised in 2019-20. 462 people had a concern that proceeded to an investigation (i.e. a safeguarding 'enquiry').
- In 75% of cases, risks to the person reduced and in 15% of cases the risk was completely removed.
- 60% of safeguarding issues occurred in the adult's own home.

2019-20 Achievements

- A comprehensive review of safeguarding practice and policy over summer 2019, examined over 100 local authority cases. An action plan was developed to address learning areas such as mental capacity assessments skills.
- Throughout Safeguarding Month in November 2019, several events raised awareness and better equipped staff to deal with safeguarding risks and concerns.
- A July 2019 conference raised the knowledge and skills of over 100 staff on themes such as domestic abuse, substance misuse and learning disabilities.
- A January 2020 workshop enabled the SAB to review its strategy, agree the 2020-21 business plan and undertake a review of Board structure and governance.

2020-21 Priorities - we will:

- Continue to improve community engagement to raise awareness and improve understanding, particularly with groups that are underrepresented in safeguarding referrals and enquiries.
- Better identify 'hidden' safeguarding concerns or risks in the community created by the COVID-19 pandemic, promoting a multi-agency approach to prevention.
- Undertake rapid reviews to identify early learning on the impact of Covid-19 on people with learning disabilities and those within care homes.
- Continue to analyse Safeguarding Adult Reviews and Learning Disability Mortality Reviews, ensuring learning is monitored, actioned and embedded.
- Ensure there is a more consistent and effective learning and training programme for staff across the partnership.
- Improve our understanding of multi-agency performance data, to better enable us to identify safeguarding trends, monitor progress and help facilitate improvements through case analyses and audits.



Foreword by Christabel Shawcross (Independent Chair)



I am delighted to introduce the Annual Report for the London Borough of Tower Hamlets Safeguarding Adults Board. It sets out how the Board, collectively and through the work of partner agencies, has delivered on first year of the new five-year strategy and priorities identified following consultation in 2019. However with the end of the annual report year in March 2020 bringing the unprecedented challenge of the COVID-19 pandemic, it is impossible not to start by saying how, inevitably, the unexpected health and economic crisis would force a rapid change of priorities to protect adults at risk and save lives. The fact that the multi-agency Safeguarding Adults Board (SAB) partnership maintained its commitment to developing SAB priorities is a testament to the strength of Tower Hamlets partnerships and commitment to its diverse communities; some of the most deprived in the country. The exhaustive work by all staff and growing numbers of volunteers to keep people safe in the most basic ways was heartening to witness, as is the commitment to learn lessons from

higher numbers of deaths within care homes. All these issues reset the priorities identified by SAB in March 2020.

My focus as Chair is also to work to integrate and share priorities through membership of the Community Safety Partnership, Health and Wellbeing Board and Contest. The emphasis on promoting awareness of the safeguarding of adults at risk is a common thread, ranging from preventing domestic abuse to fire safety using intelligence from the SAB voluntary sector and community partners, to embrace working with and alongside people. Developing joint strategies with the new Tower Hamlets Safeguarding Children's Partnership (THSCP) will also be a priority.

A key statutory duty of the SAB is to seek assurance from partner agencies, and despite changes in Clinical Commissioning Group (CCG) health structures and change of staff, the commitment to safeguarding remains and has been enhanced across Waltham Forest and East London

Clinical Commissioning Groups (WEL CCG).

The drivers for improvement are through the subgroups, which deliver on priorities. Inevitably they are variable in approach due to changing staff and change of leadership, especially with a gap in consistent community engagement, now to be assisted by closer working relationship with Healthwatch.

The report details how well the SAB did in improving awareness and analysing data on needs and enhancing awareness on needs of Black, Asian and minority ethnic (BAME) and faith groups. It also shows improvements are still needed in weaker areas of effective multi agency training, learning and development and developing a new strategic approach alongside the Tower Hamlets Together (THT) partnership. An important assurance for SAB requires arrangements to understand the care market, taking a proactive approach in supporting high quality care. The SAB focused on the residents placed in the five local care

homes, and supported living accommodation. A priority has been the quality of care and safety of people with learning disabilities, enhanced by the national reporting and analysis on learning disability mortality reviews ('LeDeRs'). Evaluation from joint commissioners, the Care Quality Commission (CQC) and local Safeguarding Adults Reviews (SAR) showed the importance of increasing health checks and advocacy for people with a learning disability.

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Foreword continued



The SAB has an important role in supporting the frontline across all partners, raising awareness of issues. Its annual conference reflected the breadth of learning needed on understanding modern slavery, domestic abuse, self-neglect and hoarding. The identification of new issues from current SAR's have led to these priorities for 2020/21- the focus being on safeguarding responses to those with substance misuse issues, homelessness, multiple health and mental capacity needs. Whilst the ongoing COVID-19 pandemic requires urgent responses from all partners, it has been heartening to witness the unflagging commitment to safeguarding generally and to the work of the SAB specifically. New emerging priorities due to the pandemic as part of the recovery phase that were not anticipated in February include learning from the response to safeguard care home residents, with Tower Hamlets local authority leading the way locally working with public health and partners on a local review. As other issues emerge from national reviews, the SAB; in being agile, will seek

assurance from partners on local implementation and learning.

A key risk last year was Brexit and the impact on staffing and recruitment. Whilst we await a final agreement, most agencies have not reported undue recruitment problems whilst waiting for Brexit to be completed, but this is subject to the impact of new immigration rules on certain health and social care staff not being seen as a priority, as well as the impact of COVID-19.

Key priorities for 2020/1 are:

- Learning from the impact of COVID-19 on local communities and adults and risk to promote multi agency approaches to prevention
- Enhancing community engagement to improve understanding and awareness of safeguarding
- Improving understanding of multi-agency performance data to facilitate a consistent focus on case analysis, audit and improvements

- Effective assurance and learning on how to more effectively embed learning from Safeguarding Adult Reviews
- Ensure more effective multiagency safeguarding training and learning across SAB and partners.

These ensure that the most important role of the SAB must be to remain assured that adults are safeguarded, by empowering them to have the information needed for seeking help and support for informed decision making in an uncertain time given the pandemic and its continuing impact. I am certain that all staff and agencies will continue with their innovative and collaborative approach and would like to convey my thanks to all for this.

Christabel Shawcross

Independent Chair Tower Hamlets
Safeguarding Adults Board, July 2020



Foreword by Councillor Rachel Blake, Cabinet Member for Health and Adult Service



I am pleased to endorse the Safeguarding Adults Board Annual Report for 2019-20. The report reflects the ongoing commitment of partner agencies and the staff within them to prevent adult abuse and neglect as much as possible, and to tackle it swiftly and effectively when it occurs. Tower Hamlets is a diverse community with wide number of partners involved in safeguarding. This report describes the activity and achievements of the Safeguarding Adults Board over the previous year. I have attended 2 Safeguarding Adults Boards since becoming the Cabinet Member in June 2020.

The achievements are presented under our six main priorities for safeguarding: Empowerment, prevention, protection, proportionality, partnership and accountability. Much has been done under these areas; such as the delivery of a successful safeguarding training workshop for General Practitioners within the borough as

well as a multi-agency learning event that focused on the recommendations from a Safeguarding Adults Review.

Towards the end of the year, the Covid-19 pandemic significantly impacted local authorities and adults safeguarding throughout the country. Tower Hamlets had been impacted significantly due to key risk factors, such as the borough having a high Black, Asian and Minority Ethnic population and comparatively high levels of deprivation. The report briefly highlights the impact of the pandemic, and also articulates our priorities for the forthcoming year, which focuses on learning lessons from the pandemic as swiftly as possible, identifying hidden risks in the community, tackling underlying health inequalities, continuing to promote awareness of safeguarding as well as continuing to train and develop staff on emerging safeguarding risks.

The report also sets out the Safeguarding Adults Review activity

carried out over 2019-20. These reviews ensure lessons are learned in cases where an adult has died or experienced significant harm or abuse. Over 2019-20, 6 reviews were published, including two thematic reviews which looked at key themes such as homelessness, substance misuse and social isolation. You can find published reviews on the Tower Hamlets website, or by searching “Tower Hamlets Safeguarding Adults Reviews”.

The final part of this Annual Report sets out the structure of the Safeguarding Adults Board, setting out how the work is done and how the Board fits into the wider strategic picture in the borough. This vital area of work continues to be a priority for services in Tower Hamlets, and I hope you find it helpful reading about how this commitment has been put into practice over the last year.



Local demographic data



Tower Hamlets continues to have one of the fastest growing population nationally and now has an estimated population of 324,745.

Tower Hamlets remains one of the youngest boroughs in the country with a median age of 36.6. The 2011 Census showed that 73 per cent of people in Tower Hamlets are aged between 16 and 64, compared to the London average of 67 per cent.

According to the 'Indices of Multiple Deprivation 2015-19', 44% of older people live in income deprived households, the highest proportion in England and more than double the average.

The borough is increasingly diverse - as of the 2011 Census more than two thirds (69 per cent) of the borough's population belong to minority ethnic groups (i.e. not White British), 43 per cent of the borough's population are born outside of the UK.

In 2016-18, life expectancy for men in Tower Hamlets was the same as in the UK, while for women it was slightly higher than the UK average. However, healthy life expectancy was below the national average, with a particularly large gap for women.

Female disability free life expectancy was below both the London and UK average and was the 3rd lowest among 32 London Boroughs at 60 years. Male disability free life expectancy was below the London average but slightly above the national average at 63 years.



Safeguarding adult's performance data 2019-20



The report presents information for 2019-20 in relation to safeguarding adults. It gives an overview of the number of safeguarding concerns that have been received, and the number and type of enquiries (i.e. investigations) that have been concluded. The council in its lead role for safeguarding has an overview of all safeguarding concerns received within the area. As such, data from the council's system has been used to inform this section.

Number of safeguarding concerns

In 2019-20, 1,115 safeguarding concerns were raised in Tower Hamlets, which is a 1.2% increase on the number of concerns received the year before (1,102 in 2018-19). This number has been on an upward trajectory for Tower Hamlets over the past 4 years, which we believe is reflective of the increased awareness of adult abuse and neglect amongst staff and residents in the borough, rather than an actual increase in the level of abuse.

Who is being referred?

Although the number of concerns received has increased, the proportion of those referrals that relate to women and older people aged 65 years of over has remained consistent over time at 54% and 48% respectively.

48% of referrals relate to people from people with a 'white' ethnic background, down from last year (53%). 28% of referrals relate to people from an 'Asian' ethnic background, who make up over 40% of the total population in Tower Hamlets. Although this is a complex issue and the figures may be impacted by the age profile of the borough, the Safeguarding Adults Board is committed to understanding the reasons why this is the case.

Safeguarding adult's enquiries

Safeguarding adult's enquiries are concerns received that have proceeded to a safeguarding investigation.

462 people had safeguarding adults' enquiries commenced in 2019-20, which is a slight increase compared to last year (433). The 'conversion rate' from concerns to enquiries is based on the gross number of cases rather than number of people. This year it is 38%, similar to last year (39%)

Following guidance issued by the LGA/ADASS on the conversion rate, the council has analysed its data to ensure it reflected this and continues to monitor the rate.

Overall, there were 678* concluded safeguarding adults' enquiries, up from 662 last year

*Note that this figure differs to the enquiries commenced as that is counted per individual. Some individuals have may have more than one safeguarding incident and complex enquiries may involve multiple types of abuse, each is recorded separately.



Safeguarding adult's performance data 2019-20 continued



Where the abuse takes place

Based on concluded safeguarding investigations, the majority of safeguarding issues take place in the alleged victim's own home - 60% in 2019-20. 10% of enquiries related to people in care homes, which is up slightly compared to last year (9%) and 7% related to hospital settings.

The low proportion of enquiries from care homes in Tower Hamlets compared to the national average reflects the small number of residential and nursing care homes in the borough.

The Board have looked at detailed information on the quality of home care and care homes in the borough and at the systems in place to safeguarding people receiving support.

Types of abuse

Neglect and acts of omission was the largest single type of abuse investigated in Tower Hamlets in 2019-20 at 32%. This is a slight increase compared to last year (30%).

Financial abuse accounted for 19% of investigations, slightly down from 22% last year. Physical abuse accounted for 12%, down from 15% last year, whilst self neglect accounted for 10%. Psychological abuse decreased from 15% in 2018-19 to 11% this year. Domestic abuse accounts for 8% of reported cases. Sexual abuse reported levels remain similar over time - 5% this year compare to 6% in 2018-19. the remaining 2% was recorded as 'other'.

Safeguarding enquiries outcomes - managing risk

Safeguarding and risk management can be complex processes with a number of factors that will render a person or situation being at risk. Where risk cannot be completely removed, strategies are in place to monitor and inform the individual of what support is available to them.

In an increasing proportion of completed enquiries the risk to the individual has been reduced - 75% in 2019/20 up from 70% the previous year. The risk was removed in 15% of enquiries, whilst it remained for 10%.

Deprivation of Liberty Safeguards performance data

The Deprivation of Liberty Safeguards (DoLS) is an amendment to the Mental Capacity Act 2005 (amended in 2007). The Mental Capacity Act allows restraint and restrictions to be used but only if they are in a person's best interests and they lack capacity to make decisions about their care or treatment. The Deprivation of Liberty Safeguards (DoLS) can only be used if the person will be deprived of their liberty in a care home or hospital. In other settings the Court of Protection can authorise a deprivation of liberty.

In July 2018, the government published a Mental Capacity (Amendment) Bill, which passed into law in May 2019. It replaces the Deprivation of Liberty Safeguards (DoLS) with a scheme known as the Liberty Protection Safeguards, which will come into effect in April 2022.

The majority (approximately 65%) of all DoLS request received in 2019-20 were from care homes. Hospitals accounted for nearly 29% whilst the remainder of requests were from hospice/other agencies. Throughout the previous two years, care homes accounted for 57% and 55% of all DoLS requests respectively.

The total number of DoLS requests have been decreasing since 2017. This is partly due to the closure of wards in Mile End Hospital as well as the closure of a residential care home.

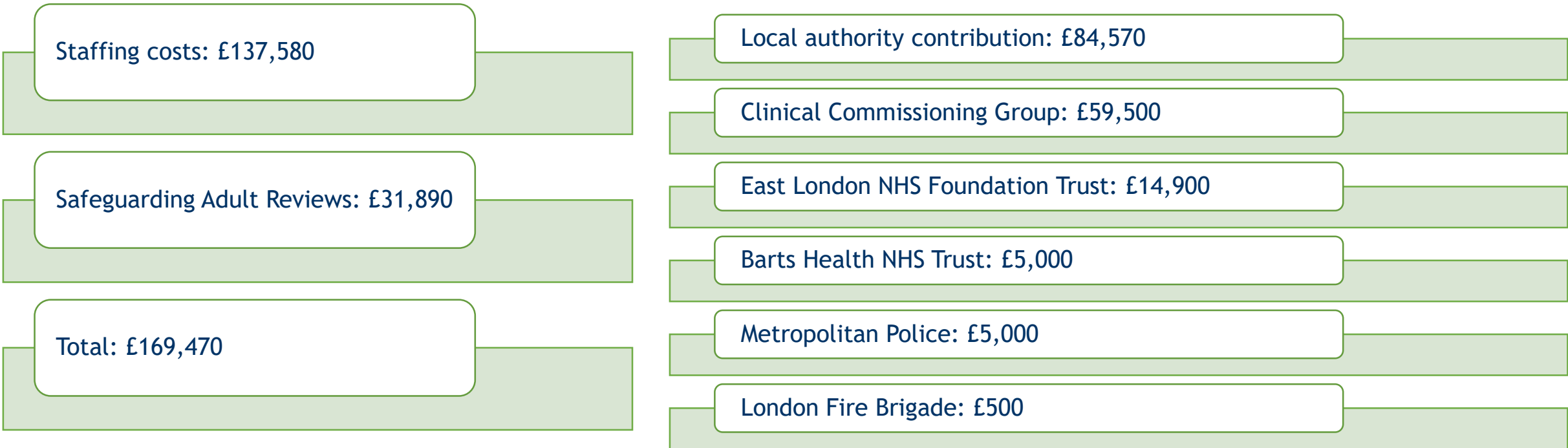
	2019-20	2018-19	2017-18
Total DoLS request received	596	630	741
DoLS authorised	293	213	191
DoLS not authorised	80	30	40
DoLS withdrawn	223	341	247

Funding for the Safeguarding Adults Board 2019-20



Funding of Tower Hamlets Safeguarding Adults Board is received both in monetary terms and in kind. It is acknowledged that every organisation faces financial challenges each year; therefore, it is with appreciation that partner members give their time and resources to support the functioning of the board.

The tables below set out expenditure and contributions in relation to the Board for 2019-20:



Learning and development over 2019-20



Tower Hamlets council provides a range of safeguarding adults training for staff at all levels. It ranges from basic awareness raising training to training for managers of staff undertaking investigations. Bespoke training is provided on topics including domestic abuse, hoarding, human trafficking and female genital mutilation.

Partner agencies also provide a range of training for their staff. Safeguarding adult's basic awareness e-learning is a web-based training portal and is available to all Tower Hamlets staff and those working in the private, independent sectors, carers and volunteers working with adults. Training is provided free of cost to the recipient.

The SAB had a priority to improve the range of multi agency training and agreed to participate with Tower Hamlets Together in a multi agency approach, to assess training needs and analysis for front line staff. This is still work in progress.

In July 2019, the SAB held its annual safeguarding conference, building on learning from local and national SARs. Approximately 100 people from partner agencies, including frontline health and social care organisations, attended the event, with an aim of sharing best practise, raising awareness and exchanging ideas around various safeguarding topics. The two keynote presentations focused on domestic abuse and learning disabilities in the context of adult safeguarding. Participants were also invited to attend several workshops, covering Safeguarding Adults Reviews, critical thinking, substance misuse and Prevent. The conference was a huge success, with positive feedback from participants.



Safeguarding Adults Board achievements over 2019-20



The priorities for 2018-19 came from the Safeguarding Adults Board Strategy of 2015-19. Each priority was built into the business plan relating to the six principles of safeguarding. The importance of supporting people in a personalised way runs throughout these principles in order to promote 'Making Safeguarding Personal'. The business plan is monitored by the Safeguarding Adults Board, whilst the work is undertaken via the sub-groups. Each partner agency has worked to ensure their organisation continues to provide a service and that the workforce receives safeguarding training and understands how to recognise abuse respond to it. Here is a summary of the work carried out.

Empowerment

Our goals - people being supported and encouraged to make their own decisions and give informed consent.

Tower Hamlets Council: “We developed an escalation tool to assist staff and managers to be aware when they need to escalate a safeguarding case to a more senior manager when circumstances are challenging in order to manage risk safely”

Tower Hamlets Clinical Commissioning Group: “We continue to promote the importance of the use of the Mental Capacity Act and advocacy within their multi-agency working partnerships. This area of work is essential in terms of ensuring the voice of the service user is clearly heard and at the centre of the safeguarding process”.

Police: “We have delivered training to all front line staff and safeguarding officers to better understand vulnerable adults and make relevant referrals so help can be offered. Officers work in partnership to understand and solve the root cause of vulnerabilities.

Prevention

Our goals - it is better to take action before harm occurs

Police: “We have delivered awareness raising sessions and training to officers to help identify, report, and investigate modern slavery. We have also focused on forced labour, domestic servitude and County Lines (cuckooing of vulnerable adults addresses)”.

East London Foundation Trust: “We now have a newly appointed GP safeguarding lead for adults who is working closely with the designate to plan the delivery of training across primary care”.

Tower Hamlets Council: “We conducted a workforce skills analysis and review of safeguarding training resources with an inclusive focus on sharing of in-house skills via workshops, and lunch and learn events in addition to formal training”.

Barts Health NHS Trust: “In October 2019 we introduced Level 3 safeguarding training in to target key roles as a priority to all registered staff including nursing, medical and allied health professionals”



Safeguarding Adults Board achievements over 2019-20



Proportionality

Our goals - *The least intrusive response appropriate to the risk presented.*

Tower Hamlets Clinical Commissioning Group: “We joined Waltham Forest and Newham CCGs this year to become a WEL CCG. This will ensure the three boroughs work and learn together and ensure safeguarding adults from abuse and neglect is prioritised and that responses are proportionate”.

East London Foundation Trust: “The domestic abuse agenda continues to be a significant priority area for the us. We have implemented the Domestic Abuse and Harmful Practices policy, developed the Domestic Abuse steering group, developed domestic abuse leaflets and also participated in the National White Ribbon Campaign”.

Protection

Our goals - *support and representation for those in greatest need.*

Tower Hamlets Council: “We helped facilitate a Level 3 safeguarding training workshop with the CCG for General Practitioners so that they are better able to assess, intervene and evaluate the needs of adults where there are safeguarding concerns”

Barts Health NHS Trust: “We have seen a 42% increase in the reporting of safeguarding adults concerns in our patients aged 65 or over and an overall increase of 48% in patients aged under 65. This is a positive trend and reflects the impact of training and the increased visibility and access to the Safeguarding Adults team”.

East London Foundation Trust: “We consistently promote the use of community meetings, service user groups and forums where safeguarding is on the agenda so there can be open discussions between staff and service users, therefore encouraging preventative measures and early intervention. The Co-Production group in the Isle of Dogs Community Mental Health Team is a good example of where strengthening the relationship between providers and users of the service can build trust and openness in the relationship”

Police: “We continually strengthen safeguarding practice through our own dedicated Inspection Team, Internal Reviews and feedback sessions”.



Safeguarding Adults Board achievements over 2019-20



Partnership

Our goals - *local solutions through services working with their communities.*

Communities have a part to play in preventing, detecting and reporting neglect and abuse.

Police: “We are committed to partnership working to fully safeguard vulnerable adults. This is demonstrated by our commitment within the Multi Agency Safeguarding Hub (MASH), and via the Multi-Agency Public Protection Panel Arrangements (MAPPPA) working with the probation service and adult social care to ensure vulnerable offenders are supported whilst also ensuring that offender management is in place to ensure public safety. Information sharing is at the heart of our approach to partnership working.

East London Foundation Trust: “We have actively sought to engage partners across Tower Hamlets in the local authority, Clinical Commissioning Group, voluntary sector and regionally. Interagency meetings attended include the Safeguarding Adults Board, learning forums, Domestic Homicide Review’s, the High-Risk Panel and SNAP panel”.

Barts Health NHS Trust: “We held two awareness-raising events on modern slavery to mark anti-slavery month in October 2019. They helped to raise awareness and staff knowledge on modern slavery and was positively received by all”.

Accountability

Our goals - *accountability and transparency in delivering safeguarding.*

East London NHS Foundation Trust: “We have a robust safeguarding adult’s policy. All staff receive safeguarding adult training commensurate with their role, developing an organisational culture where all staff are aware of their professional responsibilities to report safeguarding concerns”.

Barts Health NHS Trust: “We developed a new safeguarding dashboard in 2019 for internal and external reporting. This helps with better reporting and ensures greater transparency throughout the trust”.

Tower Hamlets Council: “We held a multi-agency learning event that focused on the learning that arose from the themed SAR we undertook on social isolation, ensuring that partners embedded the recommendations from the SAR more efficiently”.



Summary of achievements by the Safeguarding Adults Board and partner agencies



Our priority last year:

Focus awareness raising activity on self-neglect and preventing abuse

What we have done:

A range of activity has been carried out throughout the year. Throughout Safeguarding Month in November 2019, a series of events were held to not only raise awareness, but to better equip front line staff members to deal with safeguarding risks and concerns. These include a safeguarding training workshop for GPs, a play on hoarding, a SAR learning event as well as safeguarding awareness sessions for the public which were held throughout key community sites in the borough.

As previously mentioned, the July 2019 staff conference on safeguarding was attended by over 100 staff from partner agencies to promote learning from SARs.

Our priority last year:

Continue to analyse all Safeguarding Adult Reviews and Learning Disability Mortality Reviews in order to ensure that learning is actioned and embedded efficiently.

What we have done:

The Safeguarding Adults Board published six Safeguarding Adult Reviews (SARs) between April 2019 and March 2020. The Board continues to ensure that learning from all SARs have been actioned, with work underway in analysing action plans in order to identify common themes. A safeguarding conference is planned for September 2020 to explore the common themes arising from Safeguarding Adults Reviews.

The Board received an analytical review of all Learning Disability Mortality Reviews in Tower Hamlets, which highlighted a consistently high performance in terms of case completion, allocation and length of review. Several overarching themes

were identified and incorporated into the Tower Hamlets Adults Learning Disability health work stream, whilst a number of achievements were noted, including a 82% uptake of annual health checks as well as the implementation of the 'Health Quality Checker Scheme', improving the lives of people with a learning disability in the borough.

The Board has also continued to provide input into the Social Care Institute of Excellence national SAR library; an evolving project which will help the Board better analyse learning from SARs throughout the country; ensuring safeguarding risks can be mitigated and best practise replicated where possible.

Our priority last year:

Analyse underrepresented groups in the borough, in order to focus relevant safeguarding campaigns towards them.

What we have done:

The Board received a report on the analysis of underrepresented groups in the borough towards the beginning of the 2019-20. The report found that even when adjusted for age, people from an Asian ethnic background are underrepresented in safeguarding figures, consistent with national trends. The Board is committed to work with established networks (such as faith groups) to explore how this can be addressed going forward.



Summary of achievements by the Safeguarding Adults Board and partner agencies (continued)



Our priority last year:

Develop the council website as a better resource for staff and residents on safeguarding.

What we have done:

The Safeguarding Adults Board undertook initial work on ensuring that the council website was an effective resource for staff and residents alike. Policies and procedures were updated and refreshed, and work was done to ensure the website was accessible and user friendly. This remains a priority for the Board next year, with plans in place to further develop the website.

Our priority last year:

We will continue to focus on making safeguarding personal.

What we have done:

SAB partners undertook a self-audit analysis for the year, which demonstrated an improvement from agencies on several key areas, such as having robust safeguarding policies, strong recruitment procedures as well as ensuring the principle of 'Making Safeguarding Personal' remains at the heart of the organisations practise.

The Board also received a report in September 2019 which audited 28 safeguarding cases in the local authority, highlighting improvements on risk measures as well as identifying several cases where substantial effort was put in hearing the service users voice, and planning for what they wanted despite several challenges.

Our priority last year:

Develop a new multi-agency dashboard to better identify trends and monitor outcomes.

What we have done:

The Safeguarding Adults Board scrutinised regular evidence and data in relation to safeguarding, and the development of a multi-agency dashboard remains a key aim going forward.



Safeguarding Adults Reviews 2019-20



Section 44 of the Care Act 2014 places a duty on Safeguarding Adults Boards to arrange a Safeguarding Adults Review (SAR), in cases where an adult has died or experienced significant harm or neglect. The purpose is to ensure learning from the lessons and to prevent situations occurring again. On conclusion of the SAR, an action plan will be drawn up to ensure the recommendations of the findings are implemented. The executive summary of each SAR will be available on the council webpage and a full report is available on request from the Safeguarding Adults Board Coordinator.

The purpose of the SAR is to:

- Establish what lessons are to be learnt from a particular case in which professionals and organisations work together to safeguard and promote the welfare of adults at risk.
- Identify what is expected to change as a result, to improve practice.
- Improve intra-agency working to better safeguard adults at risk.
- Review the effectiveness of procedures, both multi-agency and those of individual organisations.

In 2019-20, six Safeguarding Adult Reviews were published.

Mr D: Mr D was a 30-year-old severely learning disabled (SLD) man diagnosed with sensory defensiveness, cerebral palsy and epilepsy who died in May 2015. A post-mortem attributed Mr. D's death to gastrointestinal haemorrhage, bleeding peptic ulcer and cerebral palsy. This was a complex review and found numerous areas for learning and improvement. These included the need for a better understanding of mental capacity and people with learning disabilities, more effective sharing of communication between health partners, wide promotion of health checks and hospital passports for people with learning disabilities and the need for training and competence testing on areas such as consent, mental capacity and the equality act.

Ms C: Ms C was a woman in her mid-twenties, who took her own life. Ms C had a range of mental health diagnoses: personality disorder, Asperger Syndrome, depression and anxiety. The review found that when Ms C became homeless, a minority of professionals identified the safeguarding needs of Ms C and that coordination of care was extremely important for someone such as Ms C, who was known to several different services and had a complex combination of vulnerabilities. The learning focused around the need for the Board to assure itself that partners were able to identify safeguarding risks, improve pathways between mental health, housing (homelessness team) and adult social care and assure itself that professionals in assessment services are able to make reasonable adjustments for people with autism.



Safeguarding Adults Reviews 2019-20 (continued)



Mr Z: Mr Z had a learning disability, a history of being depressed and could get frustrated at times. He also had epilepsy and a diagnosis of paranoid psychosis, as well as several physical health needs. Mr Z was found dead in his home in April 2016 due to bowel ischemia, which occurs when the blood flow through to the major arteries that supply the intestines slows or stops. The review found that there wasn't one single safeguarding incident that resulted in the death of Mr Z, but highlights a lack of professional curiosity and focussed interventions over a number of years especially on his health needs. The review makes recommendations for partners in several areas, including on health and social care needs being reviewed, ensuring hospital passports are kept up to date, record keeping and information sharing, assessments/reviews of capacity and training around the mental capacity act.

Mr F and G: This review was a thematic SAR of two individuals who met the safeguarding criteria, namely Mr F and Mr G. In addition, four other individuals care support was considered. Mr F and Mr G shared some similarities in that they were both over 65 years old, were socially isolated or had limited social networks and both vulnerable to abuse and neglect and in need of multi-agency service support. The themed review made several recommendations to the SAB, some which were case specific and some which related to the impact of social isolation. These include the facilitation of a multi-agency learning event, the development of a Safeguarding Quality Assurance Framework as well as raising awareness of the escalation pathway to the Multi Agency High Risk Panel coordinated by the council.

Mr V: Mr V was a man in his 80s who was receiving support and support from the council. The review focuses around allegations of financial abuse which came to light after the death of Mr V in 2014; concerning an individual who befriended him whilst on a placement with a voluntary day centre who subsequently became a registered social worker working in another borough. The person then led services to believe they were a relative. After referral to the Health and Care Protection agency; the person was removed from the register. The review found that Mr V was not adequately safeguarded whilst receiving support and that safeguarding enquiries were insufficient. The report made recommendations on several areas including mental capacity assessments, leadership behaviours and safeguarding policies and practises. A key point was the lack of understanding of the term 'next of kin' and the need to ensure robust checking of authenticity of people purporting to be relatives.

Ms H and I: This was a thematic SAR focusing on homelessness and substance misuse following the death of Ms H and Ms I. Ms H was a 52-year-old woman, a wheelchair user, with a history of physical and mental health needs, self-neglect, drug and alcohol misuse, who was at risk of homelessness at the time of her death in a flat of a friend in April 2018. Ms I was a 33-year-old woman who had been sleeping rough since 2000 and had a longstanding history of alcohol and drug misuse. Ms I experienced physical and mental health needs and died in June 2018 whilst in hospital. Her death resulted in the hospital conducting a serious incident report due to her being deemed missing but was in fact still in hospital. Due to the similarities between the two cases, a themed approach was agreed, namely looking at self-neglect, homelessness, substance misuse and physical and mental ill health. The review made several recommendations to the Board, including the need to produce and circulate best practice guidance for professionals working with people who experience multiple exclusion homelessness, the need to commission regular audits of the effectiveness of multi-agency high risk panel and the need to review the multi-agency training available to staff.



Learning Disability Mortality Reviews (LeDeRs)



The National Learning Disability Mortality Review seeks to review all deaths of people who have a learning disability aged 4 years upwards. The programme has been running since 2015. The programme was set up to review all deaths, review practice, identify where care delivery can be improved, share good practice and replicate it wherever possible.

LeDeR in Tower Hamlets

In Tower Hamlets, there have been 32 deaths reported for people with a learning disability, of which 27 reviews have been completed.

Across NEL boroughs, Tower Hamlets trends on average in regard to the number of deaths being recorded while remaining the leading borough in the number of completed reviews due to being a pilot site and the pool of proactive reviewers from the CLDS.

55% of all LeDeR cases in Tower Hamlets in 2019-20 related to people under the age of 50 and the majority of all cases have respiratory or

cardiac causes of death.

Since the beginning of the COVID-19 pandemic there have been four deaths of people with a learning disability relating to the virus; two confirmed and two suspected cases where the individual had the virus and sadly died.

Learning from LeDeRs is being taken into action with a project to develop a new and improved online alternative to the Hospital Passport and an initiative with workshops and engagement with families to improve the uptake of bowel and breast cancer screening for people with a learning disability.

The hospital passport is designed to give hospital staff helpful information that isn't only about illness and health and can include what you like or dislike. If you go into hospital, the passport will go with you, and helps all hospital staff know how to make you feel comfortable.

Themes from reviews

There have been a few consistent themes emerging from the LeDeR reviews:

- *Care coordination:* A care coordinator should be assigned to individuals with complex care needs
- *Consultation:* Patients, their families and carers should be included and consulted in all health care decisions.
- *Learning and Development:* Primary care staff should be better trained in learning disabilities, dementia and other challenging behaviour. There also needs to be greater understanding and training around the Mental Health Capacity Assessments.
- *Advocacy:* Independent advocacy is important for people with a learning disability and should be offered to families and individuals

These key themes have been incorporated into the Tower Hamlets Adult Learning Disability health work stream, which is responsible for implementing these actions as part of the Tower Hamlets Together partnership system. Whilst a number of successful initiatives have been implemented, such as the increased uptake of annual health checks and the 'Health Quality Checker Scheme, others require further development. As the reviews continue, their recommendations and learning will continue to evolve and shape the future commissioning and strategies within the health and social care system.

	2016-17	2017-18	2018-19	2019-20
Number of deaths	5	14	8	5
Completed reviews	0	3	15	9



Impact of the COVID-19 pandemic on safeguarding adults



One of the most significant challenges we have faced as a Board since March 2020 has been dealing with the impact of COVID-19 pandemic.

As of 15th June, there have been 644 confirmed cases in Tower Hamlets, and 183 confirmed deaths as a result. In Tower Hamlets as elsewhere, we know that older people, those living in care homes and those with longer term conditions have been at particular risk during the pandemic. In addition, Tower Hamlets had been impacted significantly due to key risk factors, such as the borough having a high Black, Asian and Minority Ethnic (BAME) population and comparatively high levels of deprivation.

The direct impact of COVID-19 on adults at risk of abuse and neglect are significant, as are the wider impacts that include mental health impacts, homelessness, financial scams and substance misuse. For example:

Nationally, the UK's largest domestic abuse charity, Refuge, reported a

significant increase in calls to their helpline, seeing an average increase of around 50% in calls and over 400% in visits to its website since lockdown measures began.

SCIE research found that those at most risk of financial abuse tended to be older people, who had mental capacity but did not yet need any care or support. Action Fraud received nearly 2,000 reports from victims of COVID 19 related fraud, with losses totalling nearly £5m. The majority of these relate to online shopping scams, often targeting the most vulnerable groups within communities.

In Tower Hamlets, the number of safeguarding concerns raised through March and April 2020 seem to be in line with previous year figures. March 2020 saw a total of 130 concerns raised, of which 45% turned into a safeguarding enquiry, whilst April 2020 saw a total of 114 concerns raised, with approximately 30% of them progressing to an enquiry. To put this into context, September 2019 saw 186

safeguarding concerns raised in Tower Hamlets, with 40% going on to become an enquiry. The Board will continue to monitor this going forward.

The SAB has been proactive in trying to better understand the impact of COVID-19 in Tower Hamlets to ensure safeguarding awareness is promoted. The SAB has contributed to the London SAB to provide data and information for lessons to be learnt for future waves. The Business Plan for 2020-21 details our priorities for the forthcoming year and has been adapted with the pandemic in mind. Key priorities for the Board include identifying early learning on the disproportionate impact of COVID-19 on people with learning disabilities and those within care homes, identifying the 'hidden' safeguarding concerns/risks in the community created by the pandemic and adopting a more rapid, grassroots approach to community engagement in light of the pandemic.



Our priorities for 2020-21



1. Learning and communication

- Agree how and when to pool budgets across partners in order to commission joint staff training on safeguarding (Q2)
- Establish and deliver a 6 monthly/annual multi agency learning event that focuses on the learning that has come out of recent SARs (Q3)
- Hold a staff conference in July 2020 that incorporates the training needs identified in SARs on topics such as Mental Capacity, Learning Disability and Homelessness and Multiple Exclusion (Q3)
- Complete the review of the governance of the Safeguarding Adults Board (Q1, led by SAB Executive)

2. Quality assurance and performance

- Develop a new, comprehensive, multi-agency dashboard and audit programme that has a clear focus on outcomes (Q1)
- Collectively agree on a method to better identify the 'hidden' safeguarding concerns/risks in the community created by the Covid-19 Pandemic (Q2)
- Explore how data is shared between partnerships to better inform the work of the SAB (Q2)
- Identify and conduct a 'deep dive' on new and emerging risks such as modern slavery and/or cuckooing (Q3)
- Carry out further analysis on the interplay between housing and safeguarding in Tower Hamlets (Q4)

Safeguarding Adults Board Strategy 2019-24

At a strategic level, we have worked to ensure the views and experiences of service users drive out plans: A number of resident service user groups, many of whom with experience of adult social care, contributed to the Safeguarding Adults Board Strategy 2019-24, including the Older Peoples Reference Group, Carers Centre and the Learning Disabilities Partnership Board.

3. Community engagement

- Carry out a promotional campaign around safeguarding promoting adult social care services as 'business as usual' (Q1)
- Undertake a comprehensive safeguarding awareness raising campaign targeted towards those that are 'underrepresented' in safeguarding referrals/enquiries i.e BAME group (Q2)
- Reflect on ways of working around community engagement during Covid and develop a more rapid, 'grass roots' action approach (Q2)
- Carry out a detailed programme of public awareness-raising activity over November 2020 (Q3)

4. Safeguarding Adult Reviews and other key activity

- Continue to commission Safeguarding Adult Reviews where necessary, but with a more innovative approach to better embed learning quickly (table top SAR exercise) (Q1)
- Undertake rapid reviews to identify early learning on the disproportionate impact of Covid-19 on people with learning disabilities and those within care homes (Q2/Q3)
- Develop a joint priority with the THCSP around exploitation (Q3)
- Develop the Safeguarding Adults Board internet pages on the London Borough of Tower Hamlets website as a better resource for staff and residents on safeguarding (Q4)

The Board also organised an away day in January 2020, whereby partners discussed and explored the priorities of the Safeguarding Adults Board, as well as discussing how we can successfully deliver those priorities.



Tower Hamlets Safeguarding Adults Board Governance and Accountability



The Care Act 2014, requires all local authorities to set up a Safeguarding Adults Board (SAB) with other statutory partners: the Police and Clinical Commissioning Group (CCG). Tower Hamlets Safeguarding Adults Board continues to work with partners to embed the requirements of the overarching Care Act to:

- Assure that local safeguarding arrangements are in place as defined by the Act
- Prevent abuse and neglect where possible
- Provide timely and proportionate responses when abuse or neglect is likely or has occurred.

The Safeguarding Adults Board is chaired by an Independent Chair.

The legal framework for the Care Act 2014 is supported by statutory guidance which provides information and guidance on how the Care Act works in practice. The guidance has statutory status which means there is

a legal duty to have regard to it when working with adults with care and support needs and carers.

The SAB takes the lead for adult safeguarding across Tower Hamlets to oversee and co-ordinate the effectiveness of the safeguarding work of its members and partner organisations.

The SAB concerns itself with a range of matters which can contribute to the prevention of abuse and neglect such as:

- Safety of patients in local health services
- Quality of local care and support services
- Effectiveness of prisons in safeguarding offenders and approved premises
- Awareness and responsiveness of further education services

Safeguarding Adults Boards have three core duties, they must:

- Develop and publish an Annual Strategic Plan setting out how they will meet their strategic objectives and how their members and partner agencies will contribute.
- Publish an annual report detailing how effective their work has been.
- Arrange safeguarding audit reviews for any cases which meet the criteria for such enquires, detailing the findings of any safeguarding adult review and subsequent action, (in accordance with Section 44 of the Act).

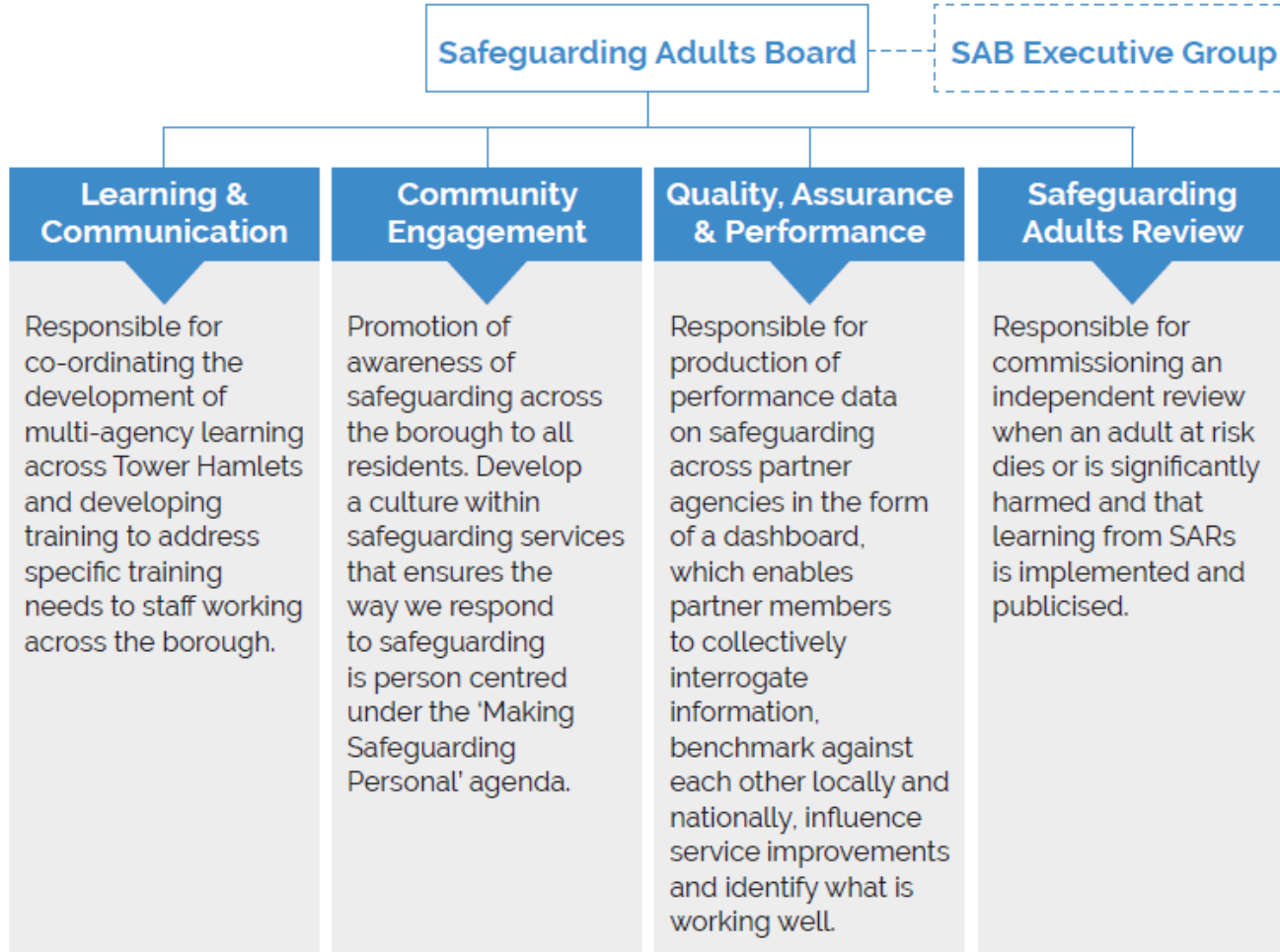
The Safeguarding Adults Board monitors and mitigates risk via a shared risk register. The risk register is updated frequently and discussed at the Safeguarding Adults Board when appropriate.



Tower Hamlets Safeguarding Adults Board partner members



Safeguarding Adults Board structure



The Tower Hamlets Safeguarding Adults Board (SAB) has four sub-groups that assist the board in meeting its obligations as set out in the Tower Hamlets Safeguarding Adults Board Strategy 2019-24. The sub-groups are chaired by partners from agencies which represent the SAB and meet on either a bi-monthly or quarterly basis. The sub-groups each have their own work programme, the monitoring of which is undertaken by the Adults Safeguarding Governance and Strategy Manager.



Strategic boards linked to the Safeguarding Adults Board



The Safeguarding Adults Board has strengthened its relationship with other partnership boards - the Chair of the Board sits on the Community Safety Partnership and Prevent Board to ensure integration of safeguarding issues.

The Health and Wellbeing Board

Having a Health and Wellbeing Board is a statutory requirement for local authorities. The board brings together the NHS, the local authority and Health Watch to jointly plan how best to meet local health and care needs, to improve the health and wellbeing of the local population, reduce health inequalities and commission services accordingly.

Tower Hamlets Safeguarding Children Partnership

The Children and Social Work Act 2017 introduced significant changes to the safeguarding landscape in England, including the replacement of Local Safeguarding Children Boards with new local safeguarding partnerships led by three safeguarding partners - the Local Authority, Clinical Commissioning Group and Police. The vision of the partnership is that the statutory partners, wider relevant agencies, community and voluntary sector and residents work together to ensure that everyone does everything they can to ensure that all Tower Hamlets children and young people are safe, supported and successful.

There has been more focus on the Safeguarding Adults Board and Safeguarding Children Partnership to work more closely together and this has resulted in shared areas being developed to improve responses to both children and adults safeguarding.

Community Safety Partnership Board

The Community Safety Partnership Board is required by law to conduct and consult on an annual strategic assessment of crime, disorder, anti-social behaviour, substance misuse and re-offending within the borough and the findings are then used to produce the partnership's Community Safety Plan. There is a strong link between the Safeguarding Adults Board and the Community Safety Partnership Board; the Violence against Women strategy was refreshed in 2019, reflecting a Safeguarding Adults Board priority to prevent domestic abuse and increase the awareness and reporting of it.

Prevent Board

The Counter Terrorism & Security Act 2015 places a legal duty on specified authorities (including the local authority) to consider the Prevent Strategy when delivering their services. The legislation contains a duty on specified authorities to have due regard to the need to prevent people from being drawn into terrorism. This is also known as the Prevent duty.

The Prevent Board is responsible for the statutory oversight of the delivery of the Prevent Strategy by the local authority. The board also has oversight of the functions of the Channel Panel and the multi-agency arrangements for the safeguarding of vulnerable individuals from radicalisation.

