# National Network of Safeguarding Adults Board Chairs: Annual Report on 2020 to 2021

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**How the report is set out**

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## Section 1: The National Network of Safeguarding Adults Board Chairs

### 1.1 The Care Act (2014)

This established Safeguarding Adults Boards ("SABs") in law. The Care and Support Statutory Guidance to the Act set out expectations of Safeguarding Adults Boards chairs. SABs existed before they were made a legal requirement and the network started in 2009 as a peer support group for independent chairs. The Care and Support Statutory Guidance says that where possible the chair should be independent, but this is not a requirement, and the network opened up membership to all SAB chairs in 2016. The network model is not one of subscription or affiliation that brings in money from members or SABs. The funding section sets out the headlines about our finances.

### 1.2 What the Care and Support Statutory Guidance (2020)[1] says

Chapter 14, section 150, states: *Although it is not a requirement, the local authority should consider appointing an independent chair to the SAB who is not an employee or a member of an agency that is a member of the SAB. The chair has a critical role to lead collaboratively, give advice, support and encouragement but also to offer constructive challenge and hold main partner agencies to account and ensure that interfaces with other strategic functions are effective whilst also acting as a spokesperson for the SAB. An independent chair can provide additional reassurance that the Board has some independence from the local authority and other partners. The chair will be accountable to the chief executive of the local authority as the lead body responsible for establishing the SAB but should be appointed by the local authority in the name of the SAB having consulted all its statutory partners. There is a clear expectation that chairs will keep up to date with, and promote, good practice, developments in case law and research and any other relevant material.*

### 1.3 Why Safeguarding Adults' Boards are important, and the value of sector-led support for chairs

**1.3.1** The year has seen constant media coverage of adult safeguarding issues. In part this was due to the Covid pandemic. By March 2020 there were huge concerns from relatives, and professional bodies that run, arrange and regulate care homes. These concerns centred on devastating outbreaks of Covid in some care homes, and on how to prevent reoccurrences and keep residents safe. The debate then moved focus as the question of whether 'blanket' policies were wrongfully being applied to not resuscitate older adults and adults with learning disabilities who were gravely ill with

[1] See https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

Covid. Coverage of government initiatives to move rough sleepers, many of whom are excluded from society and service for multiple reasons, also shone a media spotlight on this group of adults who often have unmet care and support needs and are regularly part of SAB work programmes. The BBC Panorama reporter's exposure of abuse of adults with learning disabilities and autism in the private Whorlton Hall hospital in May 2019 was followed during 2020-2021 with reports by the Care Quality Commission about restraint and segregation, and on the issues raised by 'closed cultures'. Families and their supporters continued to raise troubling instances of segregation and restraint and to respond with anger and dismay to subsequent inspection reports of settings where professional abuse and neglect of adults with learning disabilities and autism was found, and action taken.

**1.3.2**. Our network enables us to share best practice, and to take agile and consistent approaches to issues of national importance. Our connections and influence have grown greatly during the pandemic – the section on that particular priority sets out how. Chairs responded with examples for us to use and pass on, represented us in regional and national consultations and events, and fed that information back into the network. Examples are given throughout this report. Professional bodies have their safeguarding structures – the Association of Directors of Social Services; the National Police Chiefs Council, the NHS Safeguarding Adults National Network; the National Fire Chiefs Council – to give four examples. However our network enables us to pull out what is crucial and relevant to the multi-agency leadership role of the SAB chair.

**1.3.3** The network agreed principles of proportionality at the start of the pandemic and all members were sent information about working to those principles, with regional groups holding meetings to discuss their implications. The principles were:

> *To be proportionate in seeking assurance about multi agency adult safeguarding in each SAB area by asking only about plans that are extant*
>
> *To encourage and support consistency across the SABs with the exec being a conduit to the whole network*
>
> *Disseminate as few messages as possible but make them the crucial ones*
>
> *To let our board networks and members get on and do their jobs at this time*
>
> *We aim to be supportive, agile and in the confidence of government and national bodies so we can promote messages together*

This report reflects our attempts at achieving that proportionality whilst continuing to champion the rights of adults at risk who need safeguarding.

**1.3.4 SAB Business Managers' Network –** during the year the business managers who fill a unique and greatly valued role for SABs around the country, formed their own network. Liaison between their network and ours has begun and is already with agreement on projects that we can support each other with as we have a number of priorities that are the same.

### 1.4 The Network's Terms of Reference

The Network's terms of reference mirror the Care and Support Statutory Guidance (2020).

- Share best practice and good examples with regards to the implementation of the Care Act 2014;
- Support the implementation of SABs becoming statutory bodies under the Care Act 2014 in a coherent and consistent way;
- Share and disseminate knowledge and learning between Boards;
- To work with partners in respect of information sharing agreements, budgets and performance;
- Improve consistency of approaches to safeguarding and contribute to the raising of overall standards of adult safeguarding;
- Continue to develop a national voice and resource for consultations and advice on safeguarding matters; and
- Provide peer support and networking opportunities.

### 1.5 Geographical reach and variety in models of Safeguarding Adults Board

The network is open to chairs in England and Wales, Northern Ireland, the Channel Islands and the Isle of Man. Last year's report summarised new chairing arrangements including four places that combined arrangements for one independent person to chair the three statutory partnerships – children's safeguarding, adult safeguarding and community safety. Some of our network members hold those roles. Of note this year is the effect of changes, now a couple of years into implementation, to the way children's safeguarding partnerships are governed. Gradually they may be having some impact on approaches to Safeguarding Adults Boards. It is too soon to assess these changes, but the concept of independent scrutiny, which is underlined in the children's safeguarding statutory guidance is beginning to be applied to SABs. In Hampshire, the Director of Adult Social Services has taken on the role of chairing the SAB and an independent scrutineer has been

appointed. Both are members of our network. In South Tyneside, there is one partnership for adults and children who have appointed an independent scrutineer with the chairing role being undertaken by the Local Authority, CCG and Police on an annual rotation.

### 1.6 Network membership / coordination and communication

On 31st March 2021 at year-end, 101 individuals were chairing 140 adult safeguarding partnerships. Some chairs work across areas as part of their contract, others choose to work in more than one area. Not all chairs respond to communications from the network, but everyone is included in the circulation of material. The relatives' representatives who have looked at this report and the previous year's report, asked "is it ok for chairs not to take part in the network?". In terms of keeping up with knowledge and case law, the Care and Support Statutory Guidance makes it clear that this is a requirement. The network is a peer support model and not there to measure performance, rather to support it. During the year a couple of chairs who were leaving their roles contacted me to say they found my regular mailings of information useful although they did not take part in any national activity. In addition, some regions have a representative who takes part in national activity and feeds back to other chairs. This made sense as an arrangement when the network met face to face. The section below explains how things have changed over the last year and how participation has increased. The point is, however, that lack of active participation in the network is not an indicator that a chair is neglecting their duties. There is continual turnover of chairs and on average one chair per month has joined or left the network.

The network met on
10th September 2020
2nd December 2020
3rd March 2021

This was one meeting less than planned, but there was agreement to cancel the June meeting and concentrate on regional meetings that were scheduled around that date, and to rely on regional representatives to take back a common agenda to each region. This decision made sense in the context of the pandemic.

### 1.7 Increased participation in the network during the year

There are nine English regional groups which cover everywhere in the country. London is unique in having a regional Safeguarding Adults Board with an established chairs' network attached to it, that

benefits from some dedicated administrative support. Each of the other regions relies on voluntary effort by chairs to network and take local coordinated action when it makes sense to do so on a regional basis. Last year's report said that our regional network was stronger and more active in some areas than others. This year the self-organising regional groups have all been meeting or sharing information and support during the pandemic, with one region getting together for the first time in some years. This is a welcome development arising from an unprecedented situation. The three meetings of the entire network have taken place using Zoom, and attendance has averaged 45 chairs which is a greater than 50% increase on numbers when we met in venues around the country. Using this platform has made it easier to have a panel of speakers in national leadership positions in a way that was logistically impossible for meetings in London or Birmingham. Their engagement with us has helped us meet our objective of being more influential, as well as giving us the latest information. As coordinator I have spent the last two years trying to get to know colleagues and their interests and skills so that they can lead and take forward pieces of work where the whole network benefits from their expertise and I would like to thank them for doing this.

The professional and volunteering experience of members is extensive, and colleagues bring a spread of knowledge and approaches. This is in turn means we can contribute to national debates. In terms of sector-led improvement, chairs with particular expertise can set out what good looks like. This in turn gives us all the basis to scrutinise, provide constructive challenge, and credibly call out shortcomings which leave adults with care and support needs at risk.

## Section 2: A model of self-led peer support – how we organise and sustain the network

### 2.1 Funding

The coordinator's role was funded through the Care and Health Improvement programme of the Local Government Association with additional days allocated due to the unprecedented situation and demands of the Covid 19 pandemic.

### 2.2 Network Chair/ Coordinator – Fran Pearson

One of the few paid roles in the network is that of national chair / coordinator. This combines administration with networking and influencing as well as being a conduit to all members. The role has always been filled by a SAB chair. The role is advertised every two years so this is my second and final report.

### 2.3 The Executive Group and their role

The Executive group of SAB independent chairs who have volunteered their help, has been a huge support to me as coordinator of the Network. I would like to thank them all.

| Name | Representing / bringing to the group | Chairs in |
|---|---|---|
| Fran Pearson | Coordinator | Leicester City; Leicestershire and Rutland; Newham |
| Fiona Bateman | Legal expertise; vice chair London | Barnet; Sutton |
| Adi Cooper | Attending as Care and Health Improvement Adviser from the Local Government Association | City & Hackney; Haringey |
| Tim Bishop | E Midlands | Northamptonshire |
| Mark Godfrey | Coordinator of 3-yearly member survey; prisons working group | Greenwich |
| Michael Preston-Shoot | London | Lewisham; Brent |
| Diane Hampshire | Yorkshire and the Humber | Wakefield |
| Anne Baxter then Darren Best | North East | Darlington; Teeswide |
| Ivan Powell | West Midlands | City of Bristol; Shropshire; Herefordshire |
| Deborah Stuart-Angus | East | Essex; Southampton |
| Simon Turpitt | South East | Surrey |
| Sian Walker | South West | Bath & North East Somerset; Lambeth |
| Shirley Williams | North West England and Greater Manchester | Warrington |

The role of the executive group has changed and formalised over the last two years. In 2021-2022 the aim is to review the executive terms of reference to reflect these changes. The positive developments have been

- Comprehensive representation from each region and a direct link back into each region
- Equitable sharing of work and projects on behalf of the network

- Subject (for example policing, probation, NHS, public health or social care) expertise that increases our credibility as a network and alongside that, connections to particular professional workstreams or organisations.

**Section 3: Making Safeguarding Personal**

**3.1** The network draws on examples from different boards in order to drive up safeguarding practice and collaboration / co-production with adults who have care and support needs. It recognises the role of their families, and others who are important to them. The range of work is broad, spanning community engagement to Care Act (2014) requirements about capturing, reporting on, and responding to individual experiences of safeguarding processes (Making Safeguarding Personal). The Making Safeguarding Personal Programme began in 2010, initiated by the Local Government Association and its importance was recognised in the Care Act. We draw on national frameworks or "toolkits" that help us set high and consistent standards on putting service users and their families at the heart of all we do. Another value of such a framework is that it supports our assurance work at our individual boards, meaning that chairs are all asking the same questions consistently, which in turn allows us to form a picture of the current effectiveness of our efforts. At the start of 2021 the London Safeguarding Adults Board established a London Safeguarding Voices Group that puts people with lived experience of safeguarding and their voices at the heart of safeguarding governance across our city. All SABs in London are now expected to recruit three people with lived experience by mid-May 2021. We will assess the value of this as an approach and share the learning across the network. Previously the network has drawn on examples from Leeds and Merseyside and will continue to use best practice to raise standards.

**Section 4: Our priorities for 2020-2021**

**4.1**

I would like to begin this section by offering our condolences to all those who lost loved ones in social care settings, secure institutions, hospitals, or in their own homes during the pandemic. On behalf of the network, I want to acknowledge the role of all professionals who delivered services to adults with care and support needs, often at considerable personal cost, and overlooked or rarely referenced in the media. Our network was also concerned about the stress for family carers as a result of reduced or suspended support services and managing increased risk whilst trying to keep their loved ones safe.

### 4.2 Our four priorities

**Prevention** - sharing and promoting the most impactful local initiatives with the aim of innovating, improving wellbeing; and reducing the need for safeguarding 'further upstream'. Includes service user/community engagement.

**To contribute and add value to strategic legislative and policy development by working with government and other relevant national bodies**

**Explore the opportunities to improve outcomes for adults at risk arising from new arrangements for children's safeguarding – particularly around transitions and Liberty Protection Safeguards**

**To lead and influence the development of accountability and assurance frameworks** that all SABs can draw upon, informed by the most current work on

Quality standards

Governance

Risk

Safeguarding Adults Reviews and their impact on safeguarding systems.

### 4.3 Network meeting agendas – all were planned to directly link to delivering our priorities

**September 2020**

I. The Insight Project – data collection and analysis from SABs to help us respond to safeguarding and Covid
II. Reviews, SARs and Learning: National SAR analysis; new methodology: "Safeguarding Adults Reviews in Rapid time"
III. Policing and our influence
IV. Local Resilience Forums and influence of SABs
V. Missing Adults

**December 2020**

I. Adults with learning disabilities and autism who also have complex mental health problems and behaviour that can challenge – the culture of closed environments / tracking the implementation of "Host Commissioner Guidance"
II. Covid and Safeguarding Research Project https://www.health.org.uk/funding-and-partnerships/programmes/covid-19-research-programme

III. First National Analysis of Safeguarding Adults Reviews - focus on sector-led improvement
IV. Human rights and care homes
V. Strengthening Advocacy – Making Safeguarding Personal

**March 2021**

I. Department for Health and Social Care Adult Safeguarding and Liberty Protection Safeguards Team
II. Escalating Safeguarding Adults Review issues of national importance
III. Understanding and appreciating what Fire and Rescue Services can bring to SAB
IV. Taking forward strategic improvement priorities from the national SAR analysis: SAB Chairs - SAB role in improving safeguarding.

**Progress on Priorities**

**Priority One: Prevention - introduction**

Our prevention work focused on learning rapidly from the early stages of the pandemic in order to reduce and prevent further harm. It therefore felt very different to previous years. This showed the network being agile and giving sector-led support by sharing experiences from around the country and contributing to the development of resources in partnership with other national organisations and programmes. The expression "hidden harms" was one increasingly used across national agencies and in the network. This refers to the kind of safeguarding issues that were taking place behind closed doors due to lockdown and which we wanted to assess the scale, prevalence and type of, but most importantly share practice on how to intervene and prevent them.

| Area of work | Achievement |
|---|---|
| **The "Insight Project" and "Issues for SABs"** | The Local Government Association and Association of Directors of Adult Social Service set up the COVID-19 Adult Safeguarding Insight Project to shed light on changes to adult safeguarding concerns and enquiries up to June 2020 and the impact of the first lockdown on safeguarding work. A second data collection then took place to see how Covid-19 continued to affect safeguarding activity during 2020. All councils in England were invited to take part in this voluntary return. The value of this work was recognised by SAB chairs who used it to explore local data for comparison. In addition, the same Covid and Safeguarding programme circulated and collated chairs' comments on two versions of the "Issues for SABs" grids. The purpose of these was to help SABs and partners |

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| | identify key areas for consideration in relation to safeguarding adults, actions that have been taken to mitigate risks for others to learn from, and further actions for SABs to consider within their own business planning as the lockdown rules were eased. It was a source of information and also a mechanism for escalating issues to a national level where clarification could be sought from national bodies or networks, as relevant. Finally, the grids were an opportunity to share good practice. |
| **Safeguarding Adults Reviews in Rapid Time** | Chairs took an active interest in work funded by the Department of Health and Social Care as part of the Covid-19 Action Plan for Social Care. The funded work was delivered by Social Care Institute for Excellence and was about developing with SABS a methodology called Safeguarding Adults Reviews in Rapid Time. Covid required an urgent need for a rapid process that was<br>• Proportionate given other demands<br>• Can identify learning from safeguarding incidents occurring in the new corona context<br>• Makes it possible to share locally, regionally and nationally in a timely way<br>• Relevant also as lock-down is eased; for recovery and renewal<br>Working with chairs, SCIE delivered:<br>• guidance and templates for the SAR In Rapid Time process and outcomes<br>• supporting familiarisation with the process with webinars, and remote support<br>The work continues and has now moved on to liaising with SABs to enable the submission of rapid review reports to the national SAR library, routine collation of learning, and dissemination of regular learning briefings. Four boards tested out the methodology and another nine boards joined a training cohort to develop local capacity to carry out these reviews. |
| **Advocacy and Making Safeguarding Personal** | The network had a presentation on a recently-published framework to help with setting standards and measuring success in one aspect of Making Safeguarding Personal that had become a particular focus during lockdown https://www.local.gov.uk/strengthening-role-advocacy-making-safeguarding- |

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| | personal. This was relevant to our work on hidden harms because as the toolkit sets out: Advocates have a regular presence in closed provider environments such as care homes, hospitals, mental health wards and treatment and assessment units. They provide additional safeguards in the prevention and identification of abuse and/or neglect. The potential contribution of advocacy to safeguarding in these environments can be further supported and enabled, including through commissioning of advocacy that has a focus on and supports this important aspect of the role. |
| **Assessing our effectiveness in working with Local Resilience Forums** | Network members have differing levels of knowledge about established local emergency arrangements called Local Resilience Forums. The network was invited to send representation to the national Foresight Project which included independent assessment of LRF effectiveness. This is turn led to chairs and business managers for Safeguarding Adults Boards developing a workshop together - to reflect on the findings of the final LRF review and to develop top tips on what LRFs are, and how to work with them most effectively. Over 60 business managers and 30 chairs signed up for the workshop on April 20th 2021. Relevant learning will be included in next year's report. |
| **Working with Fire and Rescue services** | Local Fire and Rescue Services are members of SABs. The aim of an item at the network meeting in March 2021 was to share best practice and raise awareness about the safeguarding work of the National Fire Chiefs Council. Fire service leads for the country, who each belong to different SABs, led the item and set out the benefits of joint working and their expectations of their own colleagues. There was considerable appreciation from chairs about the value of the fire service in getting into people's homes during the pandemic when many other services were restricted, and therefore linked to preventing hidden harms. The discussion also covered ongoing prevention work on hoarding disorders and self-neglect and how the service can support SABs. In addition, FRS safeguarding leads talked us through their internal work on raising standards and assessing how well local services were doing in adult safeguarding – a standard which they are inspected against. Overall, the item enabled chairs to assess how well their SAB was engaging with the fire service, and in the few instances where this was felt to be limited, how to address it. |

**Priority Two - To contribute and add value to strategic legislative and policy development – introduction**

The network already had strong links with the safeguarding policy network of the Association of Directors of Adult Services. And as this and previous reports set out, the network collaborates with, and consistently benefits from, the Care and Health Improvement Programme at the Local Government Association. We already had a long-established working relationship with the NHS Safeguarding Adults National Network. However, as the list above shows, our influence and value as a partner at the most relevant and strategic safeguarding forums, reached the level of influence that we had wanted to achieve. I attended the majority of these national meetings on behalf of the network. To make sure we all got the benefit of these new links, I

- Consulted the network when asked to do so or called on volunteers to do tasks such as commenting quickly and authoritatively on guidance from a SAB perspective
- Made suggestions about the framing of communications to the network. Particularly welcome were two letters from the Department of Health and Social Care
- Sent out information, sometimes immediately, if an urgent response was needed or there was important information to be shared rapidly.

| Area of work | What we achieved |
|---|---|
| **National Covid groups and our joint working with them, and engagement with the Department for Health and Social Care Adult Safeguarding Team** | By June 2020, the network was a member of the following groups<br>I. ADASS policy network – four times a year<br>II. Department of Health and Social Care Adult Safeguarding Forum, led by the Chief Social Worker for Adults – every month from June 2020 when it first met<br>III. Network coordinator's catch-up with Department for Health and Social Care Adult Safeguarding and Liberty Protections Safeguards Team – every month<br>IV. NHS Safeguarding Covid Partnerships Group – every two weeks<br>V. NHS Safeguarding Adults National Network – every week till June 2020, then every two weeks |

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| **Proportionality and assurance for SABs – a mutually supportive relationship with the policy leads at the Department for Health and Social Care** | we worked closely with this team over the year, first of all on responding to Covid, but as some of the examples below illustrate, on other longer term shared goals as well. In early April 2020 we discussed whether the pandemic meant that government might extend the principle of proportionality to two duties that SABs have to carry out under s43 and 44 of the Care Act – namely the production annual reports and carrying out Safeguarding Adults Reviews to certain standards. This resulted in a first helpful letter that was valued by chairs in May 2020, setting out what flexibilities were acceptable. This was followed by a second letter to chairs from the policy leads in January 2021 which usefully pulled together links to relevant resources and restated what a reasonable expectation of SABs would be as the country went into the second national lockdown. The same DHSC colleagues attended our network meeting in March 2021 and the other issues we progressed together are listed in the relevant sections of this annual report. |

**Priority Three - Explore the opportunities to improve outcomes for adults at risk arising from new arrangements for children's safeguarding – particularly around transitions and Liberty Protection Safeguards - Introduction**

Although some of our work this year covers adults' and children's safeguarding, this is the priority we made the least progress on as a network due to Covid.

| Area of work | Achievement |
|---|---|
| **Liberty Protection Safeguards** | The Liberty Protection Safeguards (LPS) will provide protection for people aged 16 and above who are, or who need to be, deprived of their liberty in order to enable their care or treatment and who lack the mental capacity to consent to their arrangements. The revised date for the implementation of this major change was confirmed during the year. It is currently set at April 2022. Through two chairs in our executive group, the network is linked into work that led by the Association of Directors of Adult Social Services. Because the Liberty Protection Safeguards will apply to people aged 16 and above, this an area where we can work with children's safeguarding colleagues at a national level. All work on LPS will become a focus of the network as Covid recovery begins. |

**Priority Four - To lead and influence the development of accountability and assurance frameworks - introduction**

Last year's report focused on our work building connections with the Care Quality Commission. This relationship has developed further, but it shows how far our network has come that this section sets out examples of working with a much wider set of national bodies that set standards and develop assurance frameworks that are relevant to SABs. For consistency and assurance, the first two sections on this priority return to issues I highlighted in last year's report. The remainder of this section is a shorter summary of achievements in other pieces of joint work.

| Area of work | Achievement |
|---|---|
| **Actions from the national analysis of Safeguarding Adults Reviews** | As reported last year, this national analysis was a first for adult safeguarding. This report was commissioned by the sector-led Care and Health Improvement Programme (CHIP), co-produced and delivered by the Local Government Association (LGA) and the Association of Directors of Adult Social Services (ADASS) in England. One of the authors, Professor Michael Preston-Shoot is SAB chair in Brent and Lewisham and network member – this added to our conversations at the network however network members took part in many of the webinars and events organised in the run up to publication of the report. https://www.local.gov.uk/analysis-safeguarding-adult-reviews-april-2017-march-2019<br>Network meetings this year have focused on defining what follow-on actions are the greatest priority and identifying chairs to join the sector-led work on them. The recommendations from the report fall into five areas (with thanks to Cumbria SAB, whose action plan this is taken from).<br><br>A. SAB practice on the conduct and commissioning of SARs<br>B. Supporting sector wide learning from SARs<br>C. Support for adult safeguarding practice improvement<br>D. Revision to national policy/guidance<br>E. Further research to inform sector led improvement initiatives<br><br>At the March network meeting, Jeanette McDiarmid, chair of Cumbria SAB, shared Cumbria's action plan. This was a useful template for all SABs particularly any that were yet to start work to assure themselves about the |

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| | conduct and commissioning of SARs. Two task and finish groups were also set up at national level. The first to work on the safeguarding practice improvement that the national analysis indicates is vitally needed, and the second working with Social Care Institute for Excellence to finish SAR Quality Markers that were the previous work of SCIE and involved the network. |
| **Developing an escalation protocol in order to address issues from SARs** | The National Analysis of SARs included a priority recommendation that *SABs, regionally and nationally, should discuss the role of SARs in sharing learning with central government departments and national regulatory bodies, and holding them to account when findings require a response that is beyond the scope of local SABs*. Subsequent discussions with safeguarding policy leads at the Department of Health and Social Care clarified that a nationally agreed escalation protocol would be helpful to confirm a process for escalating issues that arise from local Safeguarding Adults Reviews, which require a national response. Thanks to the willingness of everyone involved, within three weeks of the DHSC policy leads attending our meeting, they had jointly drafted a protocol with the Care and Health Improvement Team at the Local Government Association. |
| **Championing and influencing quality assurance for adults with learning disabilities and autism** | Last year's annual report set out our intentions in response to the BBC Panorama programme in May 2019 that exposed abuse of adults with learning disabilities and autism at Whorlton Hall private hospital. Extensive work by the Care Quality Commission and NHS England has taken place on what are increasingly known as "closed cultures". I circulated relevant material to chairs over the year including the Association of Directors of Adult Social Services "Safeguarding during Covid" which chairs said they found helpful. However, as a network we have additional and ongoing concerns about the inequalities faced by adults with learning disabilities. The media highlighted one aspect of this in relation to Covid vaccination – on behalf of the network I had raised this issue when vaccination priority groups were set out, and sadly it was one that neither we nor other organisations or campaign groups were able to influence. Health inequalities and discrimination mean that adults with learning disabilities die younger than they should and in too many cases, without the right care. The Learning Disabilities Mortality Review (LeDeR) programme is funded by NHS England. Its overall aims are: |

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| | • To support improvements in the quality of health and social care service delivery for people with learning disabilities.<br>• To help reduce premature mortality and health inequalities for people with learning disabilities.<br><br>Individual SABs need to assure themselves on the local picture from LeDeR reviews but the national annual report is an opportunity for the network to engage at network level. I invited the National Safeguarding Advisor Children and Adults for the CQC, and NHS England's National Clinical Director for Learning Disability and Autism to our December 2020 meeting to update us and have a panel discussion. In order to keep the adults who have to use these services at the centre of our conversation I also invited the director the Learning Disability Network that innovates and develops services to help adults with the most complex and challenging needs to move to new and appropriately less restrictive settings. Because our concerns were many, it was useful to receive assurance on what actions the Care Quality Commission and NHS England were taking. As a result of our engagement, from April 2021 I will be representing the network on the newly formed national oversight board for a responsibility introduced in 2020, called Host Commissioner, which is intended to provide a robust new layer of oversight for adults with learning disabilities and autism placed in hospitals far from their home. |
| **Responding to consultations on national issues** | Thanks to chairs who took on work at short notice and to organisations who sought our views, we responded to consultation or requests for conversations on the following<br>– National Institute for Health and Clinical Excellence consultation on guidance on safeguarding adults in care homes https://www.nice.org.uk/guidance/ng189<br>– Local Resilience Forums – representation on a national working group - the Foresight Project<br>– Various aspects of policing and the prosecution of crimes against older people<br>– Public Health England Covid Test and Trace system – developing a consistent approach on responding to Welfare Concerns |

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| | – Missing Adults National Framework following the All-Party Parliamentary Group of the same name https://www.missingpeople.org.uk/for-professionals/information-and-policy/policy/a-national-framework-for-the-response-to-adults-missing-from-health-and-care-settings<br>– Developing principles for adult safeguarding concerns related to People in Positions of Trust: task and finish group due to report July 2021, co-chaired by a SAB chair and SAB business manager. A joint project with the NHS Safeguarding Adults National Network. |

**Section 5: Looking ahead to 2021 and 2022 - Next steps on our priorities including the impact of Covid on adult safeguarding**

**5.1** As we hopefully move into a period of Covid recovery, the network can plan and prioritise its work for the year ahead. 2020-2021 involved being responsive to circumstances and temporarily putting to one side some of the work we had intended to do. Without pre-empting a priority setting exercise, it seems likely that over the year we will work on the following areas and report to you on our progress next year.

**5.2 Inequalities and disparities for adults with care and support needs who require safeguarding.** To include the impact of and continuing experience of SAB work on the Black Lives Matter agenda.

**5.3 Hidden Harms** including adults with learning disabilities in segregation or placed in settings where there is a "closed culture"'; the issues uncovered as care homes continue to open up; the impact of shielding or the closure of services and less face-to-face delivery of services.

**5.4 Liberty Protection Safeguards** including the significant task of resourcing and implementing changes but also the opportunity of working with safeguarding children's partnerships on implementation for 16-17 year-olds.

**5.6 Working across integrated care footprints.** This means assessing how SABs and adult safeguarding fit with substantial NHS reorganisations which are currently under way. Looking ahead we need to resume our plans to make the most of this opportunity including that of working with safeguarding children's partnerships with whom we may have much in common on this issue.

**5.7 Responding to the SARs analysis** will continue to be a focus as different workstreams complete their tasks. The volume of work over the year has been substantial but we need to share best practice and support each other with assurance methods, and the highest standards of governance so we can make an impact with these reviews.

**Thank you for reading this:**

I would like to conclude by again offering our condolences to all those who lost loved ones in social care settings, secure institutions, hospitals, or in their own homes during the pandemic. It has been a year like no other and the network has been a real source of mutual support.