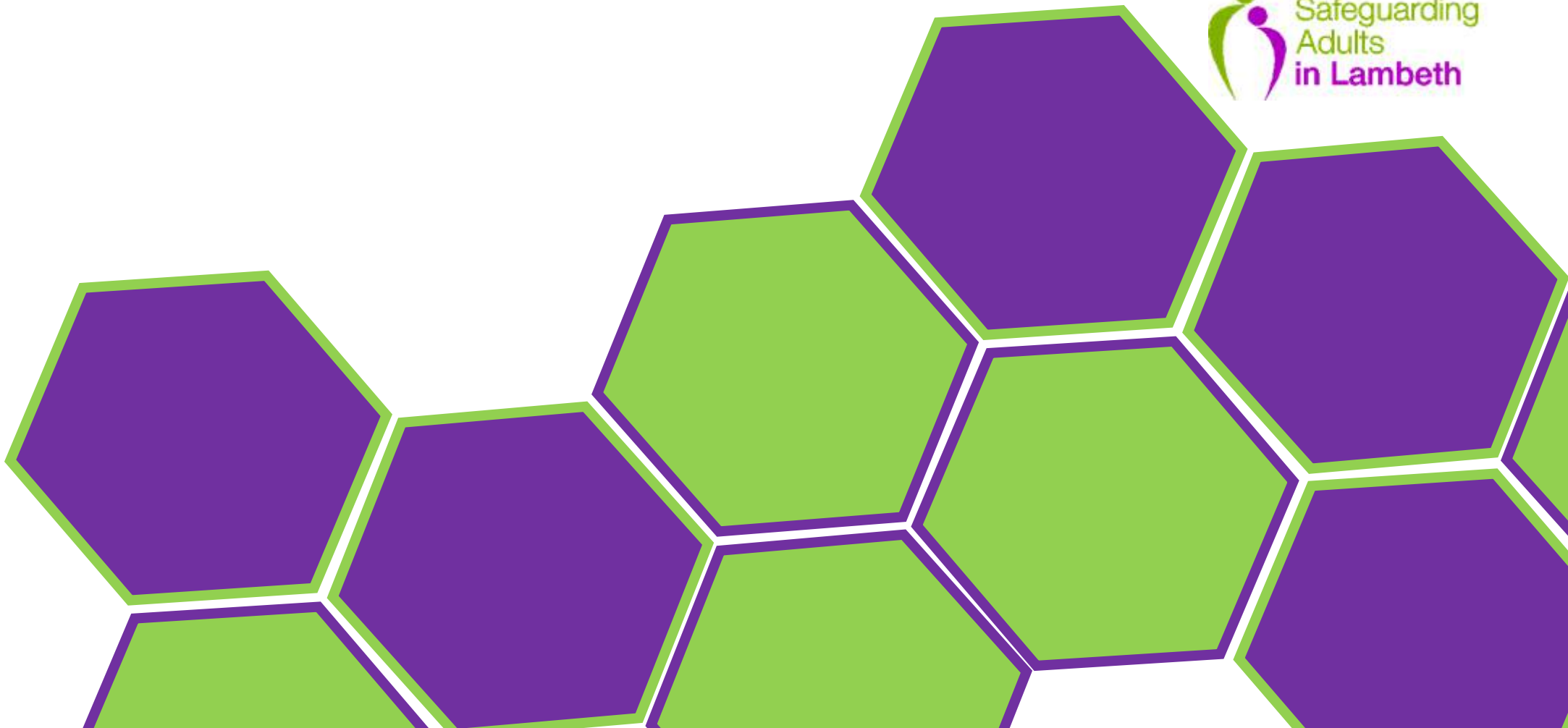


Lambeth Safeguarding Adults Board Annual Report 2018/19



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Introduction from the Independent Chair

Every year we look to deliver an Annual Report which is a little different, whilst ensuring that we report useful information to inform Lambeth Citizens about our work. Our approach is to make the report accessible and I am pleased to be able to present this 2018/2019 report which showcases the work undertaken in the borough on adult safeguarding.

The partnership of public and voluntary sector organisations which makes up the Board and the commitment of agencies in Lambeth to work together effectively to safeguard adults from abuse and neglect remains strong.

We have seen some changes in board membership and I would like to thank Moira McGrath (Director of Integrated Commissioning NHS Lambeth CCG & the Borough of Lambeth), Lambeth Councillor Jacqui Dyer, Rachel Sharpe (Director of Strategic Programming for Lambeth Housing Services) and Detective Superintendent Sean Oxley from the Metropolitan Police – all of whom contributed much to the Board during the last year and previous years. The commitment of all Board members and the leadership they have shown in their own organisations is demonstrated in this annual report and in particular, we have highlighted the new initiatives and progress made this year.

The Board's sub-groups continue to be effective and we have seen great achievements as the Community Reference Group goes from strength to strength in promoting safeguarding across all the voluntary and community sector in the Borough. The Mental Capacity Act sub-group produced an excellent Charter and Guidance Tool on the application of the Mental Capacity Act for all front line staff who work with the public. The Safeguarding Adult



Review (SAR) Sub-Group has worked particularly well in ensuring that recommendations in respect of SARs are made to the Board – one SAR was delivered to the Board during this year and work continues on others. SARs are commissioned to highlight learning for all partners - they are published on the Board's website and some information about SAR E, is contained within this Report. The challenge for the Board moving forward is to continue to keep the Review outcomes under constant scrutiny.

One of our commitments last year was to ensure we promoted all this work more effectively and this has been delivered by making better use of the LSAB website and other communication tools, as highlighted in this report.

A major achievement for the Board has been the delivery of a series of masterclasses to staff from all partner organisations, with nationally recognised speakers. We were also delighted to promote these masterclasses across our borough boundaries. The whole series was well received and I commend the booklet published on the Board's website. In particular I would like to thank the Board team, Ceri Gordon & Janna Kay for their work in delivering this.

Over this next year we will continue to ensure that effective services which meet the requirements of the Care Act are delivered through continuing changes anticipated in the public, community and voluntary sector, not least the NHS changes which will be delivered in South-East London. Our partners continue to deliver services to people with increasingly complex needs and the Board will explore how we can work together more effectively to protect people with care and support needs from abuse, harm and neglect.



Siân Walker, Independent Chair of the Lambeth Safeguarding Adults Board

Introduction to Lambeth

Nearly a third of a million people live in the London borough of Lambeth. It has one of the largest geographic areas of any inner London borough, and is situated in south London, between Wandsworth and Southwark, and south from Westminster.

It has several distinctive neighbourhoods including Waterloo, Brixton, Clapham, Streatham and Norwood, and landmarks include Waterloo station, the London Eye, the South Bank arts complex, the Oval cricket ground and Lambeth Palace, the residence of the Archbishop of Canterbury.

Largely residential, Lambeth is one of the most densely populated places in the country. It has a complex social and ethnic mix, with large African and Portuguese populations, and is an important focus for the UK black Caribbean population. Although it is a largely residential borough, it is a destination for young working age people and as a result Lambeth has a relatively young age profile. Lambeth also has a 'high turnover': 40,000 people leave the borough, and over 40,000 others move to the borough every year. This coupled with Lambeth's poverty rate of almost 30% (above the London average of 27%), presents a challenging picture for local services seeking to support those most in need.

In response, Lambeth is committed to finding ways of working that brings this all together. The [Lambeth Together](#) project has been set up and sees organisations working alongside the communities they serve. This new way of working has seen collaboration with the Lambeth Safeguarding Adults Board on a number of key projects this year. The details of this are highlighted in this report.



What is safeguarding adults?

Safeguarding adults' means protecting an adult's right to live in safety, free from abuse and neglect. It is something that everyone needs to know about.

The legal framework for safeguarding adults work is set out by the Care Act 2014. Safeguarding involves:

- People and organisations working together;
- Preventing abuse or neglect from happening in the first place;
- Stopping abuse and neglect where it is taking place;
- Protecting an adult in line with their views, wishes, feelings and beliefs;
- Empowering adults to keep themselves safe in the future; and,
- Everyone taking responsibility for reporting suspected abuse or neglect.

Who is an adult at risk?

An adult at risk of abuse or neglect is someone who has care and support needs and is therefore unable to protect themselves from either the risk of, or the experience of, abuse or neglect. Their care and support needs may be due to a mental, sensory or physical disability; age, frailty or illness; a learning disability; substance misuse; or an unpaid role as a formal/ informal carer for a family member or friend. More information is available on the Board's website at:

www.lambethsab.org.uk

Principles of adult safeguarding



Empowerment: people being supported and encouraged to make their own decisions and give informed consent



Prevention: it is better to take action before harm occurs



Proportionality: the least intrusive response appropriate to the risk presented



Protection: support and representation for those in greatest need



Partnership: local solutions through services working with their communities – communities have a part to play in preventing, detecting and reporting neglect and abuse



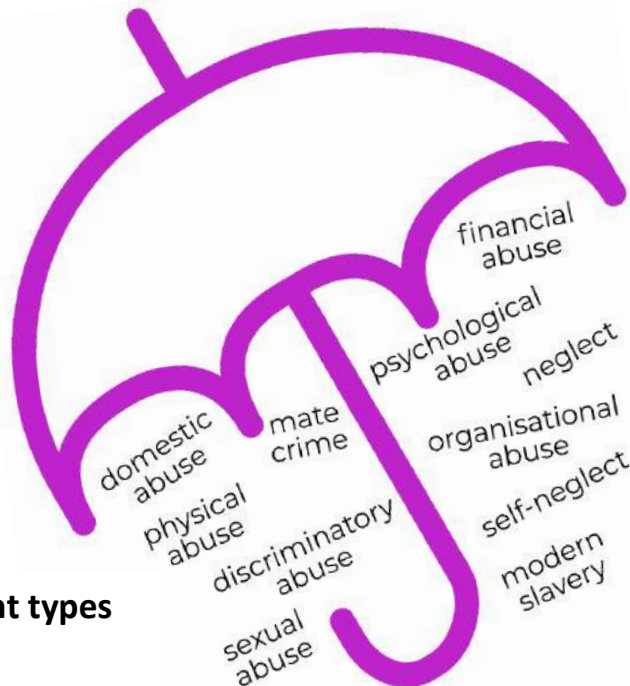
Accountability: accountability and transparency in safeguarding practice

What do we mean by abuse?

Abuse is when someone treats an adult in a way that harms, hurts or exploits them. It can take many forms – ranging from shouting at someone or undermining their confidence and self-worth, to causing physical pain, suffering and even death.

Abuse can happen just once or many times; it can be done on purpose or by someone who may not realise they are doing it.

It can happen anywhere including at home, in care homes or in day care centres or hospitals.



The different types of abuse

What happens when a Safeguarding Adults Concern is raised?

- ① A social worker, or someone that knows the person well, will talk to them about their situation and ask them what they would like to see happen.
- ② After the first discussion, the social worker will contact those people the person would like to have involved to build up a picture of what happened. This could take a few days or a few weeks.
- ③ If the person has been at risk or actually been harmed, some formal actions may need to be agreed to prevent this happening again. But sometimes, finding out about the situation and talking to the person about it is the limit of the enquiry.

Sometimes, concerns are raised due to confusion over what is happening in a certain situation. Sometimes, concerns are raised because a family member is struggling to care for an adult with needs, and requires support. Sometimes concerns are raised because someone really is being abused or neglected.

Adult Safeguarding Work in Lambeth

Mary's story

Mary is a 22 year old lady with autism who is living in a supported living service. The social worker receives a call from the Housing Warden, to report that Mary's rent has not been paid. There is a risk that Mary will be evicted. Mary's aunt is her appointee and is responsible for her finances. A safeguarding adults concern is raised regarding this situation and Housing agree to suspend eviction proceedings. As part of the safeguarding enquiry, the Social Worker contacts Mary's aunt but discovers she is living overseas. Mary has not been able to receive any income for some time. The Social worker notifies the Department of Work and Pensions (DWP) as the appointeeship is arranged through them. The DWP conduct their own enquiries and agree that the appointeeship arrangements are no longer appropriate. A new appointee is identified and set up. Mary's rent is then paid by the new appointee and all eviction proceedings end. Mary is also then provided with an income which allows her to go out and to buy the personal items she needs.

Mr. Williams' story

Mr. Williams has dementia which is progressing. His GP notices he has bruising on his body and that he looks increasingly frail and unkempt. The GP raises a safeguarding concern with the Local Authority. The Social Worker learns that Mr. Williams' 42 year old son, who lives with him struggles with drug addiction. This causes him to behave in aggressive and volatile ways toward Mr. Williams. Mr. Williams does not want his son to get into trouble because his son cares for him full time. The social worker suggests that they take a break and Mr. Williams goes into respite care for a couple weeks. During this time, Police interview Mr. Williams and discussions are held with Mr. Williams about how to keep him safe. An agreement is made that Mr. Williams' son will be offered Substance Misuse Services but that he must move out and find alternative accommodation. This enables Mr. Williams to return to his own home where he is provided with a care service. Mr. Williams maintains a relationship with his son but is no longer vulnerable to his son's volatile and abusive behaviour.

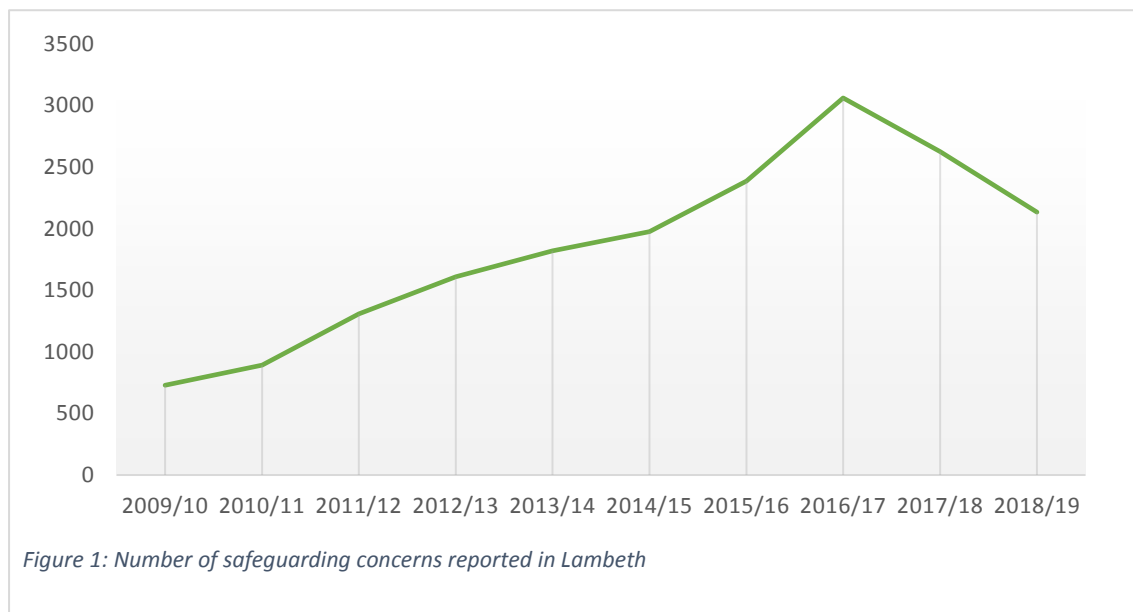
How to report abuse

- The quickest and most secure way to raise concerns is using Lambeth Adult Social Care's online form, which can be found at www.lambethsab.org.uk
Alternatively, you can contact the Initial Contact Service
 - Tel: 020 7926 5555
- If you would prefer to contact someone other than Lambeth council, there are charities who can offer advice and support:
 - Action on Elder Abuse can be contacted via their Helpline on 080 8808 8141 or by email at enquiries@elderabuse.org.uk
 - Respond can be contacted via their Helpline on 0808 808 0700 or email at helpline@respond.org.uk

In an emergency – you should always call the police or emergency services on 999.



Safeguarding activity in Lambeth



Since the Care Act came into force, the number of adult safeguarding concerns reported has risen year on year. However in 2017/18, this started to dip and this trend has continued in 2018/19.

Lambeth has consistently had one of the highest number of recorded safeguarding concerns when compared to other local authorities in London. This is a reflection of the commitment Lambeth has to safeguarding adults.

The recent decrease in numbers seen locally is a result of a change to the way that we practice in Lambeth. For instance, we now have a new way of recording referrals for other types of support that are initially reported as a safeguarding concern. This does not mean that we are not responding to these concerns, but means that they are being directed to more appropriate pathways e.g. to receive an assessment of needs.

There have also been changes to the way in which South London and Maudsley (SLaM) NHS Foundation Trust manage safeguarding concerns. As of December 2018 all safeguarding work within SLaM is being picked up by dedicated mental health social work teams.



60% of reported concerns of abuse or neglect took place within the person's own home. This is consistent with previous years and the national picture. These cases include incidents of domestic abuse as well as concerns related to domiciliary or health care services provided within people's own homes.



54% of individuals involved in safeguarding concerns in 2018/19 were female. This is in line with national trends.

The Community Reference Group are focused on making improvements to ensure that all communities in Lambeth are represented



White (50.03%) Asian / Asian British (4.67%)
Black / African / Carib.. (33.84%)
Other Ethnic Group (2.67%)
Mixed / Multiple (2.43%)
Undeclared / Not Known (6.37%)

Approaches to adult safeguarding should be person-led and outcome-focused. In Lambeth, people were asked about their desired outcomes in 85% of safeguarding enquiries undertaken in 2018/19



Data relating to ethnicity is generally reflective of the Lambeth population.

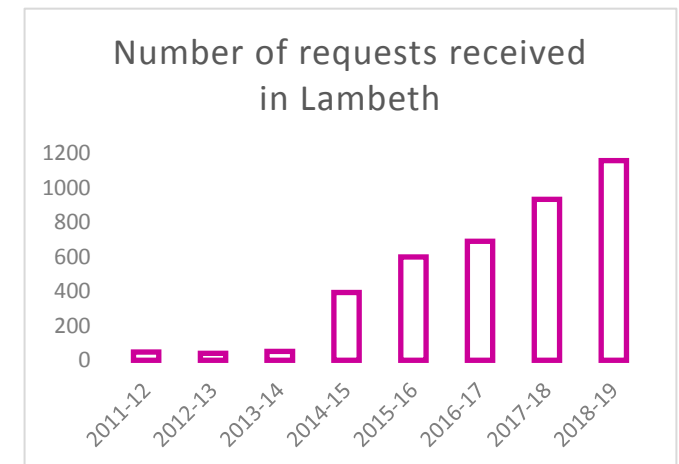
The proportion of people in Lambeth who describe themselves as white British increases with each age group, and safeguarding data on ethnicity should therefore be considered in conjunction with data on age. This data shows that the majority of safeguarding concerns in Lambeth relate to individual's aged 65+.

Deprivation of Liberty Safeguards (DoLS)

The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act (MCA). The safeguards apply to people who lack capacity to consent to their care and treatment in hospitals and homes (whether privately or publicly funded) and their purpose is to prevent arbitrary decisions that deprive vulnerable people of their liberty. In the event of it being necessary to deprive a person of their liberty, the Safeguards give them rights to representation, appeal and for any authorisation to be monitored and reviewed.

People can be deprived of their liberty in settings other than hospitals and care homes such as supported living or their own home. However in such cases the deprivation can only be approved by the Court of Protection and applications for authorisations in such circumstances should be made to the Court.

The DoLS scheme has been criticised for many things including being overly bureaucratic and costly. These criticisms have been exacerbated by the increase in demand for authorisations since the Supreme Court judgment of 2014 in the case now popularly known as Cheshire West, which effectively lowered the threshold for eligibility and significantly increased the volume of requests. As such, the workload demands in relation to the DoLS remains a challenge.

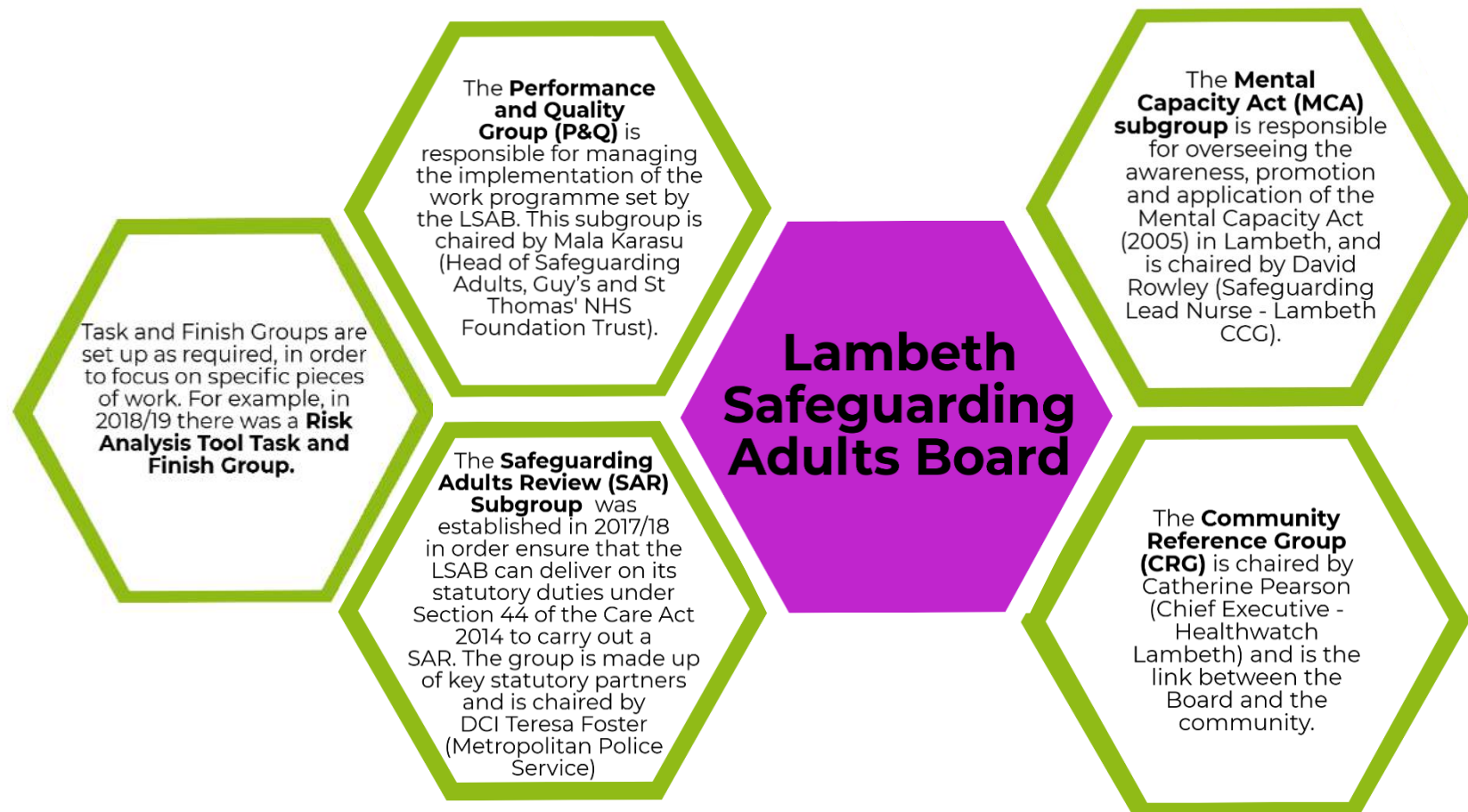


In March 2014, a House of Lords Select Committee published a detailed report concluding that the DoLS arrangements were “not fit for purpose” and recommended that they be replaced. The Mental Capacity (Amendment) Act 2019 received Royal Assent on 16 May 2019. The Act provides for the repeal of the Deprivation of Liberty Safeguards (DoLS) contained in the Mental Capacity Act 2005 (MCA), and their replacement with a new scheme called the Liberty Protection Safeguards (LPS). The government has not yet announced the date on which the Mental Capacity (Amendment) Act 2019 will come into force but it has been suggested that this could possibly take place in spring 2020.

Introduction to the Board and its subgroups

The Lambeth Safeguarding Adults Board (LSAB) is a statutory board set up in accordance with the S44 of the Care Act 2014.

Its main objective is to assure itself that local safeguarding arrangements and partners act to help and protect adults at risk and those most vulnerable, in its area. To help the LSAB achieve this objective, there a number of focused subgroups. These groups work hard to raise awareness of tackling adult abuse in the wider community and to build assurance that adult safeguarding practice in Lambeth is of a good quality.



What have we done in the last year?

The LSAB's [Strategic Plan](#) for 2017 to 2020 focuses on three key priorities of representation, prevention and awareness. These priorities have guided our focus through the last year, and we have sought to make improvements based on baseline measurements gathered in 2017/18. Our achievements in 2018/19 year include:

Improving our communication and raising awareness of adult safeguarding in Lambeth

- Over the last year we have made progress in improving channels for sharing the latest information and promoting new guidance in the field of adult safeguarding. This has included launching a new e-bulletin and continued updates on the [LSAB website](#).
- In response to the findings of the awareness survey completed in 2017/18, the Community Reference Group have developed new awareness raising materials. This has included a new poster which sets out to encourage people to talk about adult safeguarding concerns with a trusted professionals, a new information sheet which outlines the key indicators of neglect of an adult at risk. Both are now available to download from the [LSAB website](#).

Improving responses to domestic abuse

The Community Reference Group worked with Lambeth's VAWG Team and Quality and Safeguarding Adults Service to deliver two sessions focusing on domestic abuse and adult safeguarding in July 2018.

- The first of these sessions, '*Responding to Domestic Abuse*' was tailored to professionals and set out to give attendees a better understanding of the impact of trauma on victims. It provided information on effective risk assessment and referrals to the Multi Agency domestic abuse panel, and [guidance](#) on adult safeguarding procedures.
- The second session, '*Keeping Safe from Domestic Abuse*' was opened up to the wider Lambeth community and guided attendees through the different support services available to victims of domestic abuse and where to get advice about any concerns.



Focus on the Mental Capacity Act

The [Mental Capacity Act](#) (MCA) is a legal framework designed to protect and empower people who may lack the mental capacity to make their own decisions. The MCA Subgroup has made good progress in the last year, and has established a dedicated and effective membership. Over the last year, the group made a number of achievements:

- **Quality assurance audit** – was undertaken involving all key partner organisations. This found that organisations do have systems in place to facilitate good MCA practice, and to ensure restriction and restraint are used proportionately with regular monitoring. The process also found key areas which require further attention in order to improve the application of MCA in practice - this has guided the group's work-plan over the course of 2018/19.
- [MCA Charter](#) was written which sets out 10 key principles to adhere to when applying the MCA. This was endorsed by all LSAB Members.
- [MCA Guidance](#) tool was created to support professionals in their practice by outlining the essential steps for following the MCA process and which captures the key information that needs be considered.



“There was an excellent range of speakers – my favourite MCA event ever!”

- In March 2019, an event which focused on Best Interests Decision was held at Kings College Hospital. The MCA Subgroup led preparations for the day, with the support of Lambeth Together. The event was attended by a wide range of professionals working across Lambeth, and members of the public.

Safeguarding Adults Masterclass Series

In 2018/19 the LSAB hosted a series of safeguarding adults masterclass events, with funding from Lambeth Together and the Health Innovation Network. These sessions covered key areas for multi-agency learning including:

- Coercion and Control for capable adults (Alex Ruck-Keene)
- Self-Neglect & Hoarding (Suzy Braye)
- Making Safeguarding Personal (Jane Lawson)
- Safeguarding Adults Reviews (Michael Preston-Shoot)
- Modern Slavery (Paul Griffiths)

The series was a huge success and attended by a wide range of professionals working across Lambeth. 93% of attendees across all sessions said they felt the session they attended left them better equipped to deal with adult safeguarding issues. A new permanent resource, based on the key content, learning and discussion from each session is now available to [download](#). This booklet captures the essential knowledge and legislative frameworks that can guide professionals working with adults at risk, and provides links to further resources and research on best practice.

“I found the training to be well presented from trainers with expert knowledge and accompanying data... Many thanks for organising these superb Masterclasses”



Achievements of partner organisations

The Lambeth Safeguarding Adults Board is made up of senior members from a range of organisations who are all committed to achieving the aims of the Board.

Lambeth NHS Clinical Commissioning Group (CCG)

Lambeth CCG has continued to promote the development of adult safeguarding practice in primary care, including offering bespoke advice and support to GP Practices on a range of matters. The Designated Nurse for Adult Safeguarding and Named GP have both regularly contributed to a successful joint adult and child 'safeguarding supervision forum' for local GPs to gain both support and development in safeguarding through reflective practice. The CCG also carried out a primary care training needs audit which has informed the new CCG Primary

Care Training Strategy which will be launched in summer 2019.

The CCG has developed robust governance processes and structures to ensure that it meets its statutory responsibilities as a commissioning organisation.

The CCG's Designated Nurse for Adult Safeguarding played a key role in developing the LSAB's Mental Capacity Act (MCA) Charter and Guidance documents, and led on delivering the successful MCA Masterclass event for professionals working in Lambeth (see above).

Guy's and St. Thomas' NHS Foundation Trust (GSTT)

Safeguarding Adults is high priority within GSST with referrals increasing every quarter, with evidence of early recognition and referrals of safeguarding concerns for vulnerable adults across the hospital and community sites. There is good joined up working with children's safeguarding to achieve best outcomes for children and families.

The GSTT safeguarding team worked on a programme of raising awareness of the

Mental Capacity Act (MCA) in summer 2018. A new interactive MCA training package was developed and delivered to over 1000 staff. Weekly screen-saver messages on MCA and Deprivation of Liberty Safeguards (DoLS) were visible on all GSTT computers and staff were given lanyard cards to aid learning. Efforts were further enhanced by placement of Safeguarding Adults and MCA stalls within GSTT public areas to encourage staff to visit and talk to the team about any concerns or questions they had about safeguarding or MCA. This was well received and attended by the staff.

The Trust has focused on improvements and safe care for vulnerable adults and created a Director of Vulnerable Adults role to drive sustainable change within the services we provide to vulnerable adults including those with mental health or learning disability needs.

Skilled staff - the 'bedrock' of achieving good safeguarding practice, has resulted in additional training and other strategies being provided to reach the training

compliance targets of 85%. This has been challenging due to staff turnover.

GSTT has worked very closely with the LSAB through consistent representation at Board meetings and subgroups supporting local developments such as the MCA staff guidance and MCA Charter.

Kings College Hospital NHS Foundation Trust (KCH)

Safeguarding Adults remains a key priority for KCH. In 2018/2019 KCH has worked proactively to develop our safeguarding service including a more joined up approach with the Child and Midwifery Safeguarding services as part of the 'Think Family' ethos. Work includes the integration of the adult and child safeguarding committees to a joint quarterly meeting which has been well received by internal and external colleagues.

The Mental Capacity Act (MCA) has been a focus for 2018/2019. The Safeguarding Adults service has worked alongside our Legal services to host MCA 'big talks'. These sessions are held over the lunch

period and attendees hear from guest speakers from '39 Essex Chambers' on new judgements on MCA and DoLS. These are popular sessions that are well attended by clinical staff. KCH hosted the LSAB's MCA awareness day which focussed on Best Interests and Advanced decisions. This day was open to professionals and service users and received positive feedback.

KCH is committed to ensuring its workforce is sufficiently skilled in safeguarding training. Over the last year training compliance figures have improved every quarter for adult safeguarding training. It has been acknowledged by the NHS England 'Prevent' Regional Lead that KCH has made one of the best improvements nationally for its 'Prevent' training compliance.

Lambeth Adult Social Care (Lambeth ASC)

Safeguarding Adults is at the forefront of all work undertaken by all teams within Adult Social Care because adult safeguarding decision making duties,

outlined in the Care Act, sit with the Local Authority.

Lambeth ASC has focussed on supporting the frontline practitioners who are tasked with undertaking what is often, extremely complex adult safeguarding enquiries. Responding to these effectively is a priority and a challenge, given the high volume of referrals and the context of the times, where budgets and resources are diminishing. There has been a real focus on ensuring all practitioners receive the level of training required to do safeguarding work well. There have been systemic changes made to enable work that is referred in as safeguarding but which are related to a person's welfare e.g. self-neglect, be channelled to more appropriate pathways such as an assessment process.

Areas identified as being ones that practitioners struggle with, have led to targeted work being undertaken to address this. One such example has been around financial abuse. Safeguarding forums focussed on this to improve awareness and knowledge on how to

effectively respond to such abuse. This included more effective work across the Council's Welfare Benefits team, Financial Assessment Team and Client Affairs Teams. A financial management guidance document was also developed to assist practitioners to understand the range of legal options around financial management including Deputyship and Lasting Power of Attorney.

In relation to Deprivation of Liberty Safeguards (DoLS), a review of the service was undertaken and two major changes implemented. This included that Lambeth ASC agreed to fund an additional DoLS Administrator in order to relieve pressure on the service, given the high volume of requests coming in. Additionally, a requirement was made that Best Interest Assessments form part of internal social work case loads. This has seen an improvement in the time-frame in which new requests are processed and also a reduction in the numbers of DoLS requests awaiting assessments.

There has been a focus on improving joint working with partners such as the Police,

Mental Health services and Hospital Trusts in line with the new 'Lambeth Together' strategy.

Metropolitan Police Service

Lambeth Police services have merged with Southwark to form the Central South Basic Command Unit. As part of this restructure, safeguarding has been given a renewed focus, with the creation of a new safeguarding hub. Moving away from a model where Safeguarding is only the responsibility of one Command unit to the responsibility of all Police Officers and Staff, will allow the MPS to effectively support its victims across London. It will do this by ensuring Safeguarding is at the forefront of every Officer and Police Staff who will have the support required to protect the public.

South London and Maudsley NHS Foundation Trust (SLaM)

SLaM has continued to make improvements and increase access to accurate data on adult safeguarding activity. The Trust has also developed new methods of communication, including a

newsletter for all safeguarding leads across SLaM, which facilitates quick access to useful information. Further, SLaM has been working closely with local police services to improve access to support.

Age UK Lambeth

Over the course of 2018-19, Age UK Lambeth has focused on creating training opportunities for staff and increasing awareness of adult safeguarding. This has led to a better understanding of what is an appropriate referral.

National Probation Service (NPS)

The NPS is committed to reducing re-offending, preventing future victims and protecting the public. During the last 12 months we have continued to build the skills and confidence of our staff in identifying and managing Adult Safeguarding concerns by disseminating the learning from the Board on Safeguarding Adult Reviews. All staff have also attended the NPS London "Risk is Everyone's Business" workshops which incorporates adult safeguarding as a central theme. In January 2019, we

established a Vulnerabilities Forum which brings together the previous network of practitioner forums on Domestic Abuse, Child and Adult Safeguarding to ensure a more holistic response to safeguarding.

London Community Rehabilitation Company (CRC)

The CRC working in Lambeth is supported by a multi skilled team of staff. The team is now a proactive partner on the Lambeth Safeguarding Adults Board and has a focus on safeguarding planned for next year within the service. The London-wide CRC has recently implemented a new IT system which better-supports offender managers to undertake comprehensive risk assessments (including identifying concerns about vulnerable adults) and work with service users to formulate strengths-based and robust risk management plans. There is a renewed focus on quality - London CRC has also further developed its Quality Practice Standards for offender managers to identify and manage safeguarding concerns. Case audits are regularly completed, staff are supported through

ongoing internal and external learning and development opportunities, and multi-agency working is practiced and encouraged at the operational and strategic levels.

London Fire Brigade (LFB)

The LFB is a committed member of the Adult Safeguarding Board and its work. LFB is a service that often works reactively and proactively with those most vulnerable in the community. Through Home Fire Safety visits (which we offer as a free service to all Lambeth residents), we are continuously looking at new ways to protect all residents (especially those most at risk) within the borough. We are currently working with our statutory and other partners to identify those most need of support. This enables us to proactively assist with regards to Fire Safety and thereby put in preventative measures to safeguard adults at risk.



Learning from Safeguarding Adults Reviews

Under the Care Act 2014, the LSAB is responsible for the coordination of Safeguarding Adults Reviews (SARs). These are independent reviews commissioned where there has been an incident of serious harm or death involving an adult at risks. SARs set out to establish what may have gone wrong and to identify where agencies or individuals could have acted differently. SARs also however recognise the complexity of this work and will identify the areas of good practice too.

Key recommendations are made at the end of a SAR and this will often include the learning needed to prevent future incidents of serious harm or death from happening again.

In 2018/19, the LSAB finalised a SAR titled SAR E (the Executive Summary report is available on the [LSAB's website](#)).

Summary of SAR E:

Mr. E a white man aged 62, was born and grew up in the United States, with his parents. He was an only child but had some extended family with whom continued to have contact after moving to the UK. In the 1980s, he and a business partner opened their own bookshop in London. It was successful for most of the time until Mr E's business partner reportedly took money from the business to spend on a cocaine habit and the business collapsed around 10 years later. Mr E had substance misuse issues of his own, however following the loss of his business and then the death of his parents in 2011 and 2014, he started suffering with high levels of anxiety and worsening substance abuse.

Mr E has had periodic contact with mental health services up until his death. This generally focused on the issues of anxiety and depression. Mr E had been known to the Substance Misuse Team (SMT) since August 2015 and has been offered information and support to access services to reduce the harm associated with his drinking or to help him achieve abstinence. However, these had not been successful, generally through Mr E's lack of engagement or his explicit statements that he had no intention to stop taking benzodiazepines or to stop drinking. Mr. E was a man considered to

have the mental capacity to decide to refuse care and treatment offered to him. On the 17th March 2017, Mr E died in a fire at his house.

Findings from SAR E

The review found that a considerable amount of work had been undertaken by the agencies involved with Mr E and that repeated attempts were made to engage him and to encourage him to accept support. London Fire Brigade's report indicated that the fire was most likely caused by an unextinguished cigarette. It is most likely that Mr. E's ability to react may have been limited by intake of alcohol and other substances. As such, there was no link established between Mr. E's death and lack of action by those involved with him.

There were however still a number of recommendations identified as areas for improvement, which Lambeth Safeguarding Adults Board is taking forward. The following are two of the key recommendations:

1. Communication

There needs to be robust communication between agencies when working with individuals whose needs cut across the remit of different services. A clear escalation procedure should be established to agree lead agencies and what support others are expected to offer

2. Self- Neglect Policy

It should be noted that there was no "self-neglect" policy in place at the time Mr E's case was known to agencies. As such there was no clear direction around how to best respond to this. Self-neglect guidance has since been written and it is available on the LSAB website. The Board should consider adopting a multi-agency concerns framework. This would allow agencies to raise persons of concern, and seek to facilitate a multiagency approach, without necessarily requiring a safeguarding enquiry.

Future work

The Safeguarding Adults Review Subgroup will continue to monitor outcomes from safeguarding enquiries and consider cases which may meet the threshold for a Safeguarding Adults Review. Two further reviews have recently concluded but are yet to be published. Once agreed by the Board, the learning from these reviews will also be available on the LSAB website and published in this year's annual report.

What are our plans moving forward?

As highlighted in this report, the LSAB has made a number of achievements this year, however there continues to be a number of areas requiring further work and focus. Our [Strategic Plan](#) for 2019/20 aims to measure our progress in achieving the targets of our [overarching three year plan](#), and build on what we have achieved in the previous year.

- The LSAB's work-plan will continue to focus on the three key priorities of **representation, prevention and awareness**. As part of this focus, the LSAB has also agreed to specifically target issues of modern slavery, financial abuse and self-neglect over the course of 2019/20.
- There has been considerable progress made to finalise a Risk Analysis Tool in 2018/19. This **tool helps assist referrers in knowing what constitutes a safeguarding concern** and what to expect when raising a concern. As we move in to 2019/20, we are now ready to test this tool more widely. The tool will receive its formal launch in 2019/20.
- The Community Reference Group (CRG) continue to work on the targeted action plan in response to 2017/18's awareness survey. In 2019/20 the group hope to finalise **guidance to help unpaid carers** have a better understanding of proportionate restraint, and to continue raising awareness of the different categories of abuse.
- In 2019/20, the LSAB will have a **specific focus on financial abuse**. This includes working with the Department of Work and Pensions and the Office of the Public Guardian (OPG) to improve the pathways and joint working.
- LSAB Members continue to focus on **finding ways to hear the voice of service users**. This includes obtaining feedback directly or indirectly. The Community Reference Group will continue to work to improving links with community groups and ensure that the Board and its subgroups are representative of Lambeth. The CRG are leading on this work via a series of themed engagement events.
- The Performance and Quality subgroup aims to finalise a new evidence based **supervision model for adult safeguarding** that can be adapted for use by partner organisations.
- The Safeguarding Adults Review Subgroup continue to ensure that LSAB continues to fulfil its responsibility to commission a Safeguarding Adults Review (SAR) wherever there has been an incident of serious harm or death involving an adult at risk. In 2019/20, the group will **explore new methods of disseminating learning from SARs and other review processes**.