Bexley Safeguarding Adults Board

ANNUAL REPORT 2021-2022:

We're better with you!

Contents

Section 1: Statement from Eleanor Brazil

It is now 3 years since I became the chair of Bexley Safeguarding Adults Board. Hard to believe how quickly the time has gone by. Of course, much of this period has been dominated by the Covid pandemic. We've all had to adapt to new ways of working and learning new ways of living. In this time, we've had to get used to a whole range of things - PPE, vaccinations, masks, self-isolation, lateral flow tests and track and trace. I am full of respect for the many staff from all agencies who literally rolled up their sleeves and got on with caring for the most vulnerable people in our community.

Thanks to our wonderful Board manager, Anita, the national Safeguarding Excellence awards were introduced. I was one of a national panel who had the privilege of judging the nominations under the different categories. It was so heartening to read the examples of people from different agencies who had delivered such great support in their community. We had many nominations from Bexley and in recognition of their hard work we held a celebration evening in March which was attended by over 50 people. It was really great to meet them in person and thank them.

What a great way to conclude my time in this role and pass on to the new independent chair. We have held Board meetings throughout the 3 years - laterally on Teams remotely but initially in person. They are always well attended. Collaborative working has always been a strength in Bexley, but I believe the difficulties of the past 2 years has brought people even closer together. You will read several examples in this annual report of the way joint working has helped safeguard vulnerable adults effectively. Sadly, there are also a small number of cases where this did not happen, and our safeguarding adults' reviews have been important in identifying the lessons to be learnt. This has led to improvements and been the basis of our training to support the workforce to understand the issues and learn from them.

I hope you enjoy reading about the work of the Board and the difference it has made.

Section 2: What is our role and purpose?

The Bexley Safeguarding Adults Board (BSAB) is a statutory body established by the Care Act 2014. We are made up of senior people from organisations as well as lay members that have a role in preventing the neglect and abuse from adults.

Our main objective is to protect all adults in Bexley who have care and support needs, who may be experiencing and/or at risk of abuse/neglect when they are unable to protect themselves.

Part A: Our Statement of Purpose

The Board is to protect and promote individual human rights so that adults stay safe and are at all times protected from abuse, neglect, discrimination, or poor treatment.

For more information visit the About Us page on our website.

Care Act 2014

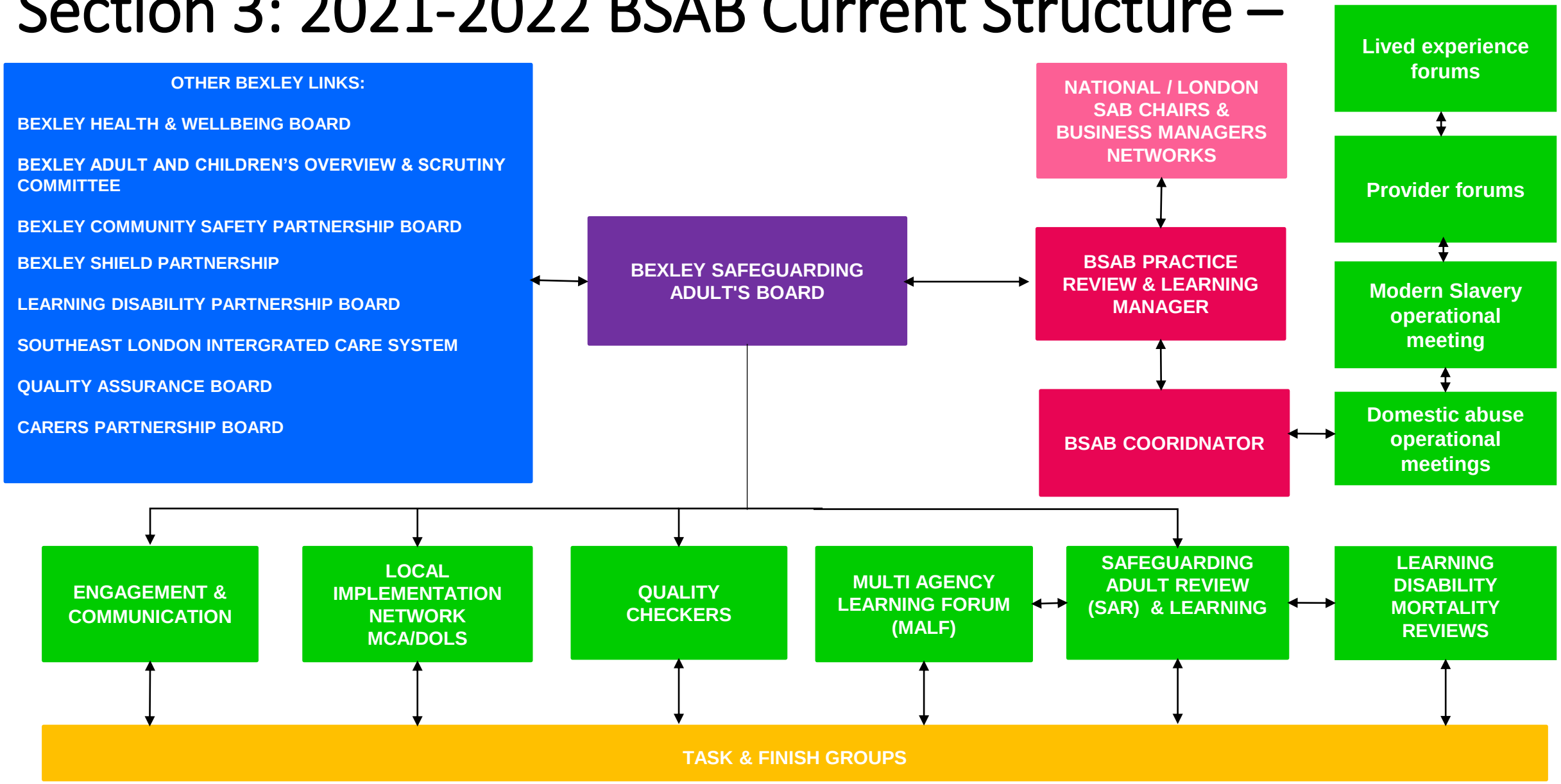
CHAPTER 23

Part B: We will:

- Not tolerate abuse
- Reduce risk to adults in vulnerable situations, as well as reacting effectively when it happens
- Ensure local systems aim to protect people at risk are proportionate, balanced and responsive
- Work together to prevent harm and improve services
- Ensure there is communication with the public to develop awareness of the need to safeguard and protect adults in vulnerable situations from harm
- Provide information and support on how to access services to ensure the safety of adults in vulnerable situations
- Hold local agencies responsible and to give good reason for practice relating to Adult Safeguarding, Deprivation of Liberty Safeguards and Mental Capacity.

Bexley Safeguarding Adults Board

Section 3: 2021-2022 BSAB Current Structure –



Section 4: Key Safeguarding Activity/Data

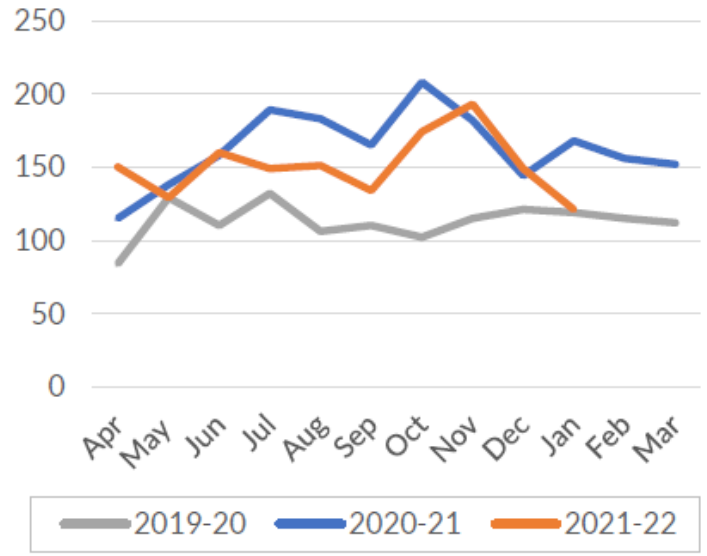
This section will show you how complex capturing safeguarding adult activity really is. There are several data sets captured across different agencies nationally, regionally and locally.

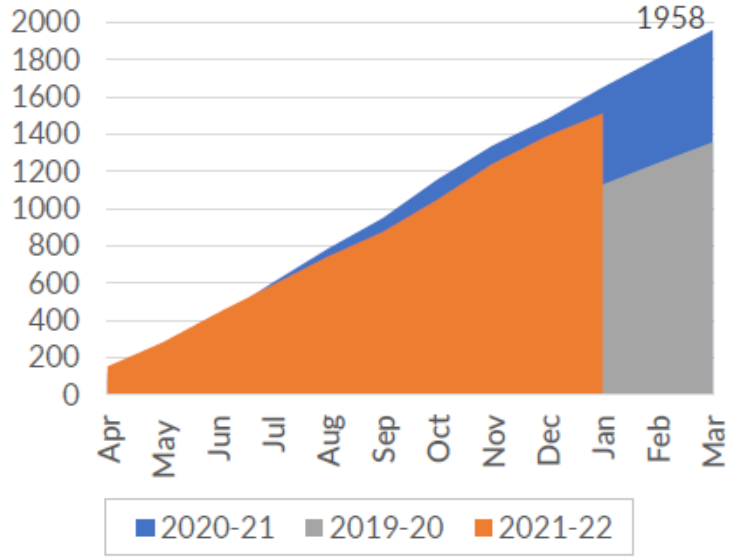
Part A: Pages 7 – 14 shows the NHS Digital Safeguarding Adult Collection (SAC). It is important to note that the full data set is published on the. NHS Digital website Data (digital.nhs.uk) We've focused in our report on Safeguarding Adult (SA) Data.

Part A: Concerns received

The graphs show the last 3 years SAC data with respect to the total number of SA Concerns received. The last 2 years show similar trend lines indicating there are peak times of year where SA concerns are more expected; for examples: a) winter season, greater hospitalisation and greater involvement of other agencies which may notice concerns; and b) summer season, which we know from national findings that more people are drinking alcohol, which leads to greater incidents particularly across domestic and physical abuse categories, but not limited to these types of abuse.

We also know that nationally this time of year has reduction in staffing across various sectors due to summer holidays, child-minding issues and personally booked holidays. As a BSAB, we've provided safeguarding adult events during these peak times – so the greater focus and awareness to professionals can also impact on increases of concerns being raised.





Understanding Section 42

The terminology used for when a SA Concern meets this criteria is called a ‘conversion’ and the process is called ‘an enquiry.’

We can see on page 10 that Year 2020-21 has the highest number of conversions and 2019-20 & 2021-22 are more in line with previous years.

Section 42

Enquiry by local authority

This section has no associated Explanatory Notes

(1) This section applies where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there)—

(a)has needs for care and support (whether or not the authority is meeting any of those needs),

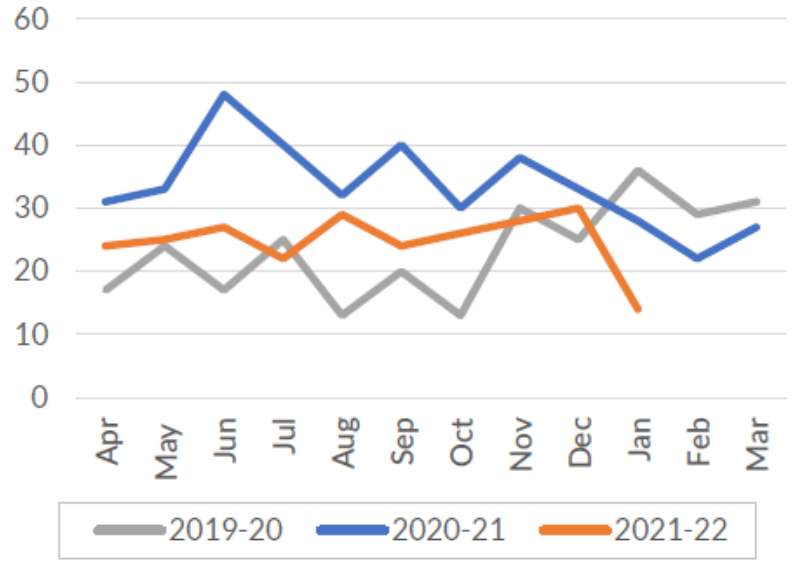
(b)is experiencing, or is at risk of, abuse or neglect, and

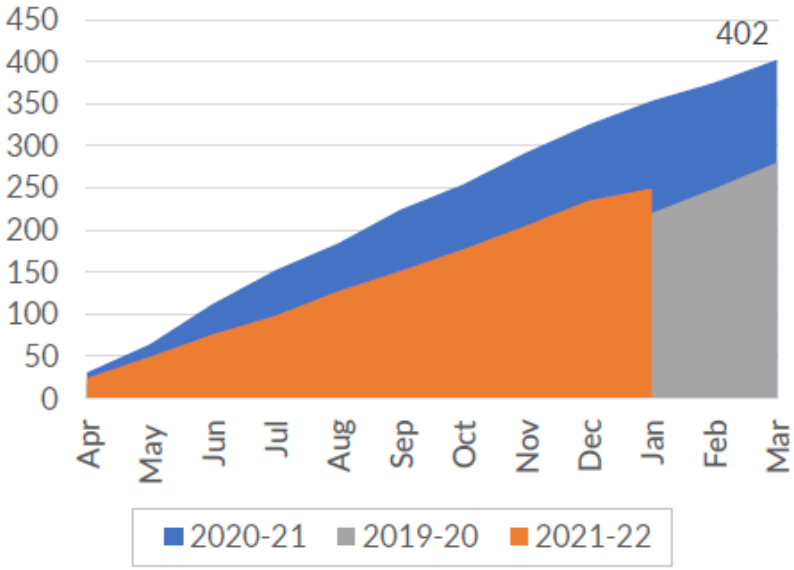
(c)as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

(2) The local authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult’s case (whether under this Part or otherwise) and, if so, what and by whom.

Section 42 enquiries commenced

The 2 graphs on the right show what happens when a Safeguarding Adult Concern as identified on page 8 meets the s.42 criteria as defined on page 9

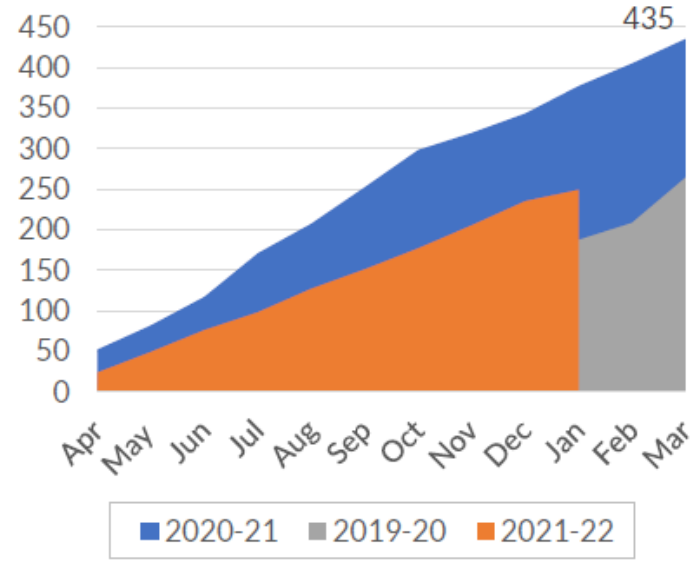


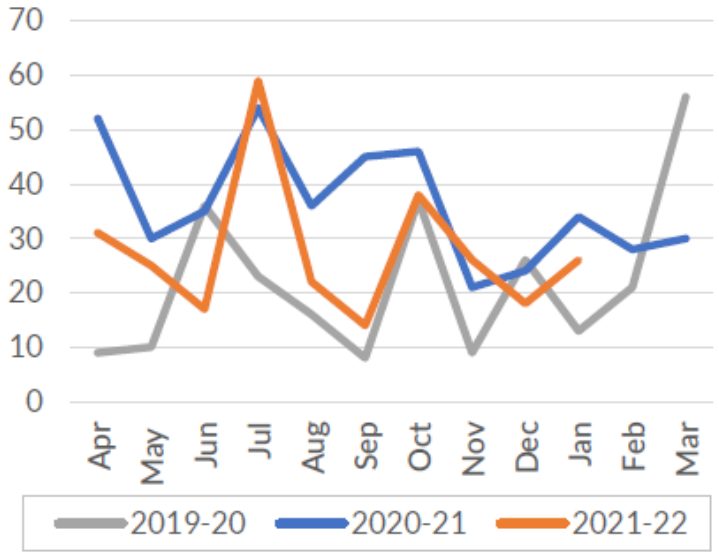


Section 42 enquiries concluded

Section 42 enquiries concluded – the 2 graphs below indicate how many s.42 enquiries concluded year on year.

Bexley SAC data shows on page 8 that in 2021-22, we had a sharp decrease in concluded enquiries. This would match the increase of complex cases across both health and social care.





Concluded Outcomes

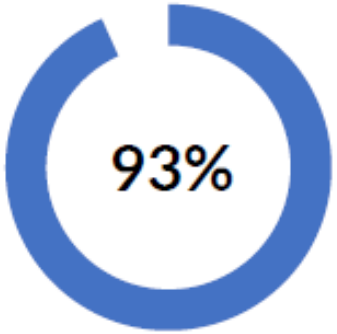
The Desired Outcomes data notes the Risks to the individual at the onset of the s.42 Enquiry Process.

You can see that 93% risks were reduced or removed completely (where identified).

The Risk Outcomes data notes the Risk Outcomes, the outcomes at the end of the s.42 Enquiry Process.

The Desired Outcomes data is on target for Bexley compared to London and Bexley's Comparator Group.

The Risk Outcomes data shows that Bexley is below target against London and Bexley's Comparator Group.

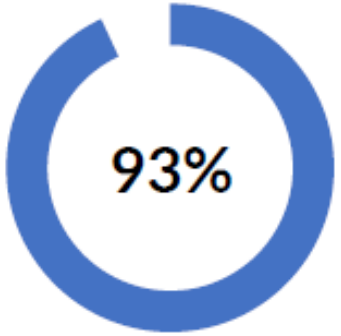


desired outcomes were fully or partially achieved
(where asked and expressed)

Desired Outcomes

London 20-21	93%	On par
Comparator group 20-21	92%	Above
Bexley 19-20 (Target)	93%	On target

In 69 cases, desired outcomes were not asked/known/recorded.



risks were reduced or removed
(where identified)

Risk Outcomes

London 20-21	91%	Above
Comparator group 20-21	90%	Above
Bexley 19-20 (Target)	97%	Below target

In 97 cases, the risk assessment was inconclusive, identified no risk or ceased at individual's request.

Data shows an Increase in section 42 enquires- referrals and location of abuse:

Abuse Location	2019-20	2020-21	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Own Home	127	296	19	19	11	33	14	8	24	16	11	10	10	14	189
In the community (excluding community services)	6	9	0	0	1	2	2	0	0	3	0	0	0	0	8
In a community service	6	4	0	0	1	3	2	1	0	0	1	1	0	1	10
Care home - nursing	37	37	1	1	2	4	2	4	3	1	1	1	0	5	25
Care home - residential	75	73	6	4	3	15	1	3	8	4	7	7	5	9	72
Hospital - acute	5	3	0	0	0	0	1	0	1	0	0	1	0	1	4
Hospital - mental health	1	3	0	1	1	0	0	0	0	0	0	0	2	0	4
Hospital - community	8	8	0	0	0	1	0	0	0	2	0	3	0	0	6
Other	1	11	3	2	2	1	2	1	2	4	2	4	1	1	25

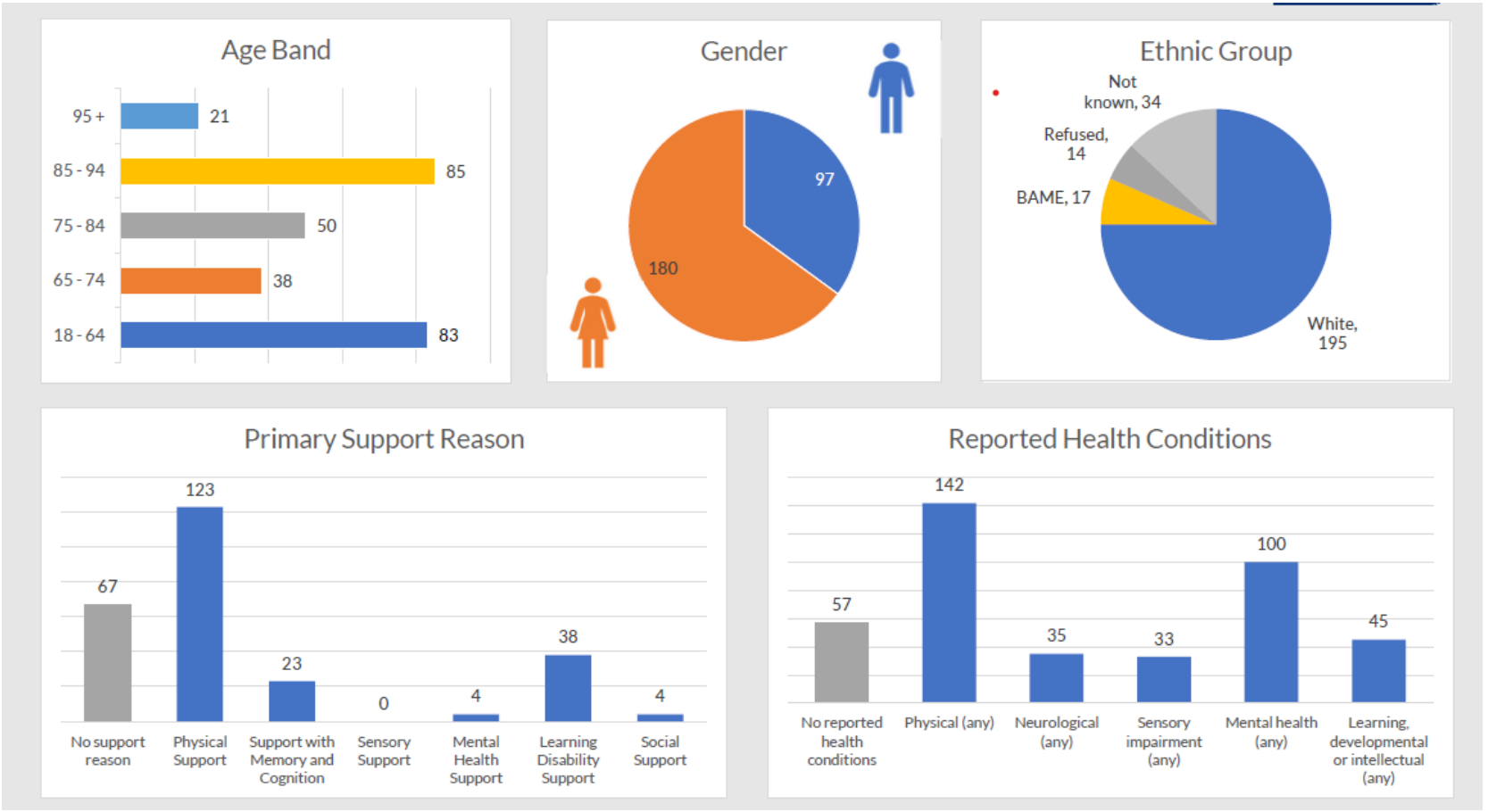
**Please note there may be more than 1 abuse location per enquiry. Full cleansing completed at year end.*

As you can see in the YTD (year to date column) abuse in the Individuals Own Home has decreased from 2020-2021.

However increases are in the following areas, Community Service, Acute Hospital, Mental health Hospital and Other.

Demographics

The Demographics Data notes that the highest number of cases for s.42 enquiries have been White Women over the age of 85 with their Primary Support Reason as Physical. However, the 18-64 Age Band was close behind with 83 cases of the same demography except also Mental Health being a Reported Health Condition. The BSAB should consider doing some work with this cohort in the next year's strategic plan.

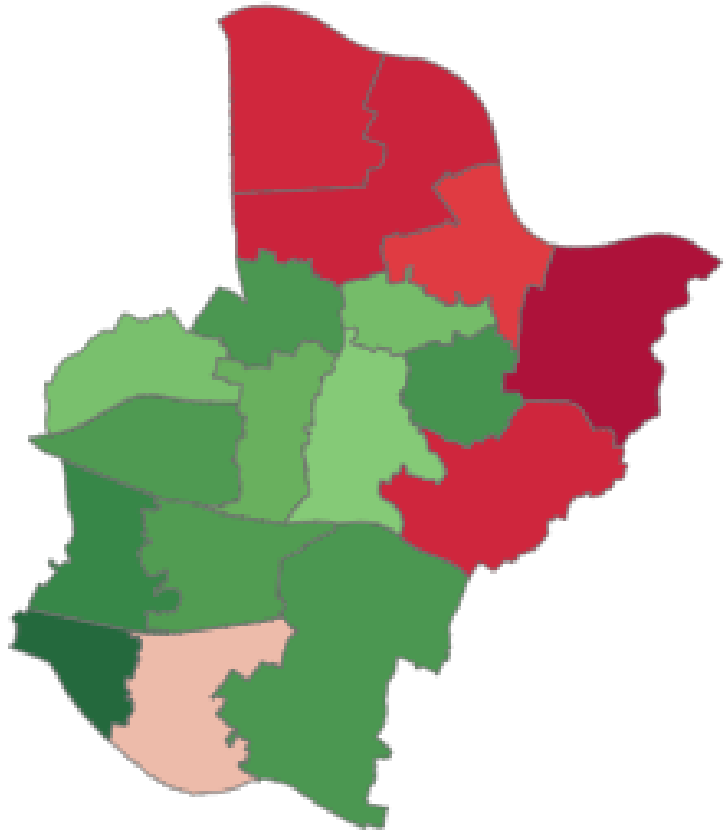


Part B: Police Reported Domestic Abuse Incidents - Bexley

MOPAC reported a total of 4110 Domestic Abuse incidents for March 2021 – February 2022. This is a 1.6% increase compared to the previous year, March 2020 – February 2021, when there were 4045 DA incidents reported.

BSAB analysis indicates that since March 2020, there's been several new learning & development sessions across both BSAB and Domestic Abuse partners in Bexley; including, hosting the National 16 days of Action Against Domestic Violence for the last 2 years. Bexley has also focused more on Domestic Abuse as a key theme following Safeguarding Adult Reviews (SARs), Domestic Homicide Reviews (DHRs) and Local Child Safeguarding Practice Reviews (LCSPRs) have identified this as an issue both locally and nationally. The Multi-Agency Learning Forum (MALF) that was set up in March 2019 brings together all the common themes. For more information on MALF, please click here.

Ward	Number of DA Incidents	%
Slade Green & Northend	403	9.9%
Belvedere	378	9.3%
Crayford	375	9.2%
Thamesmead East	374	9.2%
Erith	357	8.8%
Sidcup	264	6.5%
Bexleyheath	225	5.5%
East Wickham	212	5.2%
Northumberland Heath	208	5.1%
Crook Log	194	4.8%
Blendon & Penhill	169	4.2%
Falconwood & Welling	167	4.1%
St. Mary's & St. James	163	4.0%
West Heath	163	4.0%
Barnehurst	158	3.9%
Blackfen & Lamorbey	144	3.5%
Longlands	108	2.7%



Domestic Abuse Incidents broken down by Ward volume - March 2021 – February 2022 in the chart and map below indicate the areas where incidents have occurred over the last year. The BSAB will work with partners to seek further information regarding the Wards with most incidents to see what joint actions (if any) should be taken.

Metropolitan Police Service (MPS) Modern Slavery Data

Since December 2021 we have been receiving anonymised offence, victim, outcome, and National Referral Mechanism (NRM) based data from the MPS via the London Modern Slavery Leads (LMSL) Data Subgroup. This is provided to us within a tool from which the data has been extracted to further analyse from a Bexley perspective. The latest data supplied covers 24 months for April 2022.

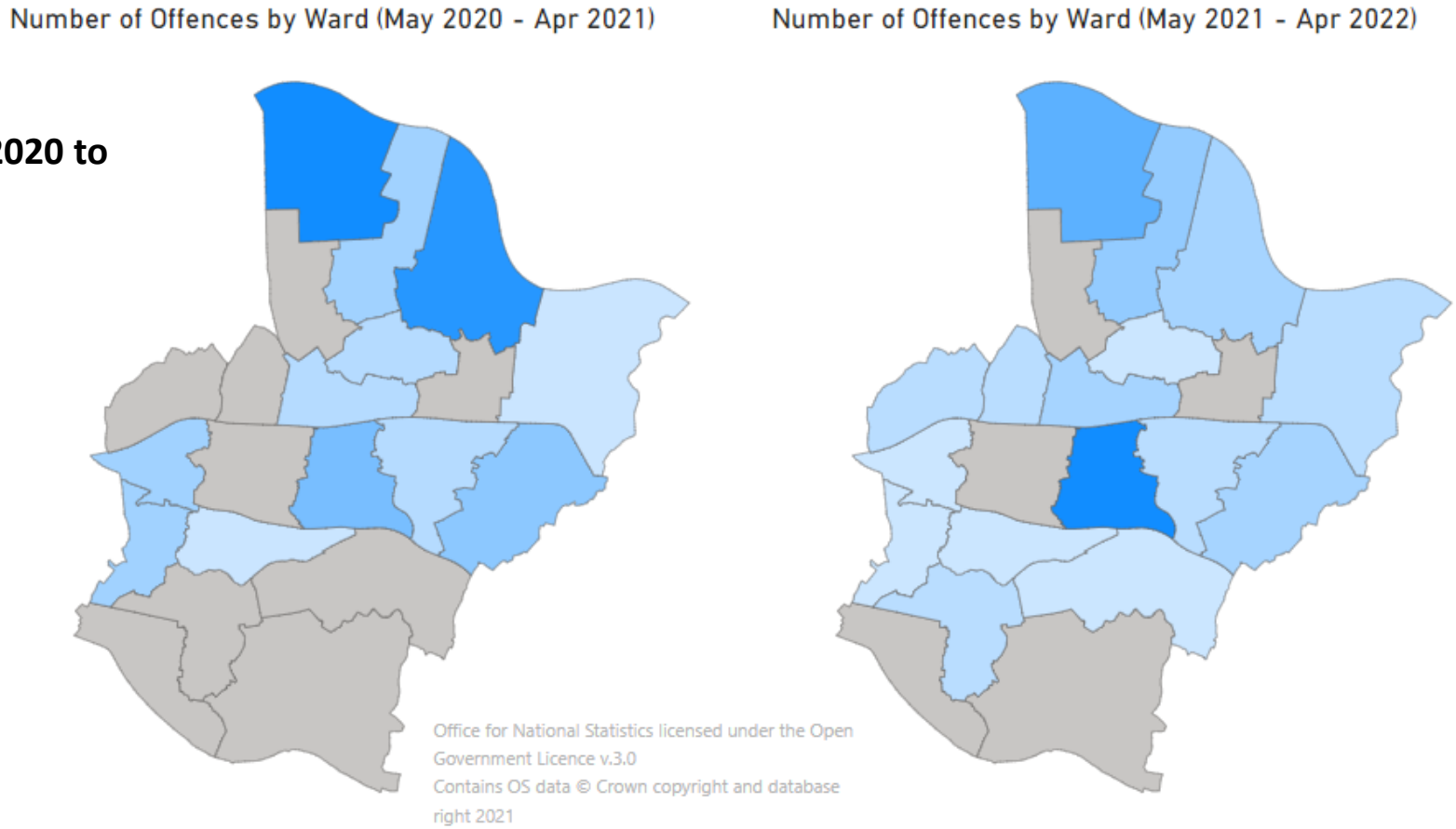


Figure 1: Number of Offences by Ward (May 2020 to April 2021 and May 2021 to April 2022)

May 2021 to April 2022 in Figure 1 shows a greater spread of offence locations throughout the borough compared to the May 2020 to April 2021 where they were more concentrated northwards.

This is despite there being only a single offence more rising from 45 to 46 offences during the respective periods.

Figure 2: Number of Offences by Month

Figure 2 shows the number of offences has remained within the 4 to 6 range since October 2021. This is still mostly in the ‘required to perform forced or compulsory labour’ class which has seen 39 offences in both the May 2020 to April 2021 and May 2021 to April 2022 periods. There is a rise in ‘hold person in slavery or servitude’ from 3 in May 2020 to April 2021 to 7 in May 2021 to April 2022 but no offences under ‘arrange travel with a view to exploit’ where there were 3 offences in the previous period

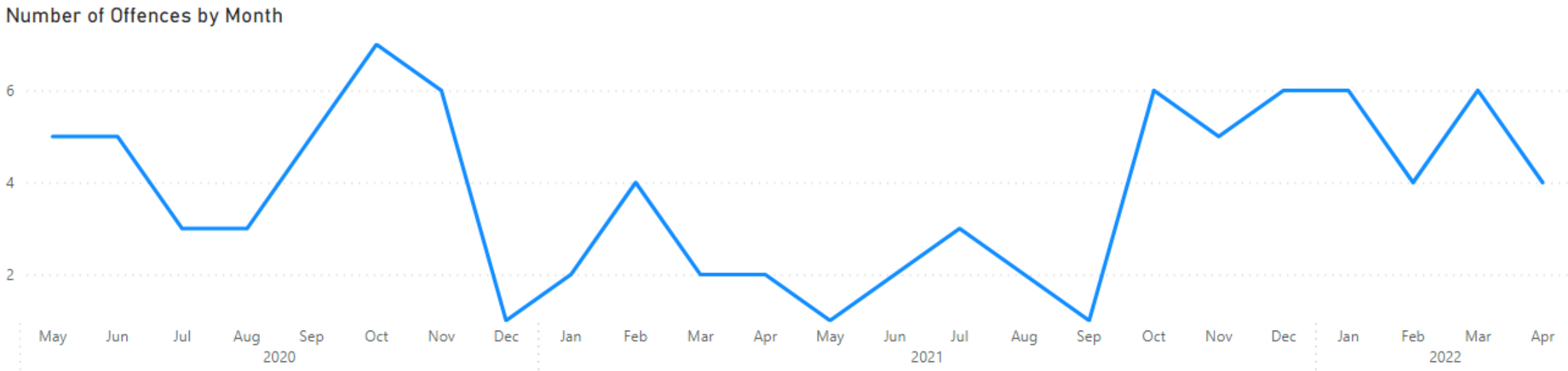


Figure 3: Number of Outcomes by Month and Three Month Rolling Average Days Until Outcome (Excluding Outcome Pending.

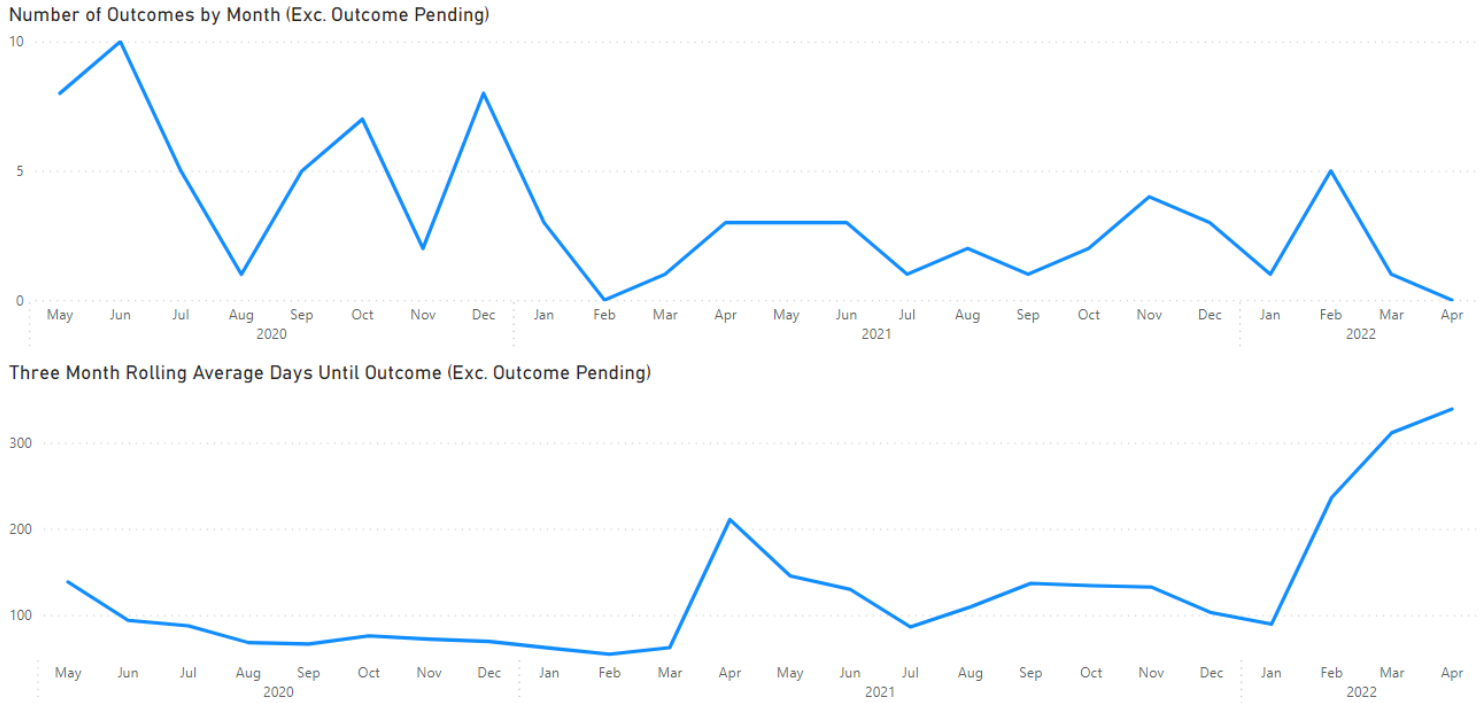
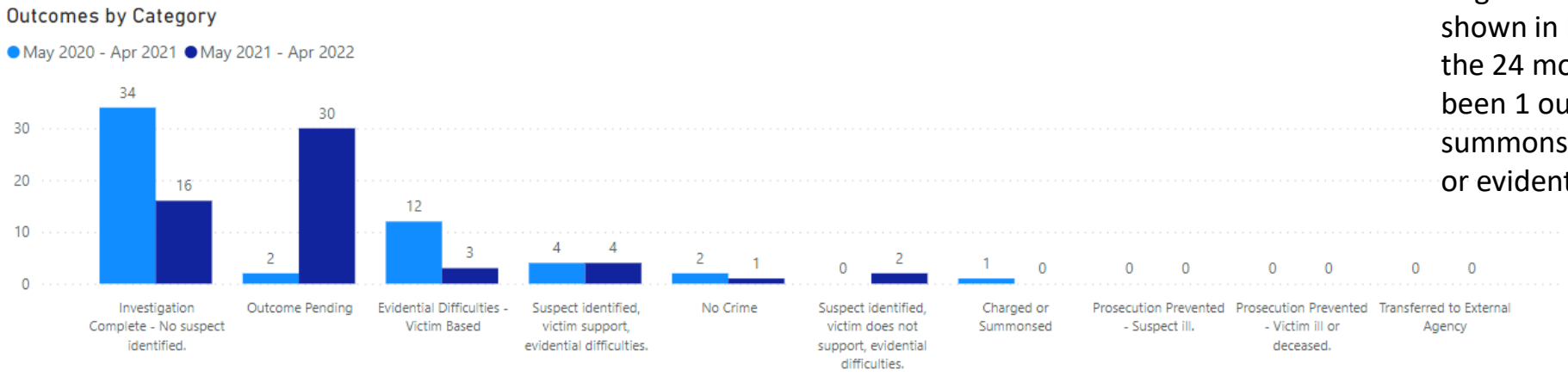


Figure 4: Outcomes by Category

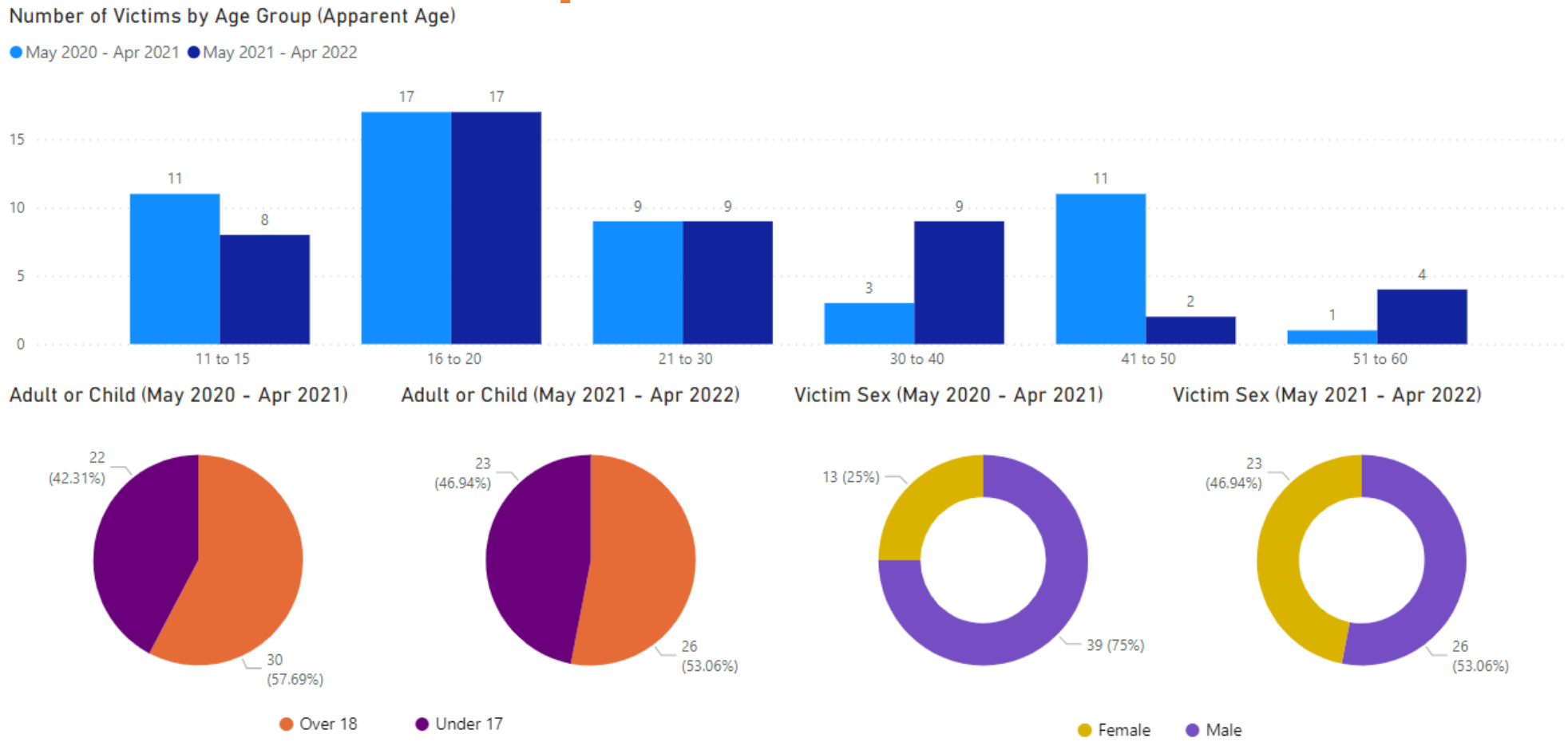


The number of outcomes, days until an outcome, and their correlation provides an interesting insight into the challenges faced. The number of outcomes has been at a low since February 2021 as shown in Figure 3. As a result, the number of days until an outcome has risen.

There was a high of 5 outcomes achieved in February 2022 followed by a fall to 1 outcome in March 2022 and 0 outcomes in April 2022. The average days until an outcome has sharply risen to 339 from 89 in January 2022. It should be noted that the more recent months have a larger number of 'outcome pending' cases, as shown in Figure 4, which are not included. In the 24 months up to April 2022 there has only been 1 outcome resulting in a charge or summons with all others facing identification or evidential issues.

Figure 5: Victim Profile

Figure 5 shows a profile of the victims for the May 2020 to April 2021 and May 2021 to April 2021. Over the two periods the split between age groups has varied with the 16 to 20 seeing the highest number of victims in both periods. The split between adults and children has remained consistent and slightly biased towards adults with 22 children and 30 adult victims during May 2020 to April 2021 and 23 children and 26 adult victims during May 2021 to April 2022. Sex of victims has seen the biggest change over the two periods from 25% female and 75% male in May 2020 to April 2021 changing to a close to even split in May 2021 to April 2022.



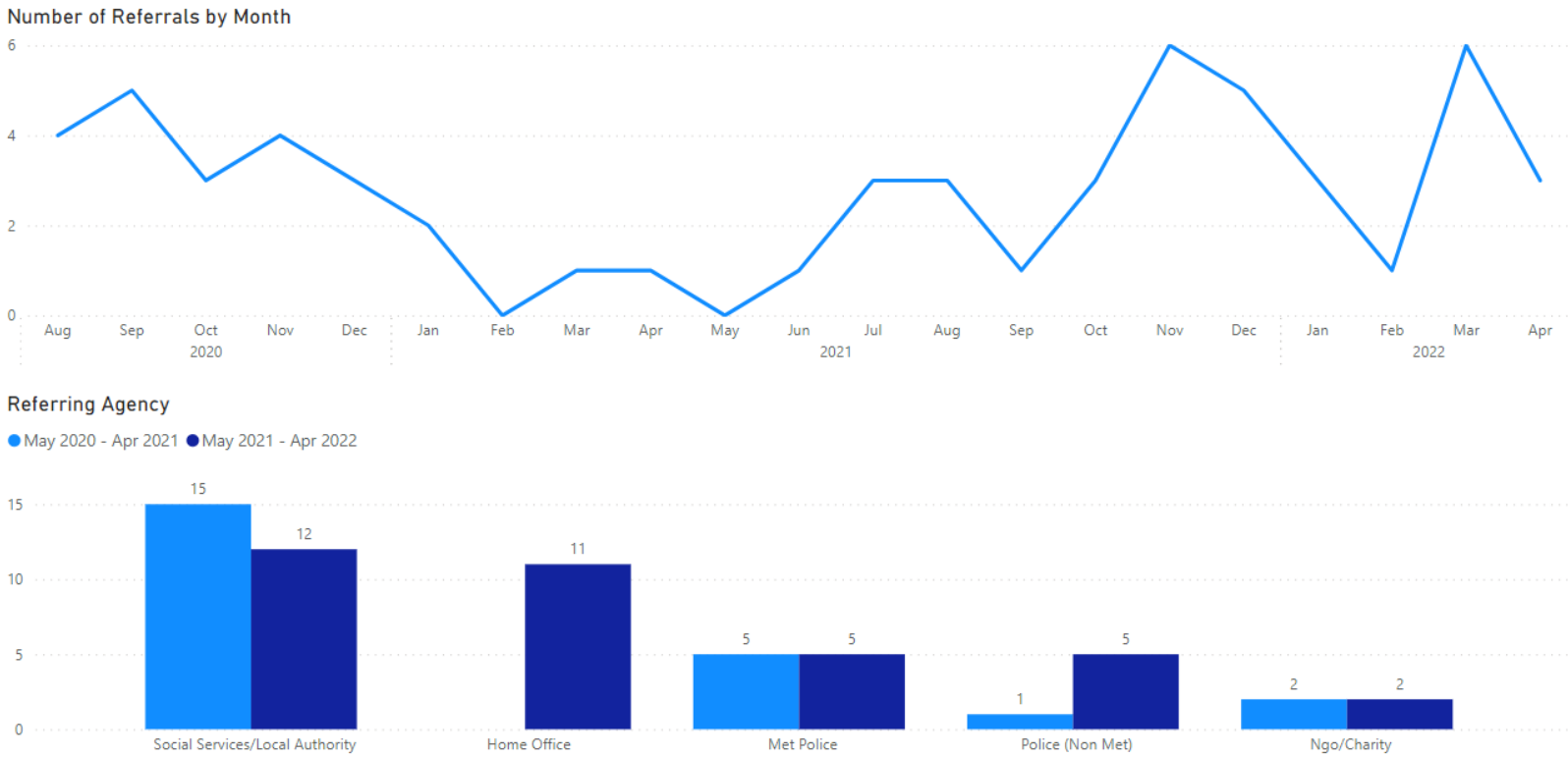
NRM referrals included in the data rose from 1 in February 2022 to 6 in March and back down to 3 in April as shown in Figure 6. Most of the referrals over the 24 months were from the local authority but May 2021 to April 2022 did see 11 referrals from the Home Office were there was none in May 2020 to April 2021 along with a rise in non-MPS referrals from the Police.

The nationality given for these referrals is either British or a mix of many other nationalities. However, of those recorded from May 2021 to April 2022 there were 8 referrals for victims of Albanian nationality.

There are challenges with obtaining data on ethnicity, nationality, relationship to perpetrator, etc, which results in many unknowns. So, whilst there is other data available in the dataset provided is often difficult to draw any conclusions from it.

All data presented here is sourced from the Metropolitan Police Service - Modern Slavery External Business Intelligence Tool.

Figure 6: NRM – Number of Referrals by Month and Referring Agency



Part C: Adult Social Care Survey (ASCS) 2020-21

This section showcases Care Act information gathered from direct feedback from service users in Bexley with 'lived experience.' When we use this phrase, we mean, someone whether directly or indirectly has care & support needs living in Bexley. This data set is published by the London Borough of Bexley and was presented to BSAB December 2022 meeting for information, discussion and suggested action.

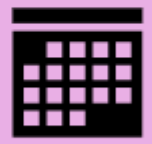
The BSAB queried the information shown in 'Activities & abilities' particularly around 35% do no leave their home and 60% can't do their own finances and paperwork as well as the comments below for 'Common reasons for feeling unsafe' have been identified by Adult Social Care (ASC) as service priorities for 2022-23 as shown on the next steps page.

LONDON BOROUGH OF BEXLEY

Trusted by Bexley residents

What is the ASCS?

Postal survey



January 2021

1129 clients
(Bexley or Oxleas)

31.6% response rate
(357/1129)

Helps ASC sector to:

1. understand how services are affecting lives

2. inform service development

3. produce 8 of the Adult Social Care Outcomes Framework (ASCOF) measures

ASCOF Outcomes

ASCOF Measure	Measure Description Outcome	Bexley 2019/20	Bexley 2020/21	% change	18 LA average 2020/21
1A	Social care-related quality of life (maximum score 24)	19.1	19.2	+0.5	19.0
1B	The proportion of people who use services who have control over their daily lives	73.6	78.0	+6.0	79.8
1I(1)	The proportion of people who use services who reported that they had as much social contact as they would like	47.4	39.1	-17.5	34.4
1J	Adjusted Social care-related quality of life – impact of Adult Social Care services	0.409	0.431	+5.4	0.410
3A	Overall satisfaction of people who use services with their care and support	60.2	67.2	+11.6	67.7
3D(1)	The proportion of people who use services who find it easy to find information about support	72.9	74.9	+2.7	70.7
4A	The proportion of people who use services who feel safe	72.6	74.4	+2.5	73.6
4B	The proportion of people who use services who say that those services have made them feel safe and secure	84.6	78.6	-7.1	88.0

Survey responses

Services

91% are quite/ very/ extremely happy with the services they receive

91% said care and support services help them have a better quality of life

62% said having help makes them think and feel better about themselves

Health

18% have bad/very bad health

58% have moderate/ extreme pain or discomfort

53% are moderately/ extremely anxious or depressed

Activities & abilities

65% spend time/ enough time doing things they enjoy

35% do not leave their home

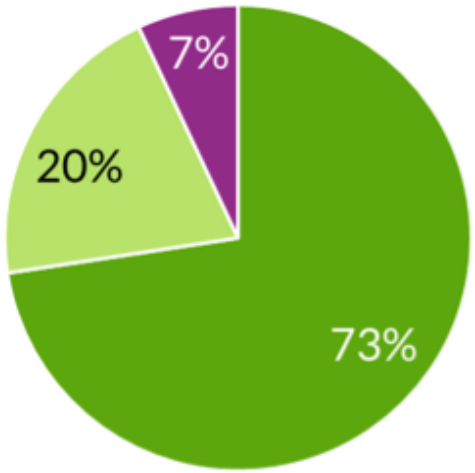
60% can't do their own finances and paperwork

Extra support

82% get help from someone

66% do not buy any additional care privately or pay more to top up their care

Safety questions



respondents said care and support services help them to feel safe

Common reasons for feeling safe:	Common reasons for feeling unsafe:
Being at home with family (although they felt afraid when left alone)	fear of falling
Receiving help from staff	Poor physical health making the client feel vulnerable
Being visited by friends and family	fear of going outside safely / fear of strangers, neighbours and other residents
	issues with carers

Next Steps

Apply learning from 2020-21 ASCS Results

- Falls are still the most concern with regards to safety.
- Continue to ensure it is easy for clients to find information about services, including Direct Payments and Personal Assistants.
- The COVID-19 pandemic and subsequent lockdown periods has impacted on clients' feelings around social contact. Consider ways to enable clients to have as much social contact as they would like.

Prepare for 2021-22 ASCS

- **Jan-Mar 2022**
  Survey fieldwork
- **Apr 2022**
  Data submission
- **Oct 2022**
  Results published
- **Post-Oct 2022**
  Results shared with respondents & ASC staff

Section 5: Safeguarding Adult Reviews

Part A: What is a safeguarding adult review (SAR)?

In 2014 the Care Act introduced Safeguarding Adults Reviews (SAR's), which became law from 1st April 2015. They are a way in which we can improve our services and multi-agency learning.

- They look at events which have resulted in a death or serious injury, with the aim of preventing what happened to one person (or a group of people) from happening to others.
- The aim is to identify where responses to the situation could be improved or learned from. They are not to seek or lay blame but to review what happened and what could have been done differently.
- The SAR peer-to-peer process chaired by an independent reviewer scrutinizes the evidence provided based on what happened, offers support to how things could or should be done differently; then produces recommended actions to improve services.
- SARs are a statutory requirement and engagement is mandatory, the lack of information submitted and/or poor attendance, can lead to poor learning outcomes, including financial implications.
- Additionally, lack of full engagement may lead to recommendations seemingly to appear 'unfair' however if engagement with the SAR been done in full, understanding why decisions were made and actions taken to evidence learning will mitigate against this from happening.
- In the event a SAB partner challenges a SAR completed, the BSAB may ask for further evidence and addendums to be made before signing off and publishing for learning.

Part B: SAR'S carried out and published:

This year the BSAB have commissioned 7 SARs, published 5 and held over 40 learning events to discuss the findings and lessons from SARs completed by the BSAB since 2017. We have 2 completed SARs awaiting publication

1) being scrutinized and finalized now
2) cannot be published as a live police investigation, however, we have published some learning.

As a BSAB, we also have learned about the SAR process this year and will be reviewing our current SAR Toolkit and arrangements for the future.

The Top 10 Themes for Bexley's SARs can be found on the page below.

The final report and executive summaries for all 14 published SARs can be found on the Board's website.

Part C:
Bexley Themes found from local published SARs -

This section covers the Top 10 Themes found in Bexley since 2017. As a SAB, we've created a Thematic Action Plan for the board but also it's partners. This is an innovation way to evidence the Care Act 2014 statutory duties of embedding learning locally and having assurances as a SAB. We've shared the Thematic Action Plan with the National SAB Managers Network, London Chairs Network and plan to write an article for JAP to share our best practice and learning from SARs in Bexley.

So what happens with the themes once identified? How do partners show their evidence of embedding? The BSAB offers a Learning & Development Programme based solely on the SAR Themes identified, then, offers these workshops to partners for free. We will then work with partners to gather their evidences - for example, we held an audit with challenge events last year. Please see page 47 for more information on the challenge events and the outcomes.

1. Mental Capacity in relation to Executive Capacity/Crisis/Duress
2. Person-Centred Planning / Strengths-based
3. SAB Governance / BSAB role in Improving Practice - Training & Awareness Raising / SAR Process
4. Information Sharing / Inter-Intra Agency sharing / Information Recording Systems / Record Sharing / Information Flow / Record-keeping
5. LA Oversight/Governance
6. Safeguarding Literacy and Knowledge
7. Risk Assessment/ Crisis Planning
8. Professional Curiosity, Professional Roles & Responsibility / Carer's Assessment
9. Safeguarding Processes
10. Basic Mental Capacity Awareness

Part D:
2021-2022 Published SARs

In this section will cover the **5 fully published SARs** completed:

- Jenny
- Elvis
- PUP Community Social Care Providers Bexley Pressure Ulcer (PUP) and Safeguarding Process
- Grant
- Rose (not in full)

In the last year and provide some learning for one that is yet to be published due to a live police investigation. Each SAR will indicate a summary as to what happened, the link to the published report and an update from statutory partners on what they've done since the review. The bolded words are the themes identified.

SAR Jenny -

Click here to read the full SAR-Jenny published report.

What happened in the case of Jenny? The subject of this review is a white British woman in her early sixties who was assessed as having a mild learning disability and a number of health conditions including epilepsy and dementia and will be known as, Jenny. Jenny died a few days after being admitted to a care home after a 17 week stay in hospital. Prior to her death she was known to learning disability and health services. The Independent Reviewer, Eleanor Brazil, as made the following recommendations and summary –

'In a situation where one or more professionals raises concerns about deteriorating health and increasing care needs, these should be proactively followed up as soon as possible. In this situation a **multi-disciplinary** review should be called. Any professional can and should ask the CLDT for such a review if they are concerned. If as in this case, there is an allocated key worker from the CLDT they should ensure a review is held if they are aware of concerns raised by other health or care professionals.

As part of a review of support needs, every effort should be made **to see an individual at home** to ascertain how well they are coping. In situations such as these a partner should be offered a **Carer's Assessment** by adult social care or the CLDT. If **safeguarding concerns** are raised during hospital admission, enquiries should be progressed and not deferred until the discharge planning process. Whilst the process relating to discharge of patients with complex needs and meeting the criteria for Continuing Health Care has changed since 2018, it is important to ensure that **Mental Capacity Act assessments and Best Interest Decisions** are completed within the hospital prior to discharge when there is doubt regarding an individual's decision-making capacity.

All agencies should ensure greater awareness amongst front line staff and managers on when to undertake a MCA assessment, to determine an Individual's capacity to agree to their **care and support plan**, and the follow-on Best Interest meeting if required. LeDeR reviews should be progressed in a timely way and wherever possible be completed within 6 months to ensure any learning is acted on. If at any point the LeDeR reviewer considers there were safeguarding issues, then **a referral should be made to the BSAB SAR subgroup**. Where there **are difficulties in accessing information requests** should be **escalated to the SAB**. The Bexley Safeguarding Adult Board has established a pressure ulcer task and finish group to consider lessons from a previous SAR. The task group should review the issues raised by this SAR and any additional learning, '

SAR Elvis -

Click here to read the full SAR-Elvis published report.

What happened in the case of Elvis? The subject of this review is a white British Male who was in his fifties at the time of his death in May 2020, known as Elvis because he loved to listen to Elvis Presley. Below are excerpts from the full report completed by local partner, Philippa Uren, SEL CCG, Bexley Safeguarding Adult Lead.

'Elvis died in hospital following an emergency admission. Elvis was a man in his 50s who had a mild learning disability and difficulty with **reading and writing**. He lived with a long-standing female friend who also had a learning difficulty. They lived independently in the community with intermittent support from GP, day centre and key ring. Their circumstances deteriorated from time to time and particularly after March 2020 and the start of Covid restrictions.

A **multi-agency assessment** might have benefitted them by co-ordinating the support needed and improved their overall quality of life. The following concerns were raised via the LeDeR review and were to be used as the terms of reference for this review:

1. The lack of investigation of gastric and liver symptoms and failure to follow NICE guidance and failure to investigate and adequately follow up his increasing anaemia.

2. The lack of capture of his LD and **literacy skills** in his GP medical records and no evidence that reasonable adjustments were made to ensure that all his specific needs were understood and met to ensure safe and appropriate management of his health.

3. The lack of clarity around social care engagement and the apparent lack of an appropriate response to concerns raised by his next of kin in January 2020 about his and his long standing-friend's vulnerability and their obvious difficulties in keeping themselves safe in their home environment.

4. Elvis making himself vulnerable to financial abuse as he was struggling to manage his finances and pay his bills. It was clear to the attending LAS crew on 5 May 2020 that they were in extreme difficulties.

5. It is unclear what arrangements were in place at the time of Covid 19 lockdown to monitor them, at a time when they would have been even more vulnerable due to increased isolation, as they were not able to go out into the community where they were well known. His [Elvis's] sister believes that her brother was going out in lockdown and therefore potentially putting him, as well as others, at risk.

Each agency involved in this SAR has submitted an IMR and the recommendations identified from each service as listed below –

Oxleas: 1) CLDT nurses will be allocated to specific GP surgeries to support LD care in this service; and 2) Promotion of the Personal Health Profiles (PHPs/Black books)

GP: The surgery has completed a significant learning event. 1) Early and prompt involvement of **patients' relatives or advocate**, especially in patient with disabilities to ensure adequate medical interventions are affected; 2) The practice is now contacting all LD patients in a more appropriate manner, usually with telephone calls, to patient and carer, but also using the **template letter** specially designed for the purpose; 3) When patients are contacted or attend surgery, note on record if they have a carer or advocate; and 4) Audit LD and similar patients who are living alone to understand level of social input - Continued on next page

QEW and LBB Housing: Nil identified

ASC: 1) **Managers / Seniors** to discuss robust recording in team meetings; 2) Opportunities for learning around unexpected deaths and the **Board's role**; 3) Ensuring staff are aware of the importance of follow up **calls, robust recording, and triangulation of information to inform decision making**; and 4) Seniors to discuss in team meetings for **reflective learning**.

The SAR panel met and discussed any further recommendations, and these are identified below:

1. **Professional curiosity** training for professionals to support understanding of complex relationships.

2. BSAB to identify and publish tools for healthy relationships in easy read formats

3. Improved reasonable adjustments for individuals with an LD diagnosis to include (but not exhaustive):

- Acute provider and GP to share information regarding lists of individuals known to have an LD diagnosis and these to be flagged on the electronic system of the acute hospital.
- Black book relaunch to support reasonable adjusted care for people with a learning disability
- Recruitment of LD liaison nurse to QEW
- Checking of understanding when with health professionals
- Involvement of family/long standing friend /carers for best interest decisions.
- Increased awareness of literacy problems and how this impacts on the individual
- Use of easy read leaflets

4. Single point of contact for CLDT for professionals to use Self-neglect Relaunch of the self-neglect toolkit.

5. Training for professionals on self-neglect to include escalations of concerns when nothing changes Use of a **complex case pathway** within Bexley Review of both the **Mental Capacity** Toolkit and Self- neglect toolkit used within Bexley to include a section on the importance of staff assessing executive capacity.

6. For professionals within Bexley to raise any **safeguarding concerns directly with screeners** rather than individual members of staff/teams.

7. For professionals within Bexley to raise concerns directly with the London Fire Brigade when there are concerns re hoarding and overloading of electrical sockets.

8. **Domestic Abuse -** continued training for DA awareness – to include hard to reach groups. Champions from each service to be identified Development and launch of easy read LD leaflet Housing to utilise the skills of the specialist housing IDVA.

9. **Role of the carer** explored by health and social care services when there is a co-dependant relationship using the **Think Family** process.

What have statutory partners evidenced for SAR-Elvis?

- Support in the development of an easy read domestic abuse information sheet
- CLDT now attend the DA Health Sub Group
- GPs from each PCN attend the DA Health sub group

SAR PUP - Community Social Care Providers Bexley Pressure Ulcer (PUP) and Safeguarding Process

To read the full PUP process click here

This SAR is following another notification of a similar one to that of SAR-Jenny, which in it's recommendations refers to this SAR and Task & Finish Group work. It was identified that what was needed following a SAR Notification was that Bexley needed a Community process to identify when and how pressure ulcers are to be considered safeguarding concerns. The hospitals and district nursing teams have a process, but no other system had one until now. The BSAB has shared this across the SAB Network and its Providers with the expectation that this is now used as a method of identifying and reporting pressure ulcers and when to escalate concerns.

Purpose -:

The purpose of this protocol is to assist professionals in:

- Understanding how all multiple category 2, category 3 and category 4 pressure ulcers will be reviewed.
- To have a consistent approach to identify when the root cause of the pressure ulcer gives rise for a safeguarding enquiry.
- Enabling staff to determine whether factors giving rise to pressure ulcer formation may indicate a safeguarding concern.

It is important that this protocol dovetails with, and is embedded within, each care home and domiciliary care provider's own pressure ulcer prevention and management policies and guidance.

Pressure Ulcers and Neglect:

Pressure ulcers can sometimes occur because of neglect and /or omission of care whether this is deliberate or unintended.

Pressure ulcers could also be acquired by people in their own home, possibly due to self-neglect or the individual themselves refusing help and advice. However, consideration must always be given as to whether neglect by others has occurred. When present, pressure ulcers require monitoring and appropriate treatment to prevent unnecessary pain and suffering for the person concerned.

It is important to note that harm does not need to be deliberate. It is not the intent that needs to be considered but the harm (developing a pressure ulcer) that has resulted from the act or omission and which should trigger safeguarding adult procedures. Self-neglect can in certain circumstances also be a safeguarding issue and should be reported as such unless the person has the capacity to refuse consent for treatment and / or for the concern to be raised.

SAR Grant -

Click here to read the full SAR-Grant published report.

What happened in the case of SAR Grant?

Grant was a British Asian Male who was in his forties who sadly took his own life. At the time of his death in June 2020. Grant had been diagnosed with Depression, anxiety, Emotional unstable personality disorder, mental and behavioural disorder due to stimulant abuse, drug induced psychosis paranoid schizophrenia. He was prescribed medications which included Atorvastatin, Clozapine, Folic acid, Omeprazole and Propranolol. He was also believed to have been self-medicating obtaining medication from on-line internet suppliers at the time of his death. At the time of his death Grant had recently returned to his supported living placement following a period of time spent living at the family home address with his mother and father. In the years prior to his death, he was well known to mental health services , had been detained on several occasions under the Mental Health Act (1983) and had spent some time in One of Her Majesty's Prisons. SAR-Grant was independently reviewed by Pippa Smith, British Transport Police and has given the following recommendations and summary,

'Specific issues to be reviewed: 1) What additional learning can be found using the National Thematic SAR Report, October 2020. 2) SAR-Mrs BA and SAR-Sahara cases to be cross-referenced and linking where actions/learning cross; and 3) Grant moved to new living spaces in March 2020, lockdown, living with parents; impact and measures due to Covid.

Grant was a British Asian Male. Grant was in his forties, and unemployed at the time of his death and was in receipt of welfare benefits. Grant had previously been a PHD student up until 2016 when his mental health issues increased. His registered GP Surgery at the time of his death was Crayford Town Surgery. He had been well known to mental health services since 2003 and previously been diagnosed with Depression, anxiety, Emotional unstable personality disorder, mental and behavioural disorder due to stimulant abuse, drug induced psychosis paranoid schizophrenia.

Grant was born and bought up in and around Belvedere, Southeast London. Grant has four siblings, he has two older sisters, one who lives abroad as well as a younger brother who also lives abroad. He grew up in an extended family setting which consisted of his mother, father and siblings sharing the family home with his uncle and his family.

Both his parents survive him, his father is registered disabled, and his mother has suffered from cancer, having been undergoing treatment for this in the period prior to Grant's death. Both are elderly and were clearly actively involved and concerned in his welfare and support as were other family member *including his uncle and cousins.*

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Conclusion/Recommendations :

It is noted from a number of reports that many organisations involved in this review have already indicated their own internal learning which includes:

- **Refresher risk assessment** training and management skills for individuals presenting with risk behaviours to themselves and others,
- **Care planning and reviewing of Crisis and Contingency plans**,
- **Review of staffing in teams** where there are large amounts of team sickness
- **Record keeping** and completion of discharge papers and plans
- Reminders to partners for discharge summaries to be received in a timely manner and notification to the Safeguarding Board

1. In a situation where one or more professionals raises concerns about deteriorating mental health and increasing care needs of them or others, these should be proactively followed up as soon as possible. In this situation a **multi-disciplinary** team meeting should be held in a timely way with key partners. **Immediate safeguarding actions/powers** should be considered and recorded. Timelines and target action dates should be identified, and options/contingencies considered when these are not achieved identified when the actions are set.

2. **Record keeping and access to reports,** throughout this review one recurring concern kept appearing, as in many reviews, which was the accurate and timely record keeping. Whilst assured many conversations and considerations would have taken place and been recorded, access to these were limited. As part of each organisation's regular reviews and inspections, record keeping and access to records (in line with relevant disclosure/relevant organisational management of information rules) should form a key area of focus and be consistently reviewed.

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3. It is acknowledged that timeliness of decisions and actions in ensuring placements and release from health establishments happen as swiftly as possible in order to ensure future availability as well as inappropriate further detention are important however **accessing information, intelligence and records** that may influence this decision making should not be underestimated and considered any less important than the need to release someone from section or discharge them from a health care environment. The need to consider delaying decisions to enable full **understanding of risk** and ensure all relevant parties are available to partake in discussions should always be a priority to ensuring the onwards **safety of any person where legally** possible.

4. If safeguarding concerns are raised during hospital admission or whilst in hospital, enquiries should be progressed in a timely way and not deferred until the discharge planning process. Whilst the process relating to discharge of patients with complex needs and meeting the criteria for Continuing Health Care has changed since 2018, it is important to ensure that all relevant partners involved in the on-going care are present or a part of the discussions before final decisions are made. Once the final decision is agreed there should be time to ensure the agreements in place are suitable and enable contingencies or safety measures for both patient and staff to be considered and implemented. No discharge should occur without all relevant **safety planning** and documentation being completed and shared appropriately with organisations responsible for on-going care and whilst there are guideline on standard timeframes of reviews this should not influence any party to not be able to consider and suggest smaller or tighter timeframes rather than standard time frames.

5. All agencies should ensure greater awareness amongst front line staff and managers on understanding impact of **cultural, community and parent/child/adult-child relationships**. Identifying pathways and key partners experience in understanding, mitigating, and managing these difficult situations will help staff and members of the community understand limitations, identify appropriate support available and understand that no one person, family or organisation can operate or work alone. Personal responsibility or the perception of and individuals' responsibility especially in parent/adult child relationships can be very complex.

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6. The death of anyone in any way but especially through suspected suicide can have a devastating impact on all involved in their care, whether personally, face to face or through reviews and reports. It cannot be underestimated the short- or long-term effects it can have on anyone. All organisations should ensure they have in place appropriate well-being support, staff support and bereavement support for their staff. That staff are able to access this in a timely way and in a manner that suits them. This support should be available at any time within any timeframe. By being involved in health, social care, crisis support and response, staff members are ultimately more exposed than many other professions of the accumulation of such impactive incidents and this should also be acknowledged and recognised with well-being and occupational strategies and pathways.

7. When various organisations all work together there will be levels of expectation on each to respond, manage and implement policies, procedures and pathways. Having an understanding of what each organisation has available to them to keep someone in crisis or suffering declining mental ill health or **capacity** is critical to maintaining professional and supportive partnerships. It is also imperative when passing **information on** to others and informing safety plans that the right advice and pathways are identified. Joint multi agency training and exchanging of polices and protocols should be considered to enhance each organisations knowledge.

8. The ability for a patient who is currently under the care of a Mental Health Team and registered with a GP who is aware of their Mental Health diagnosis and support, to be able to arrange and facilitate a private consultation and obtain diagnosis and medication on-line without consultation with either the allocated NHS Consultant Psychiatrist or his GP being informed is concerning. This together with the incorrect information that was passed by the patient to the private professional and the lack of knowledge the private professional had of the previous history of obtaining medication, drugs and overuse of prescribed drugs by the patient prior to the consultation and his detention under the Mental Health Act should be escalated higher within professional bodies who can influence change.'

SAR Rose

What happened in the case of Rose?

This a case of a woman in her 80's that died unexpectedly at home last year. The BSAB cannot report more on this case due to a live police investigation being underway; however, the BSAB did produce a 7-Minute Briefing on Hospital Discharge Pathways that was found as learning in this case, but also in other cases Bexley has reviewed. SAR-Rose was reviewed by Independent Reviewer, Eleanor Brazil.

Click here to read the SAR-Rose 7-Minute Briefing for Bexley's Hospital Discharge Pathways

Part E: Statutory Partner SAR Evidences gathered

SE London CCG (Bexley) - have continued to support the safeguarding of the residents in Bexley during 2021-2022. We continue to be active members of the following:

- Domestic abuse MARAC: a new process has been implemented to engage GPs in sharing of information to this multi-agency meeting. All individuals being presented to MARAC have been contacted for information that can be shared with the panel members and all MARAC minutes are now shared with relevant GPs. To date we have supported and shared relevant information for over 450 individuals.
- Community risk MARAC: GPs are also informed of individuals being presented to CR MARAC and asked for relevant information to inform the panel to support safety planning.
- Channel: GPs are also informed of any Information Sharing Requests and encouraged to share relevant information to inform whether an individual is vulnerable to radicalisation
- DHR and SAR panels
- In 2021-2022 the CCG safeguarding team secured funding to support the domestic abuse response:
  - Commissioned 4 sessions of specialist DA training (Solace)
  - Provided funding for Solace to provide individuals with door bars and mobile phones
  - Purchased DA lanyards and distributed to GPs
  - We have been successful in our bid for further funding for 2022: 4 further sessions of specialist DA training for primary care; Door bars; Video door bells; Commissioned training and support to cover healthy relationships, consent and LGBTQ+ issues/awareness etc.; and Links to overall health and well-being/mental health agenda.
    - Support of homeless charities to provide white goods for a homeless person with all the necessary items they need to for day-to-day living and good quality of life when they secure a unit (e.g. being able to cook and eat meals, have somewhere to sleep) and ultimately support them to retain housing and not be street-homeless.
      - Commissioned a research and training project for Identifying & Addressing Cognitive Impairment in Dependent Drinkers

Public Health Team have supplied SAR actions taken linked to Suicide Prevention.

The death of someone by suicide has a devastating and long-lasting effects on families, friends, workplaces, schools and communities. If we want to improve the life chances and secure the mental wellbeing of future and current generations, we need to understand the reasons for poor mental health and wellbeing and do more to prevent suicide. Every suicide is an individual tragedy and can happen at any age, but suicide is not inevitable, and central to our work in Bexley is to build stronger partnerships and work together to reduce suicides.

Whilst Bexley suicide rates are generally not dissimilar to other London Boroughs or the England average, we are seeing an increase in Safeguarding Adults Reviews (SARs) locally where suicide is a feature. Taking this into account, in addition to the impact of the Covid-19 pandemic on mental health and wellbeing, it is increasingly important to ensure that our residents, and staff across the local health and care system, feel supported.

Over the last year, and despite the demands of the pandemic, we have continued suicide prevention work as part of the South East London (SEL) Integrated Care System Suicide Prevention Steering Group. This group was successful in securing funding for a new Suicide Bereavement Service (funding extended until at least 2023). This service provides support for individuals and families affected by suicide https://blgmind.org.uk/bromley-mental-health/suicide-bereavement-support/ to date there have been 15 referrals from Bexley. The service is open to adults and young people and has been publicised locally through operational teams and publications including the Bexley Magazine. The steering group have also recently commissioned a self-harm pathway review and this work is currently ongoing.

Through the steering group Bexley has secured £15,000 to support a local programme of suicide awareness training. This training will support the gap identified in the draft Bexley Suicide Prevention Plan. The three-tier training programme will include on-line and face to face sessions, and will be offered to staff in the council, NHS, other public services and the voluntary sector. We will be working with Mind to offer the face-to-face elements. The first session is scheduled to take place in May 2022. In addition to our sub regional work, a public health representative has joined the safeguarding adult review process which has enabled monitoring and learning from local cases.

As we make steps to recover from the pandemic, we will be standing up a new local suicide prevention working group. This will take forward pre pandemic work to review our suicide prevention plan, taking account of the recent Covid-19 Health Inequalities Impact Assessment and children's joint strategic needs assessment (JSNA). The group is due to commence work in June 2022.

By Shanie Dengate

Section 6: What support have we offered to our partners?

This section will highlight the events the BSAB has put on for partners locally, regionally and nationally. Our BSAB Practice Review & Learning Manager is a key member of the National SAB Network, we're pleased to report that last year we offered our National SAB partners access to our Safeguarding Adult Learning & Development events to share our excellent work here in Bexley.

Part A: The following are BSAB sponsored events for 2021-22

1. Bexley GPs - Safeguarding Adult Review (SAR) Workshop
2. Bexley GPs - Basic Level 1 Safeguarding Adult Training
3. Adult Social Care - SAR Mrs BA Workshop
4. 6 Sessions of Commissioned Legal Literacy Mandatory Training
5. SAR and IMR Workshop for MALF members
6. Making Safeguarding Personal & Understanding Advocacy
7. Executive Capacity in Relation to Mental Capacity Act
8. SAR Paul Workshop - Trauma Informed Practice
9. Cultural Competency and Safeguarding Adults
10. Think Family & Domestic Abuse
11. Professional Curiosity
12. Modern Slavery
13. Understanding the Courts & Probation Pathways
14. What is Think Family?
15. Access to DWP and links to Safeguarding Adults
16. How do you know your services are safe?
17. New Domestic Abuse Bill Workshop
18. National SAR Thematic Learning Workshop
19. Scams Awareness and Safeguarding Adults at risk
20. SEL SAB Safeguarding Adults Manager and Enquiry Officer Mandatory Training
21. 4 BSAB Full Board Meetings
22. 12 Safeguarding
23. Adult Review (SAR) meetings; including 17: commissioned meetings
24. 2 Local Implementation Network (LIN) meetings
25. 6 Quality Checker Project meetings (see page 55)
26. National Safeguarding Adult Board Managers Network Awards (see page 56)
27. Local SAB Awards (see page 57)
28. 6 ASC Directorate Leadership Presentations
29. 3 London Borough of Bexley Corporate Leadership Presentations
30. Kingston SAB Professional Curiosity Workshop
31. SW Region DWP Professionals Professional Curiosity Workshop
32. LBB Councillors Basic Safeguarding Awareness Training
33. Level 1 Basic Awareness of the Mental Capacity Act
34. The Role Of The Manager In Provider Organisations
35. Safer Recruitment in the Voluntary & Community Sector
36. Making Safeguarding Personal: - Hearing the Voice of the Individual
37. Basic Awareness Level 1 – Faith Group Leaders
38. Information Sharing & Communication Skills Training
39. Carers and their rights
40. Person-Centred Planning
41. Suicide & Self-harm Awareness
42. Escalation of Risk

Training Feedback:

- Participating to complete tasks were helpful and watching videos relating to the topic was most useful as well as information given to access additional information.
- Anita is so supportive and knowledgeable she makes a difficult job easier!
- Everything about the course was relevant and very interesting
- Engaging, knowledgeable facilitator
- linking theory to actual practice and real scenarios, this really helps me learn and make it relevant to the clients that I work with
- The overall course material was very informative.
- The presentations were really interesting and useful
- The course overall was very well given

Part B: BSAB Safeguarding Adult Partnership Assessment Tool (SAPAT) & Challenge Event Summary & Findings

SAPAT/Challenge Event Aim and Purpose -

The aim of the SAPAT was to provide all SAB partners in the Borough with a consistent framework to assess monitor and/or improve their Safeguarding Adults arrangements. In turn this should assist us in ensuring effective safeguarding practice across the Borough. The SAPAT was expected to be used to help organisation/teams to improve and strengthen arrangements for safeguarding adults with care and support needs. An open and honest approach was encouraged to enable the organisation/team to get maximum benefit from the process.

The tool was developed for use across London Boroughs to help those organisations that cover more than one borough, reducing the need for them to complete different forms. The purpose of the tool was to provide Safeguarding Adult Boards with an overview of the Safeguarding Adult arrangements that are in place within partner agencies across the Borough.

We used the tool in Bexley, asking organisations to complete the form, and then attend a meeting with the independent chair, the Board manager and the CCG safeguarding adult lead, to identify and discuss:

1. Strengths, in order that good practice can be shared.
2. Common areas for improvement where organisation/teams can work together with support from the BSAB.
3. Single agency issues that need to be addressed.
4. Partnership issues that may need to be addressed by the BSAB.

Who we invited and why :

We agreed as a BSAB that we would invite those agencies most linked to our Safeguarding Adult Review (SAR) themes in Bexley. This would provide the BSAB with evidence and assurance that agencies are embedding learning from SAR.

The agencies and teams invited for SAPAT/Challenge were:

1. London Borough of Bexley -
    a. Care Leaving Team
    b. Adult Social Care
    c. Housing Services
    d. Community Safety Services
2. MIND in Bexley
3. Oxleas NHS Foundation Trust
4. SLAM - Drug and Alcohol Services
5. London Metropolitan Police Services, SE BCU
6. Solace Women's Aid
7. Lewisham and Greenwich NHS Trust
8. Dartford and Gravesham NHS Trust

What did we learn?

Area 1 – Strengths identified are :
Continuous desire and willingness to improve services
Networking opportunities for partners
Stronger links with BSAB and the work with the partnership
Shared challenges and awareness of areas for improvement
Wonderful case examples of prevention and response to safeguarding adults

Area 2 - Common areas for improvement where organisation/teams can work together with support from the BSAB:
Safeguarding adults across mental health, drug and alcohol services and adult social care
Understanding how LMPS SEBCU operates and what new services and teams have been established
Engagement with services during change and still understanding statutory duties and what to do if it isn't working well
How do we 'hear the voice of the individuals' we work with?

Area 3 - Single agency issues that need to be addressed:
LBB, Care Leaving Team and Adult Social Care – although in Children's Social Care, they are adults; better links with Adult Social Care in place and working joint approaches
SLAM – although links have been in place, the engagement back to the BSAB particularly around SAR learning and sharing of services
MIND in Bexley – reinvited as a standing member of the BSAB for greater links with mental health providers
LBB, Housing Services – there was no engagement with this exercise due to significant reduction and changes across the whole service. This has impacted on safeguarding adults and partners have raised concerns. BSAB Independent Chair has sought ongoing safeguarding assurances from Housing senior managers.

Area 4 - Partnership issues that may need to be addressed by the BSAB:
All – acknowledgement that not all individuals thrive with technology and need other ways of engagement.
All – working to gather feedback on those that not only use services but have experienced abuse and neglect
All – ongoing peer-to-peer challenge on defensible decision-making and ensuring lessons are continuously being learned and improved
Show case the excellent work that Bexley SAB are doing every single day

Part C: Quality Checker Project

This year we've launched our Quality Checkers project, these amazing new recruits are helping us gather information from service users and their 'lived experience' feedback.

This exciting new Quality Checker Project overseen by BSAB with key partners across our learning disability partnership. We established a working group to design a way for adults with learning disabilities to be recruited, trained and complete visits to speak with other service users with learning disabilities within our commissioned services in Bexley. We've asked Ambient and Mencap to assist us with the day-to-day running of the project.

We've recruited 6-8 Quality Checkers and they've completed over 6 assessments since January 2022. We look forward to carrying this project forward and learning from their assessments.

For more information, please see our website page here.

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Part D: National Safeguarding Adult Board Managers Network's, ‘We See You – We Hear You’ Excellence Awards

This year our BSAB Practice Review & Learning Manager initiated a National SAB Managers Award process, bringing together more than 50 SABs Nationally to share with their local partners to nominate individuals and teams across 8 different categories.

We had several nominees in Bexley for this award, enough were nominated that we decided to host a **Local SAB Managers Award** which brought together over 120 different individuals across health, social worker, nursing teams, home care, care homes, and fire brigade services in Bexley.

To nominate for 2022-23 Awards, click here

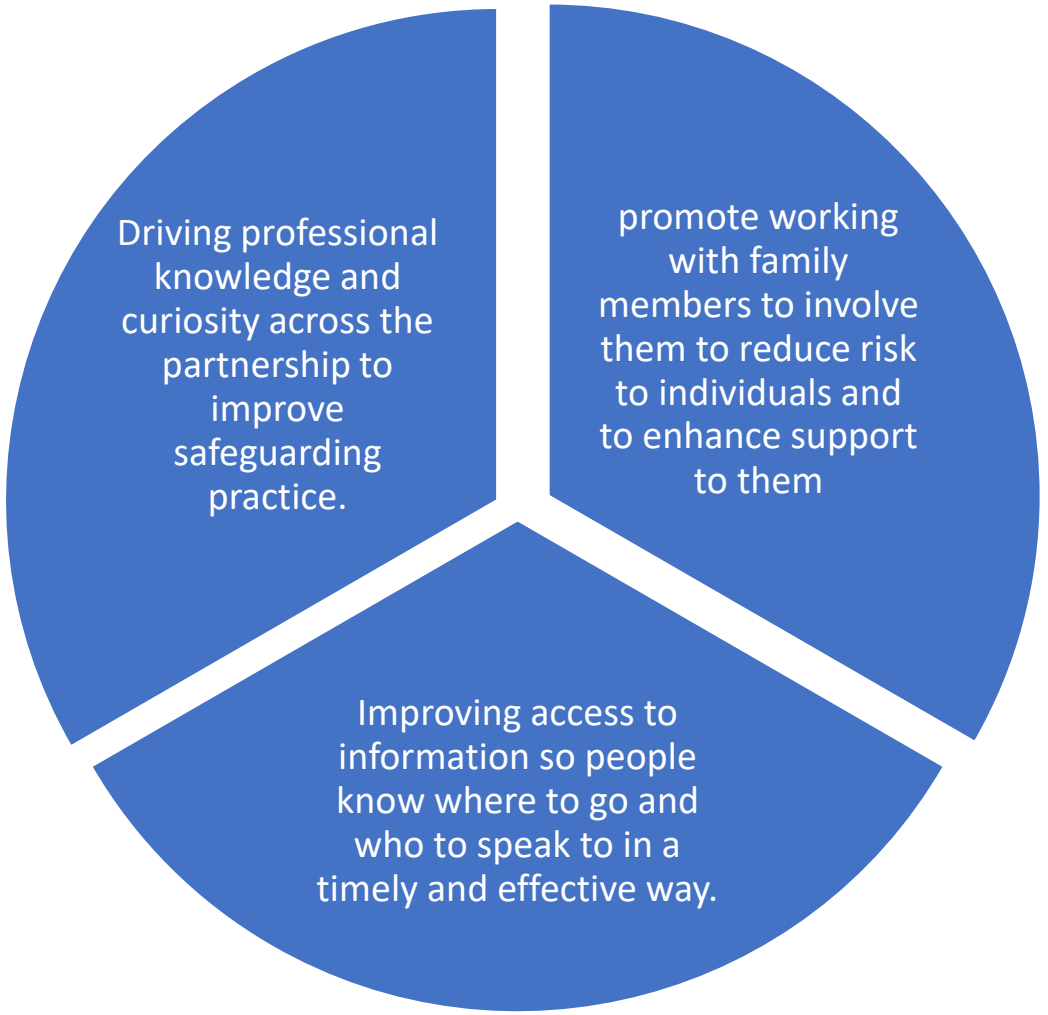
Here are just a few quotes from nominators in Bexley

'Jaz always encourages her clients to do what they can do for themselves and appears to motivate her clients to try to do so. She encouraged H to get up and walk more and managed to have her appetite increased. She can motivate B to get more interested in cooking and talking about his food, inspiring him to speak more happily. B speaks highly of her
and says that she understands and encourages him to talk about his interests.'

'During the pandemic, the Holistic Bexley Team have provided domiciliary care services with no missed visits and operated the service as usual to ensure that our clients receive the care that they require. The care workers have acted swiftly in matters of financial abuse to safeguard individuals and upon a recent inspection from Bexley council, Holistic were marked with very good practices. Care workers regularly tend to go above and beyond, with one particular case standing out. MB is a client with a recent diagnosis of dementia. She lives in her own home with her 2 dogs, her hands, clothes and property would at times be covered in faeces. She would be wetting her trousers and then putting them in the commode. There had been talk of having her move into residential care, but then would lose her 2 dogs on which she is very reliant and got very upset about. Care workers would go in and also walk the dogs to ensure that she could stay at home, and agreed to continue going in despite the circumstances so that she may remain at home.'

'Hansika Weerasinghe goes above and beyond on her duties. It's heartening to see her rolling up her sleeves and working together for the benefit of our service users and carers. I'm struggling to frame her under one award as she is an all-rounder. She is a leader. She prides herself on providing the best possible service we as a team can carry out. Working in partnership and preventing service users abuse and neglects etc. Bexley council QA team would be able to evidence above as Hansika is well known to the team and the good practices that Hansika and her Bexley team carried out to prevent service users from abuse and neglect, minimizing risks, etc . also to maintain the quality of the service.'

Section 7: Our Strategic Priorities / Successes



Updates from our statutory partners:

CCG has set up the following forums for health professionals to share information, pathways, best practice and to challenge the health response to all aspects of safeguarding:

i. Domestic abuse health sub-group
ii. Bexley Borough Safeguarding Health Forum
iii. LeDeR steering group

- The safeguarding team also attend and are active members of the MALF.
- An audit of GP practices recording routine enquiry has been undertaken and the results are being shared across Bexley GP surgeries to encourage discussion and embed routine enquiry in mental health consultations.
- We attend the Bexley Senior Management team meetings and present safeguarding reports every 6 weeks

NHS Bexley Clinical Commissioning Group

Support to colleagues across partner organisations including Housing, home care and Third sector, with ASC Triage hub a central place for support and guidance regarding safeguarding.

LONDON BOROUGH OF BEXLEY
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We have continued to invest in training officers across Public Protection and have increasingly looked to run programmes inviting officers across all departments to help raise knowledge bases and spark professional curiosity. The present training and recruitment pathways look to rotate officers through departments early in their career to help embed a wider view and knowledge of best safeguarding practise for all detectives.

METROPOLITAN POLICE

1

Driving professional knowledge and curiosity across the partnership to improve safeguarding practice.

Updates from our statutory partners:

The CCG continue to support the multi-agency response following a Think Family approach and have supported many multi-agency meetings for complex cases.

NHS Bexley Clinical Commissioning Group

ASC pathways transformation sees care and support discussions held closer to the individual and families by organisations known to the individual and their carer. Yearly carers survey and evaluation of the feedback received to inform service development.

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We have a referral system in place to ensure partners receive key information, and support accordingly. Officers are aware that the footprint created by interactions with police needs to be understood in how it impacts on wider family life, and that partnership working needs to be at the forefront of decision making to drive risk reduction. Family Liaison Officers are in place for specific operational deployment and the College of Policing is currently assessing two pilots around Family Support Interactions for any lessons or wider rollout.

METROPOLITAN POLICE

2

Promote working with family members to involve them to reduce risk to individuals and to enhance support to them

Updates from our statutory partners:

The CCG safeguarding team are DA champions and work with GPs and other health professionals giving guidance and sharing information for best practice and pathways

- We have supported the placement of an IDVA in GP surgeries across Bexley to support victims of DA and to promote learning and engagement in primary care.

NHS Bexley Clinical Commissioning Group

- Review of Information on website planned
- Actions to improve our telephone communication systems, ensuring calls are diverted if a staff member is on AL and personalised answer machine messages are recorded.
- ASC Pathways transformation is improving access to wider range of information and advice available through third sector
- The single point of contact and Integrated triage team provide a single referral point for health and care support.

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Throughout the pandemic period South East Police worked to ensure access to non-999 services, keeping station front counters open, working to expand availability of on line information and reporting systems and ensuring partners were able to contact relevant units at the height of lockdown. Lessons have been embedded from this time and it is noticeable that contact on line remains significantly higher than pre-pandemic suggesting that there was an underlying demand for this which is now being met. We continue to give out partner and support information at appropriate incidents and ensure all in custody receive information on partners who can offer assistance to reduce recidivism and address underlying issues.

METROPOLITAN POLICE

Success Measure Priority 1: learning with adults, carers and families –

- Engage and involve adults, carers and families in BSAB activity – i.e. Engagement and SAR Subgroup.
- Encourage individuals to feedback to the BSAB on what has made Safeguarding Personal to them.
- Working closely and attending the Multi-Agency Learning Forum (MALF).
- Linking with SHIELD and CSPB through joint conferences and events when shared learning can be identified – i.e. Modern Slavery, Domestic Abuse

And what we did: -

We actively invited by letter, phone or email families and carers to engage in BSAB activity. For example, with SARs: Rose, Elvis, Grant and Rachel we invited family or individuals involved to contribute towards the learning. We had to do these via Microsoft Teams Online Video. This type of remote meeting can offer those not living local to Bexley to still engage in the review process and share their opinions and views for the SAR; however, we recognise that this is not an ideal way to meet with family, carers and individuals affected by a safeguarding death or incident.

In January 2022, we launched Social Media platforms on Facebook and Twitter where we will be sharing safeguarding awareness campaigns and invites where appropriate.:-

- https://www.facebook.com/bsab.bexley
- https://twitter.com/Bexley_SAB

We've continued to chair the Multi-Agency Learning Forum (MALF), which offers joint learning across the 3 Bexley Boards (Community Safety Partnership, S.H.I.E.L.D. and BSAB) where we've identified cross-learning opportunities. The MALF is to ensure we share information to a much broader professional network. Since 2020, we've worked closely, lessening duplication, sharing more widely the learning found earlier on and offering learning sessions on: Professional Curiosity, IMR Best Practice/Expectations and Setting the Scene as to what the statutory reviews are for partners. We produced a Joint Think Family Protocol for Bexley in June 2021 which is a welcomed piece of work across the partnerships. **Please see the Joint Think Family Protocol here**

MALF cross learning themes:

- Domestic Abuse
- Information Sharing / Inter-Intra Agency sharing / Information Recording Systems / Record Sharing / Information Flow / Record-keeping
- Think Family
- Safeguarding Literacy and Knowledge / Professional Curiosity, Professional Roles & Responsibility / Safeguarding Processes
- Organisational Policy/Procedures / Organisational Practice Silos / Information System Structure Silos
- Assessing And Meeting Needs - Safeguarding Action – Referral & Response / Risk Awareness & Assessment; Working With Families And Significant Others / Responding To Characteristics Of The Individual
- Transition between local authorities

Since 2018, the BSAB has implemented a SAR Thematic Action Plan that links all the learning from SAR and the expected work of the board into one unique place. This is something that Bexley has piloted as the first board to do this nationally. This has been a refreshing way forward to gather assurances across the partnership and keep partners accountable to the learning found through SARs. **Please see page x for the full SAR Thematic Action Plan.**

We've had a few SARs in Bexley linked to fire death or incidents. Due to this the BSAB has re-launched the Fire Safety Working Group to look at a risk matrix and pathway toolkit for the partners.

Following a couple SAR Notifications regarding pressure ulcers, we've produced a Pressure Ulcer Protocol (PUP) Toolkit to provide a safeguarding tool to assist those in the Domiciliary and Care Home sector to have a way to identify and raise concerns when pressure ulcers may appear. **This can be found here:** Social Care Providers Bexley Pressure Ulcer and Safeguarding Process

Success Measure Priority 2: learning with professionals: -

- Ensuring that all relevant professionals are able to contribute towards to work of the Board.
- Ensuring that frontline practitioners have access to Board events.
- Invite and encourage professionals to attend, share and embed learning from BSAB Learning Events.
- Identify Safeguarding Champions across the partnership.

And what we did:

We continue to actively invite and encourage professional attendance to all SAR Learning Events as outlined in our **Learning & Development Programme**, including attending Bexley's Adult Social Care Director Leadership Team (DLT), Corporate Leadership Team (CLT) and sharing at various Team Meetings across the Local Authority.

We regularly email and post online key events and offered spaces to learning for professional development.

We have created 7-minute briefings on SARs and other key themes, which can be **found here**

In January 2020, we launched our Safeguarding Champions Network, gaining over 100 nominees to share Safeguarding Adults information circulated to key professionals. We continue to use this network to share information across the partnership and look to reviving this campaign in 2022-23.

We continue to encourage key professionals to contribute towards the work of the board through consultation and feedback.

Success Measure Priority 3: a good quality and healthy system: -

- Joint audits across the partnership every quarter 1 case from Adult Social Care, NHS, Police and Domestic Abuse
- Annual agency/organisational audits and Challenge Events
- Quarterly review the BSAB Risk Register - i.e. Learning from SARs
- Ensure quarterly performance data submitted is scrutinized and challenged.

And what we did:

Since, June 2020, we've continued to keep BSAB Risk Register topics as standing board items to seek action updates at all full board meetings.

We've asked to see the outcomes from the Domestic Abuse Services joint audit with Children's Services in 2020-21 to gain assurances and keep accountability across the partnership.

We've worked with LGA/ADASS on their Insight Data Project over the last year and half. This has allowed us to have data every 3-6 months instead of leaning solely on the NHSE SAC Data. Both sets of data have influenced conversations at full board level to seek assurances, identify areas for action and note pressures on the system. The summaries can be found on pages 7-22.

We participated in the London ADASS Safeguarding Adult Partnership Assessment Tool (SAPAT) with all partners linked to SARs in Bexley the summary of this and our actions can be found on page 47.

Good news stories:

In total since 1st April this year Trading Standards have had 66 interactions with residents regarding doorstep crime and scams. 41 of these have been visits to consumer's home and include scam prevention/advice, reassurance visits and intervention. Through intervention Trading Standard have saved our residents £162,250

The National Trading Standards (NTS) Scams Team identified Mr A as a potential victim of prize draw scams. Mr A is a resident in Bexley and the information was referred to us as his local Trading Standards team. We made contact and visited Mr A on several occasions spanning over several years and gave him scams advice. He always told us he used to send money but had stopped. It transpired Mr A had started sending money to prize draw scams following a bereavement and it had become an addiction. At one point Mr A had been sending around £150 per month to scammers and was receiving 15 to 20 letters a day. The more money he sent the more bogus prize draws he then received as victim's details can be sold on to over 200 different scams. On the figures given we estimate he had sent around £5000

The National Trading Standards (NTS) Scams Team, through their investigations had seized paperwork which they passed to Bexley Trading Standards last year. This was a form that Mr A had completed giving his credit card details and authorising a payment of £40 to an overseas prize draw scam. Bexley Trading Standards visited again and returned the form to him, pointing out is was a scam. Once again we gave scam advice and talked about Friends Against Scams (FAS).

Through our intervention Mr A has now signed up to be a Scam Marshall with FAS. A Scam Marshal is any resident in the UK who receives scam mail and wants to put it to good use. Scam Marshals send their scam mail to the NTS Scams Team so that it can be utilised as evidence in future Trading Standards investigative and enforcement work to stop it at source, they also share their experiences with others to encourage them to be scam aware. Mr A has seen a reduction in mail and the scams he now receives are assisting in the fight to help stop bogus and scam mail before it reaches anyone else.

Section 8 : closing statement

In closing, I am pleased with the continued work of the BSAB as noted in this year's annual report. This past year has again proved challenges to the partnership as well as those we support across Bexley. However, despite these continued challenges we've also seen strength in areas we've not previously seen. For example, we've engaged with and learned from partners in drug and alcohol services to assist with our Safeguarding Adult Reviews and how best we can support individuals who access these services; and have launched a Quality Checkers project

Bexley Safeguarding Adults Board continues to actively keep our work in the national spotlight. They do this by sharing BSAB work, experiences, learn from others to develop new initiatives both locally and nationally. We led on the creation and implementation of National SAB Managers Awards scheme and have successfully awarded over 100 Bexley individuals as an outcome of this national project with the view to continue this as an annual event.

BSAB understands there will be some situations where risks could go unnoticed, but the partners are eager to hear and learn from 'lived' experiences. We seek Lay Members for our board to help navigate this learning, if you are interested, please get in touch with bsab@bexley.gov.uk Thank you,

Councillor Brad Smith
Bexleyheath Ward
Cabinet Member for Adults Services

SOCIAL MEDIA LINKS:

Follow us on: https://www.facebook.com/bsab.bexley & https://twitter.com/Bexley_SAB

For more information about the Bexley Safeguarding Adults Board please visit – www.safeguardingadultsinbexley.com or email us at bsab@bexley.gov.uk