Richmond and Wandsworth Safeguarding Adults Board

# RICHMOND & WANDSWORTH SAFEGUARDING ADULTS BOARD

## ANNUAL REPORT 2020 - 2021

# CONTENTS

# INTRODUCTION

The Care Act 2014 requires all local authorities to set up a Safeguarding Adults Board with key statutory partners including local Police and the local Clinical Commissioning Group. The Safeguarding Adults Board is a statutory, multi-agency partnership and its core duties are to:

- Develop and publish a strategic plan setting out how they will meet their objectives and how their member and partner agencies will contribute.
- Publish an annual report detailing how effective their work has been.
- Commission Safeguarding Adult Reviews for any cases which meet the criteria.

The main objectives of the Board are to ensure that safeguarding arrangements across the partnership work effectively to prevent abuse and neglect, and to protect people with care and support needs who may be at risk of abuse or neglect.

This report covers the work of the Richmond and Wandsworth Safeguarding Adults Board (RWSAB) from April 2020 to March 2021.

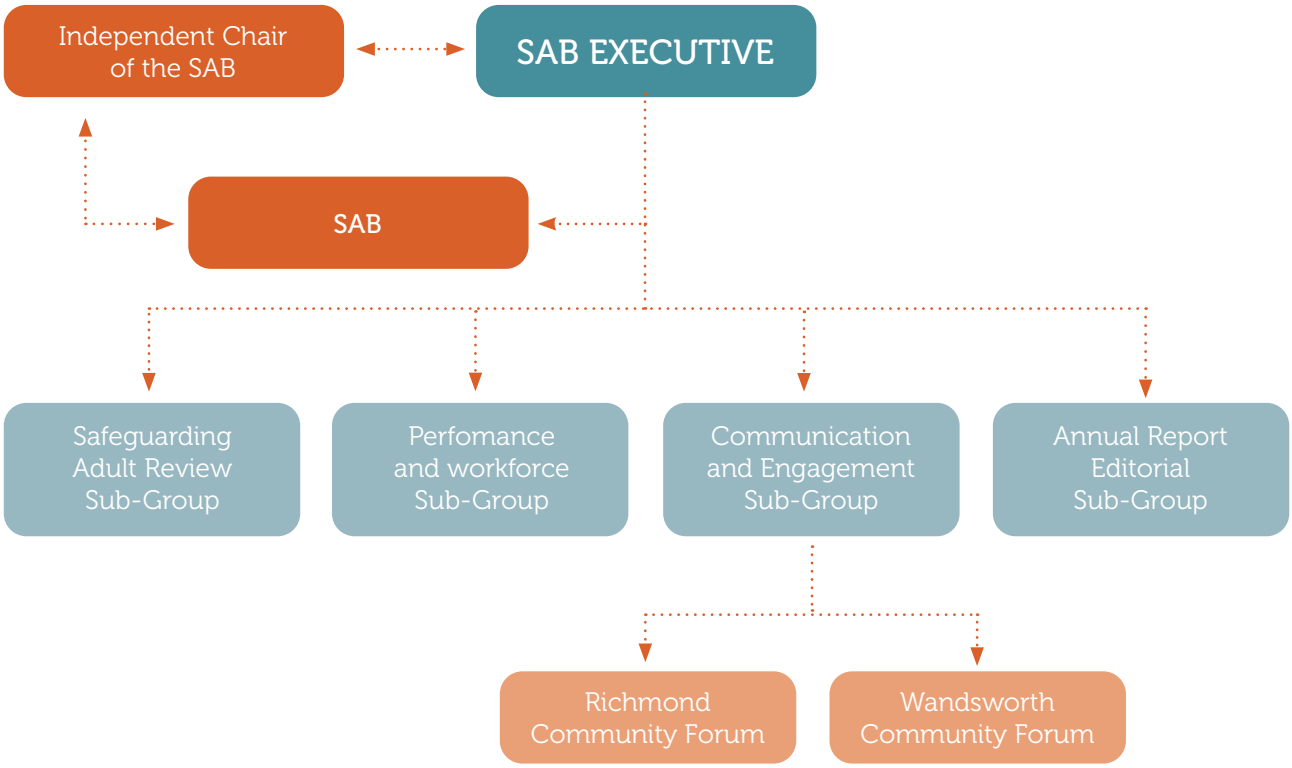
# 02

# PURPOSE AND STRUCTURE

The statutory purpose of the Richmond and Wandsworth Safeguarding Adults Board is to help and safeguard adults with care and support needs. It does this by:

- Working collaboratively to prevent abuse and neglect where possible.
- Ensuring agencies and individuals give timely and proportionate responses when abuse or neglect have occurred.
- Seeking assurance that local safeguarding arrangements are in place as defined by the Care Act 2014 and statutory guidance.
- Seeking assurance that safeguarding practice is person-centered and outcome focused.
- Seeking assurance that safeguarding practice is continuously improving and enhancing the quality of life of adults in its area.

# Structure of the RWSAB




# 03

# OVERVIEW OF RWSAB ACTIVITIES AND ACHIEVEMENTS

## Independent Chair

- Supportive approach to Safeguarding Adults Board Executive through the COVID-19 pandemic response.
- Introduced and promoted the Richmond and Wandsworth Safeguarding Adults Practice Awards.
- Supported the activities of the Sub-groups.
- Maintained collaboration and joint working with Kingston Safeguarding Adults Board.
- Developed a 7-minute briefing on Safeguarding and Policing and presented it to the Senior Representatives of South West Basic Command Unit (SW BCU) for cascading through departments.
- Initiated and chaired a successful Partnership Boards Chairs' Meeting in November 2020, which looked at areas for collaboration between different Boards in Richmond and Wandsworth (i.e., Health and Wellbeing Board, Community Safety Partnership, Childrens Safeguarding Partnerships). Some themes around training, awareness raising and communications were identified as areas for collaboration and closer connections between the Boards.
- Contributed regular blogs to the newsletter to enhance partnership engagement.
- Maintained connection with the National and London Safeguarding networks.
- Obtained assurance that Safeguarding remained a priority for all partner agencies. Examples include partnership meetings, such as SW BCU weekly Safeguarding meeting, Strategic Care Homes Oversight Group.

## RWSAB Executive

- Met six times.
- Monitored and reviewed budget and risk log.
- Received regular reports from the sub-groups.
- Signed-off five completed Safeguarding Adult Reviews.
- Hosted a successful Learning Event on Understanding Legislation during National Safeguarding Adults Week Nov 2020.
- Consolidated partnership relationships amongst strategic partners.
- Signed-off RWSAB 2019/20 annual report and shared with partners.
- Hosted a remote Annual General Meeting attended by over 30 people from 22 RWSAB member agencies.

## Safeguarding Adult Review (SAR) Sub-group

- Met eight times.
- Considered nine SAR referrals and recommended progression on two referrals.
- Commissioned one new Safeguarding Adult Review, piloting the new 'SAR in Rapid Time' methodology with immense success.
- Considered five completed Safeguarding Adult Review reports and action plans.
- Received and shared learning from one Practice Reflection Review.
- Reviewed and updated the Safeguarding Adult Review Protocol.
- Undertook thematic analysis of Safeguarding Adult Reviews and a "deep-dive" of Safeguarding Adult Review involving young people transitioning between children and adult health and care services.
- Contributed to regional and national Safeguarding Adult Review activities through contribution to the Association of Directors of Adult Social Services (ADASS) networks.

## Performance and Workforce Sub-group

- Met four times.
- Updated the Workforce Training Standards Framework.
- Revised the performance dashboard and data summaries.
- Monitored Safeguarding performance across the partnership during the COVID-19 pandemic.
- Organised a well-received Virtual Masterclass on 'Change-resistant Drinkers.'
- Monitored and promoted the implementation and adoption of a Common Safeguarding Objective amongst all partner agencies.
- Drafted six 7-minute learning summaries to share knowledge from Local and national Safeguarding Adult Reviews and Professional Reflections.

## Communication and Engagement Sub-group

- Met four times and both borough-based Community Forums met four times each.
- Benefit from active remote participation by partners and supported sharing of agencies' work during the COVID-19 pandemic.
- Produced six Newsletters to share information and provide updates on the work of the SAB.
- Focused on sharing information about Covid-19 and raising awareness about scams, particularly those around Covid-19 testing and NHS services.
- Moved to a separate, stand-alone website - www.sabrichmondandwandsworth.org.uk/
- Promoted awareness of agencies' new 'Duty to Refer' to prevent homelessness.
- Encouraged better partnership working through the "What to expect from a Safeguarding Adults Referral", 7-minute briefing.
- Shared information on social media during National Safeguarding Adults Week 16th to 22nd November 2020.

# 04

# REVIEW OF ACHIEVEMENTS IN RELATION TO THE BUSINESS PLAN

The Safeguarding Adults Board ensured that all actions in the business plan were completed or substantially progressed. Some significant achievements are:

- Safeguarding Adults Board Executive and all sub-groups continue to function effectively.
- Promoted regular information sharing across the partnership through the newsletter.
- Maintained the Safeguarding Adults Board website to promote sharing of resources and provide the public with information about the Board.
- Produced an accessible electronic Safeguarding Adults Board annual report.
- Promoted shared learning from Safeguarding Adult Reviews through sharing reports and 7-minute learning summaries.

- Sponsored enhanced legal literacy across the partnership through an effective Learning Event on 'Understanding Legislation'

- Raised awareness on keeping safe during the COVID-19 pandemic, prevention of financial abuse and on preventing and managing pressure ulcers.

- Promoted partnership working and effective risk management by highlighting the Multi-agency Risk Assessment Framework.

- Supported improved understanding of multi-agency working for young people with mental health issues through the Mental Health Transitions Framework.

- Recognised workforce excellence though the introduction of the Safeguarding Adults Practice Awards.

- Continued to support positive multi-agency working through forums such as the Wandsworth Community Multi-agency Risk Assessment Panel (CMARAP), the Richmond Vulnerable Adults Multi-agency panel (VAMA ) and South West London Safeguarding Leads Forum.

# 05

# RICHMOND AND WANDSWORTH PERFORMANCE INFORMATION

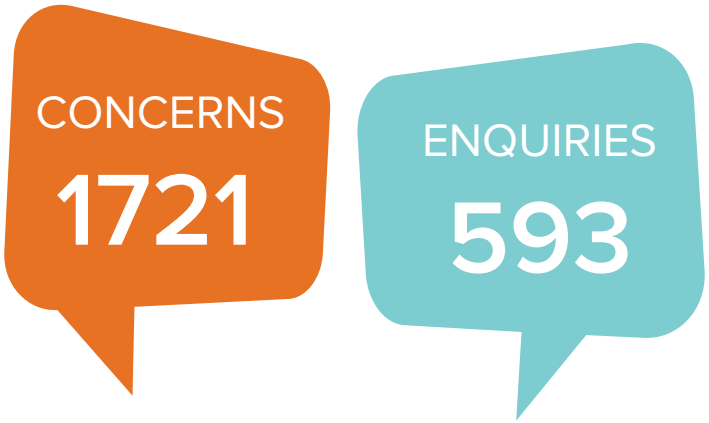
## RICHMOND

### Safeguarding in numbers – Safeguarding figures

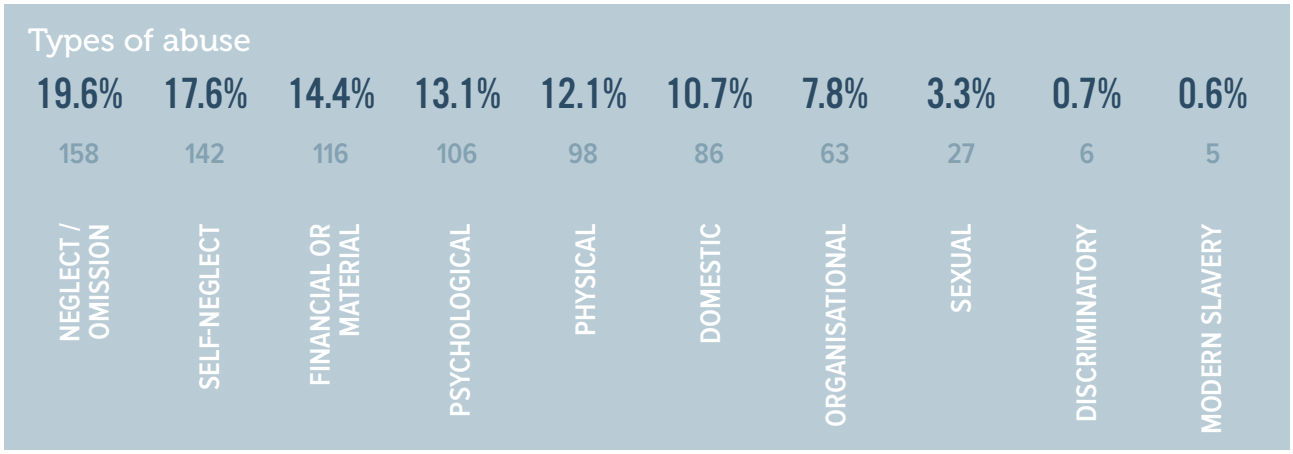
#### Safeguarding Concerns and Enquiries

A safeguarding concern is any issue raised with Adult Social Services which is identified as being about an adult safeguarding matter. Concerns are reviewed, risk assessed and resolved, or when deemed to not concern a safeguarding issue – dealt with through another appropriate route. If assessed to meet the criteria for an adult safeguarding, a Section 42 Enquiry is raised, which involves fuller investigation and formal intervention.

In the context of the COVID-19 pandemic there was a national increase in both safeguarding concerns and enquiries for 2020/21[1]. This trend was reflected locally in Richmond by an increase of 34% compared to the number recorded for last year. Likewise, the number of enquires increased by 29% compared to last year.




1 Based on the COVID-19 Adult Safeguarding Insight Project Final Report, December 2020.



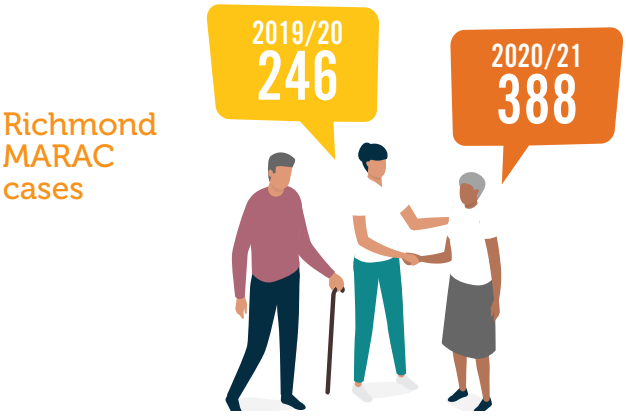

## Types of Abuse[2]

As in previous years, the top 3 types of abuse included Neglect, Self-neglect, and Financial/ material abuse. A noteworthy feature of the current year was a significant (56%) increase in domestic abuse. A total of 86 safeguarding enquires involving Domestic Abuse were completed, compared to 38 last year. This trend is also seen in Police data which showed an increase in reported Domestic Abuse offences across Richmond to a total of 1297 cases. In response to concerns about the emerging increase in Domestic Abuse cases during the initial stages of the Covid-19 pandemic, South-West Basic Command Unit (SW BCU) operated an enhanced approach to dealing with Domestic Abuse. This focused on prevention, intervention, and enforcement. It led to a significant (36%) increase in Multi-Agency Risk Assessment Conference (MARAC[3]), and Safeguarding referrals. It also increased the rate of 'detection' (i.e., perpetrators charged and appearing at court). The intention is for the police to continue with the enhanced approach to Domestic Abuse.

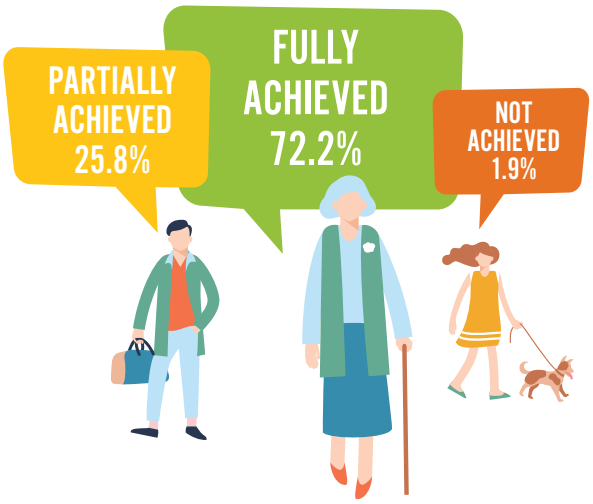
There was also a substantial increase (40%) in the number of enquires which involved psychological abuse where 106 cases were considered this year, compared to 64 last year.

The local trend in the distribution of cases across abuse types and the sharp increase in Domestic Abuse mirrors the national picture during the COVID-19 pandemic. A notable feature locally is that there were 5 cases of suspected Modern-Day slavery this year compared to zero last year. This is likely to reflect a heightened awareness of this type of abuse.

In line with previous years and Richmond's demography, most of the people who experience abuse or neglect are older adults (aged 65 and over). In terms of the relationship between age and abuse type; older adults are more likely to experience Financial abuse, Neglect and Self-neglect than working aged adults (18-64-years-old). Psychological and Physical abuse is most prevalent in working aged adults. Domestic abuse occurs across all adult age ranges.




2 A single enquiry may consider more than one type of abuse – hence there are more Types of abuse than safeguarding enquiries.
3 The MARAC is a monthly risk management meeting where professionals share information on high-risk cases of domestic violence and abuse and put in place a risk management plan.





| Completed Enquiries Outcomes 2020/21 | % |
|---|---|
| Fully Achieved | 72.2% |
| Partially Achieved | 25.8% |
| Not Achieved | 1.9% |

| Completed Enquiries which met criteria | No | % |
|---|---|---|
| Risk removed or reduced | 468 | 92.3% |
| Risk remains | 39 | 7.7% |

## Making Safeguarding Personal[4]

An important success measure of 'Making Safeguarding Personal' is the extent to which the person's desired outcomes are met. Locally, Making Safeguarding Personal is well embedded in practice, with 98% of people's outcomes being fully or partially met. In the less than 2% of cases where outcomes were not met, this is usually due to the person not engaging with the process or being unable to articulate if they consider that their outcomes were met. Almost twice as many people expressed a desired outcome compared to last year, which shows improvement in practice.

## Impact on Risk

Adult safeguarding aims to remove or reduce the risk to the adult. It is not always possible to completely remove risk and the risk will remain in cases where adults with capacity make a decision to continue living with an elevated level of risk. The impact of Safeguarding on risk is exceptionally good with the risk removed or reduced in over 92% of cases. Where the risk remains, this is usually the result of people choosing to live with risk and understanding the implications of it.

4 Making Safeguarding Personal (MSP) is a sector-led initiative which aims to develop an outcomes focus to safeguarding work, and a range of responses to support people to improve or resolve their circumstances.

| DoLS | 19/20 | % | 20/21 | % |
|---|---|---|---|---|
| Number of Requests Received | 768 | | 754 | |
| Granted | 570 | 74.2 | 494 | 65.5 |
| Not Granted | 158 | 20.6 | 227 | 30.1 |
| Not yet signed off by Supervisory Body | 40 | 5.2 | 33 | 4.4 |

## Deprivation of Liberty Safeguards (DoLS)

The Deprivation of Liberty Safeguards is an amendment to the Mental Capacity Act 2005. The Mental Capacity Act allows restraint and restrictions to be used only if they are in a person's best interests and they lack capacity to make decisions about their care or treatment. The Deprivation of Liberty Safeguards can only be used if the person will be deprived of their liberty in a care home or hospital. In other settings, the Court of Protection can authorise a deprivation of liberty. In July 2018, the government published a Mental Capacity (Amendment) Bill, which passed into law in May 2019. This law will replace the current Deprivation of Liberty Safeguards (DoLS) with the Liberty Protection Safeguards (LPS). The initial plan to implement the new model in October 2020 was delayed due to the COVID-19 Pandemic and the expected implementation is now post April 2022. There will be a year-long changeover when the current system and the new system run concurrently to ease the transition of existing cases. The code of practice is currently being developed. Additional information on Liberty Protection Safeguards can be sourced via the Government factsheets.

The total number of DoLS authorisations received in Richmond remained relatively static. The number of requests received but not yet authorised has reduced marginally, indicating improved throughput for applications. All requested authorisations are reviewed and monitored to ensure that the most urgent are prioritised and there is a process in place to ensure renewals are addressed to minimise breaks in the authorisation. A summary of the number of Deprivation of Liberty Safeguards requests and authorisations in Richmond during 2020/21 is shown above.

# Preventive interventions

During the past year because of COVID-19 restrictions, awareness raising has been carried out through social media and information published on the website on issues such as COVID-19 related scams and how to identify and get help with safeguarding concerns.

Whilst home fire safety remained a priority, the number of visits to people's homes was reduced to those who were considered extremely high risk and following a robust COVID-19 risk assessment. A total of 329 home fire safety visits were conducted compared to 1499 in 2019/20.

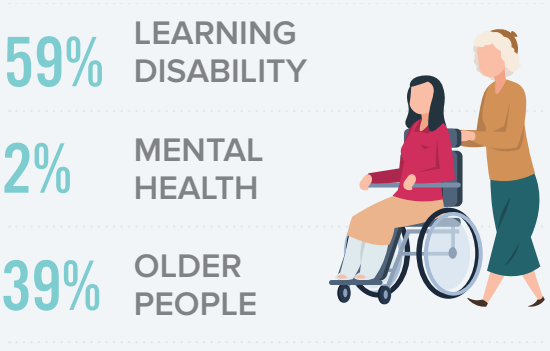
## Provider Quality

During the first half of the financial year, the Care Quality Commission (CQC) suspended routine inspections and focused on targeted visits to check on Infection, Prevention, and Control standards in care homes in the context of the COVID-19 pandemic. Locally all care homes were found to have good Infection, Prevention, and Control measures in place and no significant concerns were identified. Inspection was re-started during the latter part of the year, with a focus on three quality standards – Safe, Responsive, and Well-Led. Richmond homes retained their Good or Outstanding ratings and there are no homes rated Inadequate by CQC. This indicates that quality across the borough remains good. One Care Home recently opened and has not yet been rated by CQC.

### Provider Quality


| Care Homes CQC Rating | No | % |
|---|---|---|
| Outstanding | 2 | 5% |
| Good | 40 | 93% |
| Requires improvement | 1 | 2% |
| Grand Total | 43 | |

### Care Home Type




| Care Home Type | No | % |
|---|---|---|
| Learning disabilities | 26 | 59% |
| Mental health | 1 | 2% |
| Older people | 17 | 39% |
| Total | 44 | |

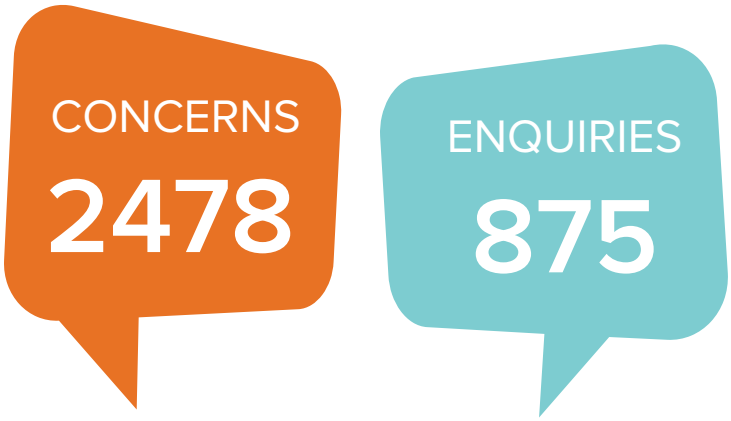
# WANDSWORTH

## Safeguarding in numbers – Safeguarding figures

### Safeguarding Concerns and Enquiries

A safeguarding concern is any issue raised with Adult Social Services which is identified as being about an adult safeguarding matter. Concerns are reviewed, risk assessed and resolved, or when deemed to not concern a safeguarding issue – dealt with through another appropriate route. If assessed to meet the criteria for an adult safeguarding, a Section 42 Enquiry is raised, which involves fuller investigation and formal intervention.

In the context of the COVID-19 pandemic there was a national increase in both safeguarding concerns and enquiries for 2020/21[5]. Locally in Wandsworth there was no significant increase in the volume of concerns; however the volume of safeguarding enquiries increased by 18% compared to the number recorded for last year.




5 Based on the COVID-19 Adult Safeguarding Insight Project Final Report, December 2020.

Types of abuse

| 20.2% | 17.5% | 15.4% | 15.1% | 15.0% | 7.6% | 5.2% | 3.1% | 0.6% | 0.1% | 0.1% |
|---|---|---|---|---|---|---|---|---|---|---|
| 225 | 195 | 171 | 168 | 167 | 85 | 58 | 34 | 7 | 1 | 1 |
| NEGLECT / OMISSION | SELF-NEGLECT | FINANCIAL OR MATERIAL | PHYSICAL | PSYCHOLOGICAL | DOMESTIC | SEXUAL | ORGANISATIONAL | DISCRIMINATORY | MODERN SLAVERY | RADICALISATION |

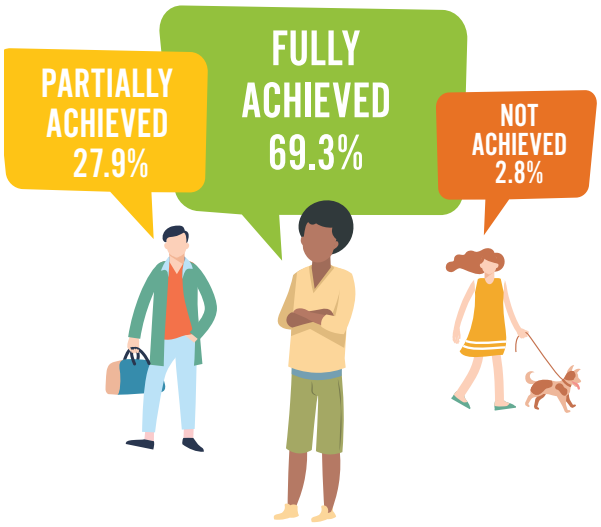
## Types of Abuse[6]

As in previous years, the top 3 types of abuse included Neglect, Self-neglect, and Financial/ material abuse. A significant feature of the current year was a substantial (45%) increase in Domestic Abuse. A total of 85 safeguarding enquires involving Domestic Abuse were completed, compared to 47 last year. This trend is also seen in Police data which showed an increase in reported Domestic Abuse offences across Wandsworth to a total of 2737 cases. In response to concerns about the emerging increase in Domestic Abuse cases during the initial stages of the COVID-19 pandemic, South-West Basic Command Unit (SW BCU) operated an enhanced approach to dealing with Domestic Abuse. This focused on prevention, intervention, and enforcement. It led to a significant (34%) increase in Multi-Agency Risk Assessment Conference (MARAC[7]), and Safeguarding referrals. It also increased the rate of 'detection' (i.e., perpetrators charged and appearing at court). The intention is for the police to continue with the enhanced approach to Domestic Abuse.

The local trend in the distribution of cases across abuse types and the sharp increase in Domestic Abuse mirrors the national picture during the COVID-19 pandemic.

In line with Wandsworth's population data, the largest proportion of people who experience abuse or neglect are older working aged adults, aged 45-64. Working aged adults (aged 18 – 64) most often experience Physical, Psychological or Sexual abuse. Older adults (over 65) predominantly experience Financial abuse, Neglect/Omission and Self-neglect.


6 A single enquiry may consider more than one type of abuse – hence there are more types of abuse than safeguarding enquiries
7 The MARAC is a monthly risk management meeting where professionals share information on high-risk cases of domestic violence and abuse and put in place a risk management plan





| Completed Enquiries Outcomes 2020/21 | % |
|---|---|
| Fully Achieved | 69.3% |
| Partially Achieved | 27.9% |
| Not Achieved | 2.8% |

| Completed Enquiries which met criteria | No | % |
|---|---|---|
| Risk removed or reduced | 715 | 92.5% |
| Risk remains | 55 | 7.1% |
| No action taken under safeguarding | 3 | 0.4% |

## Making Safeguarding Personal[8]

An important success measure of the 'Making Safeguarding Personal' is the extent to which the person's desired outcomes are met. Locally, Making Safeguarding Personal is well embedded in practice, with 97% of people's outcomes being fully or partially met. In the less than 3% of cases where outcomes were not met, this is usually due to the person not engaging with the safeguarding process or being unable to articulate if they consider their outcomes were met. The number of people asked and expressing outcome wishes has increased by 26% compared to last year.

## Impact on Risk

Adult safeguarding aims to remove or reduce the risk to the adult. It is not always possible to completely remove risk and the risk will remain in cases where adults with capacity make a decision to continue living with an elevated level of risk.

The impact of Safeguarding on risk is exceptionally good with the risk removed or reduced in over 92% of cases. Where the risk remains, this is usually the result of people choosing to live with risk and understanding the implications of it. Where no action is taken, individuals who have capacity refuse to engage in safeguarding or through the enquiry it is apparent that there was no risk.

8 Making Safeguarding Personal (MSP) is a sector-led initiative which aims to develop an outcomes focus to safeguarding work, and a range of responses to support people to improve or resolve their circumstances.

| DoLS | 19/20 | % | 20/21 | % |
|---|---|---|---|---|
| Number of Requests Received | 991 | | 1080 | |
| Granted | 706 | 71.2 | 673 | 62.3 |
| Not Granted | 232 | 23.4 | 332 | 30.7 |
| Not yet signed off by Supervisory Body | 53 | 5.3 | 75 | 6.9 |

## Deprivation of Liberty Safeguards (DoLS)

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

In July 2018, the government published a Mental Capacity (Amendment) Bill, which passed into law in May 2019. This law will replace the current Deprivation of Liberty Safeguards (DoLS) with the Liberty Protection Safeguards (LPS). The initial plan to implement the new model in October 2020 was delayed due to the COVID-19 Pandemic and the expected implementation is now post April 2022. There is a year-long changeover when the current system and the new system run concurrently to ease the transition of existing cases. The code of practice is currently being developed. Additional information on Liberty Protection Safeguards can be sourced via the Government factsheets.

The total number of authorisations received in Wandsworth was slightly higher than last year with a total of 1080 requests for authorisation received. The number of requests received but not yet authorised increased slightly to 75 from 53 last year. This is associated with the increased volume of requests for authorisations. All requested authorisations are reviewed and monitored to ensure that the most urgent are prioritised and there is a process in place to ensure renewals are addressed to minimise breaks in the authorisation. A summary of the number of Deprivation of Liberty Safeguards requests and authorisations in Wandsworth during 2020/21 is shown above.

# Preventive interventions

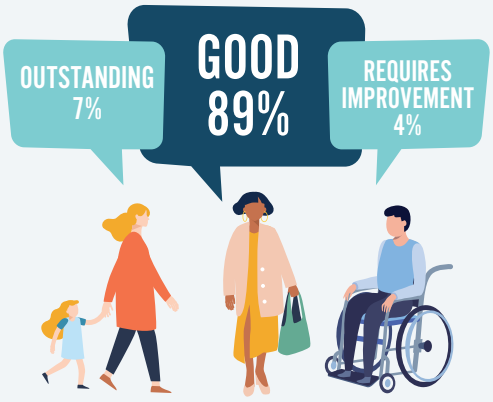
During the past year because of COVID-19 restrictions awareness raising has been carried out through social media and information published on the website on issues such as COVID-19 related scams and how to identify and get help with safeguarding concerns.

Whilst home fire safety remained a priority the number of visits to people's homes was reduced to those who were considered extremely high risk and following a robust COVID-19 risk assessment. A total of 484 home fire safety visits were conducted compared to 1907 in 2019/20.

## Provider Quality

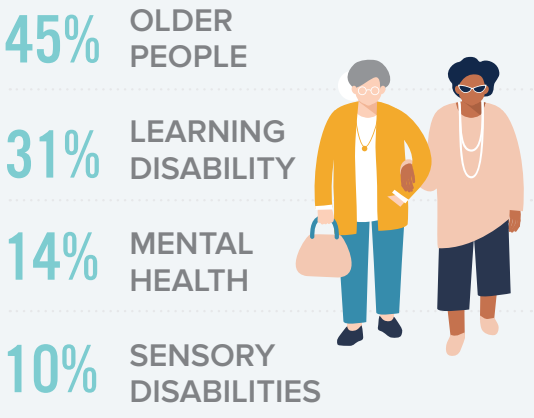
During the first half of the financial year, the Care Quality Commission (CQC) suspended routine inspections and focused on targeted visits to check on Infection, Prevention, and Control standards in care homes, in the context of the COVID-19 pandemic. Locally all care homes were found to have good Infection, Prevention, and Control measures in place and no significant concerns were identified. Inspection was re-started during the latter part of the year, with a focus on three quality standards – Safe, Responsive, and Well-Led. Two Wandsworth homes improved their rating from 'Requires Improvement' to 'Good'. Consequently, only one local care home is rated 'Requires Improvement' and there are no care homes rated 'Inadequate'. One Care Home recently opened and has not yet been rated by CQC.

### Provider Quality




| Care Homes CQC Rating | No | % |
|---|---|---|
| Outstanding | 2 | 7% |
| Good | 25 | 89% |
| Requires improvement | 1 | 4% |
| Grand Total | 28 | |

### Care Home Type




| Care Home Type | No | % |
|---|---|---|
| Older people | 13 | 45% |
| Learning disabilities | 9 | 31% |
| Mental health | 4 | 14% |
| Sensory disabilities | 3 | 10% |
| Total | 29 | |

# 06

# LEARNING DISABILITY MORTALITY REVIEWS (LEDER)[9]

The national programme aimed at making improvements to the lives of people with learning disabilities is known as Learning Disability Mortality Reviews (LeDeR). It requires that reviews are carried out following the death of anyone with a learning disability.
The purpose of the review is to identify whether there are any concerns or areas of learning to improve the health and quality of care for people with learning disabilities. These reviews are conducted by South West London Clinical Commissioning Group (CCG) and the findings are reported to NHS England. South West London is high performing in terms of the timeliness of completion of these reviews and delivered 99% on time, which is higher than both the London and national average.

9 Data taken from SWL CCG LeDeR Annual Report.

The LeDeR reviews undertaken in the past year in the context of the COVID-19 pandemic, showed an overall increase in the death rate for people with Learning Disabilities, specifically during the first phase (March 2020-May 2020). In Richmond, 45% of the deaths of people with Learning Disabilities recorded COVID-19 as the cause of death, while this was 35% in Wandsworth.

Respiratory disease remained the most common cause of death for people with Learning Disabilities. This is distinct from the general population where respiratory disease is the third most common cause .
A key area of national concern during the COVID-19 pandemic was the promotion of 'Do Not Attempt Cardio-Pulmonary Resuscitation' (DNACPR) directives. Assurance was obtained that this was not a feature locally in either Richmond or Wandsworth for people with Learning Disabilities. It is encouraging to note that family members reported positively on their experiences of interacting with acute hospitals during the COVID-19 pandemic. They stated that they were kept informed, were involved in decision making and were accommodated regarding hospital visits.

After targeted awareness raising and training for GPs and their staff, there was an improved take-up of annual health checks of people with Learning Disabilities across South-West London.

More details on LeDeR and programme reports, can be found on the SWL CCG website.

| LeDeR | COVID-19 recorded as cause of Death | Other Causes of Death recorded | Total Deaths for people with learning disability 2020/21 | % COVID as cause of death |
|---|---|---|---|---|
| Richmond Cases | 5 | 11 | 16 | 45% |
| Wandsworth Cases | 7 | 20 | 27 | 35% |

07

# LEARNING FROM SAFEGUARDING ADULT REVIEWS

## Safeguarding Adult Review Referrals

During the year nine Safeguarding Adult Reviews (SARs) referrals were considered (five from Richmond and four from Wandsworth), two of which met the criteria for a SAR (one in Richmond and one in Wandsworth).

Four SARs from Wandsworth and one from Richmond agreed in previous years were completed and learning is presented below

**Safeguarding Adult Review Referrals**

| | SAR Referrals received | Met criteria for SAR |
|---|---|---|
| Richmond | 5 | 1 |
| Wandsworth | 4 | 1 |
| **TOTAL** | **9** | **2** |

**Completed Safeguarding Adult Reviews**

| | Completed SARs |
|---|---|
| Richmond | 1 |
| Wandsworth | 4 |
| **TOTAL** | **5** |

# Richmond

Michael was a talented musician and artist who lived alone in Richmond. He experienced poor mental health over many years, and had a diagnosis of schizoaffective disorder, which was complicated by using controlled drugs. He had frequent admissions to hospital and received support from Mental Health Services. Michael had a long history of inconsistent engagement with the professionals and with his treatment. He was reported missing in January 2020 and was found murdered in his home. The police investigation determined that Michael had been a victim of a 'County Lines' drugs network, which had begun exploiting him during the summer of 2019. They had used his home to supply controlled drugs – criminality often termed as 'Cuckooing'.

Please follow the links for the full report and 7-minute learning

# 'MICHAEL'

## Findings

1. Health and social care agencies struggle to work with people who are reluctant to engage with services and there is a need to prioritise relationship-based working.
2. Without multi-agency working and sharing of information risks are missed and as a result people do not receive the support they need.
3. The form of criminal exploitation termed 'cuckooing', is not well understood, and is often overlooked by professionals.

## Lessons

1. Professionals should seek to fully understand people's life histories to better support people who are hard to reach or reluctant to engage with the available support.
2. Professionals should become familiar with the RWSAB Multi-agency Risk Assessment Framework and apply this to their practice.
3. Multi-agency working and information sharing is improved by joint working on complex cases and where partners are robust in holding one another to account for delivering actions through regular monitoring meetings.
4. Repeatedly doing the same actions and hoping for a different outcome will not mitigate risks and innovative approaches, including the use of safeguarding activity, should be considered.
5. When working with vulnerable people who use drugs, professionals should consider the risks of exploitation and be aware of the signs of cuckooing as outlined in the information leaflet for practitioners.
6. A culture of professional challenge is essential to effective safeguarding. Professionals should be encouraged to challenge a decision which they feel may have a detrimental impact.

# Wandsworth

Harvey was a young man with a long history of involvement with statutory services. During his childhood he was a 'looked after child', received support through mental health services and spent time in a Young Offenders institution. As an adult, Harvey experienced mental health issues, misused substances, and had a complex personal and social history which impacted on his behaviours. Harvey was aged 21 at the time of his death from a fatal stab wound inflicted by a neighbour in his mental health supported living service.

SAR not yet published due to parallel processes not yet completed.

# 'HARVEY'

## Findings

1. There is a need for a more joined-up approach to supporting young care leavers to strengthen their relationships with their birth families and informal support networks.
2. Adverse childhood experiences have a significant impact on how young people engage with services and there is a need for a more flexible approach particularly when the young person is also a care leaver.
3. There appears to be a general acceptance of a level of interpersonal conflict between groups of individuals with poor mental health and substance misuse, living in supported housing projects.
4. Professionals need to be more professionally curious and ready to consider that risk and behaviours can and do change, sometimes over relatively short periods of time.
5. Risk assessments are more holistic and robust when produced with input from several involved professionals.

## Lessons

1. Many individuals who have been looked after children, who have diagnoses of mental health difficulties, or who use substances can often be socially isolated, and may struggle to maintain supportive personal and family relationships. Professionals need to work to restore and support the development of effective family and informal support networks as part of the process of transition into adulthood.
2. It is important for all professionals to understand and consider the importance of childhood experiences on an adult's independence, abilities, skills, and resilience.
3. There is a risk that unconscious bias among the professionals and a general tolerance of and desensitisation to conflict between service users may result in a lack of response to incidence of interpersonal abuse.
4. The use of the Multi-agency Risk Assessment Framework supports effective partnership working and delivers better risk management.

## Wandsworth

Margaret was a 90-year-old woman who died from sepsis, because of infected pressure ulcers. Margaret was reluctant to accept support from health and care services and when her physical health deteriorated at home, her daughter struggled to provide an appropriate level of support. Despite being offered support from health professionals, Margaret and her daughter only engaged with this support sporadically. Margaret was admitted to hospital in March 2018, with many pressure sores. She developed a sepsis infection from which she could not recover.

Please follow the links for the full report and 7-minute learning

# 'MARGARET' SAR

### Findings

1. There was an over-reliance on information from family carers and as a result the views and needs of the person were lost.
2. When agencies made safeguarding referrals, they were not clear on the risks they were concerned about and as a result appropriate action was not taken. This was exacerbated by a lack of expectation on the referrer to follow up on their contact.

### Lessons

1. It is important to ensure there is equal weight given to input from the person and their family and to ensure full engagement of both in determining the desired safeguarding outcomes.
2. Practitioners should ensure that family carers have the information they need to provide safe care to the person they are supporting, particularly in relation to preventing and managing pressure ulcers.
3. Practitioners need to feel empowered to be professionally assertive when working with partners on addressing safeguarding concerns.
4. It is vital that immediate and potential risks are identified at the point of a safeguarding referral, and specific actions to mitigate those risks are agreed, allocated and owned. Risk and the response must be kept under review.

## Wandsworth

John was a quiet, softly spoken, 50-year-old black British man who died in hospital from sepsis. Both his wife and mother had died but he had a positive relationship with his mother-in-law. He had three adult children who were intermittently involved in his life. John had a severe and very painful type of eczema which covered his body. This negatively impacted on his wellbeing, quality of life and subsequently his mental health. He had frequent hospital admissions for related infections and complications. Despite repeated requests for assistance from health and social care, John only received equipment to help him with personal care. He was still waiting for a Care Act assessment when he died in hospital in July 2019.

Please follow the links for the full report and 7-minute learning

# 'JOHN' SAR

### Findings

1. There was a lack of recognition of the significance of John's care and support needs which impacted on the degree of priority he was afforded.
2. There was insufficient engagement with family networks and insufficient professional curiosity in exploring John's needs.
3. Unconscious bias impacted on professional's assessment of John's ability to obtain necessary support from health and care agencies, particularly when he was discharged from hospital.

### Lessons

1. Professionals need to be aware that undemanding people may under-estimate the level and urgency of their needs. Holistic consideration should be made of previous contacts with agencies as well as of the person's ability to understand and explain their needs in relation to what agencies can offer. Family members can offer additional information which is invaluable in understanding the situation.
2. Unconscious biases may influence the way people's needs, conditions and circumstances are understood. Professional curiosity is useful to recognise and overcome these biases.
3. Multiple hospital admissions can be a warning sign that someone's situation is deteriorating. Repeated patterns such as this can be an indication of a need for a different approach within each agency or through an adult safeguarding response.

## Wandsworth

Jasmine was a 20-year-old Black British woman, who died from natural causes secondary to her diabetes. She had been known to Children's Social Care since 2013 due to safeguarding concerns arising from poorly managed diabetes and emerging mental health issues. Jasmine found it difficult to maintain positive relationships in her personal life and would often refuse help from professionals. Her history shows patterns of seeking help in managing her chronic health conditions, but not attending follow up appointments or complying with her medical regime. She was found dead in her supported accommodation in September 2019.

Please follow the links for the full report and 7-minute learning

# 'JASMINE' SAR

### Findings

1. Transition planning can be inconsistent and delayed, in particular where young people's cases are held outside the specialist disabilities service in Children's Social Care.
2. Issues of self-neglect relating to chronic health conditions are poorly understood by practitioners and consequently opportunities to mitigate risks through safeguarding partnership interventions are missed.
3. Individuals with complex health needs alongside mental health or personality disorders, receive insufficient support to navigate their treatment pathway. The limited discussion between health disciplines results in an incomplete analysis of their health needs and a lack of holistic planning.

### Lessons

1. It is essential to identify the cohort of young people with complex needs (outside of physical and learning disabilities), to ensure that work commences early to support their transition from Childrens to adult health and social care services.
2. It is important for there to be co-ordinated action between the range of Childrens and adult professionals supporting a young person with physical and mental health issues to transition.
3. Practitioners must take note that the Care Act 2014 imposes an obligation on the Local Authority to complete a needs assessment if there is concern that the adult might be at risk of abuse or neglect, including self-neglect. Failure to comply with treatment or attend medical appointments is a form of self-neglect.
4. People with complex needs and inconsistent engagement with services/attendance at appointments are discharged from services, without sufficient consideration of the reasons for the reluctance to engage or attempts to make reasonable adjustments based on protective characteristics such as age and disability.

# 08

# PARTNERS' CONTRIBUTIONS

## Adult Social Care and Public Health – Richmond and Wandsworth Councils

The COVID-19 pandemic affected all of our services. Significant focus was on support to the provider market to access Personal Protective Equipment and Infection Prevention and Control training. Safety of Care Home residents was paramount and there was a concentration on issues such as visiting, testing and vaccination. All safeguarding meetings became virtual but face-to-face contacts with people were undertaken when needed. There was an increased volume of safeguarding concerns, particularly in terms of self-neglect and domestic abuse. However, these have been managed and there is no backlog. There was a notable increase in people with mental health problems experiencing abuse or neglect placing added demand on the service. Flexible and agile working ensured the Local Authority was able to balance risks and continue to keep our population safe. We remained fully Care Act 2014 compliant using proportionate and flexible approaches.

## Age UK Wandsworth

Age UK Wandsworth continues to make safeguarding a priority and it remains the case that all new staff and volunteers must undergo safeguarding training as part of their induction. Volunteers who work on our Befriending Plus Service, which commenced in 2020, are also now required to complete an additional higher-level safeguarding course after completing their first year of volunteering. Our office remained open and staffed throughout the pandemic and we were able to support vulnerable older people who were self-isolating with the provision of emergency food parcels. We also set up a telephone befriending service in response to the isolation felt by many. Our home visiting services were limited by the pandemic; however, we have recorded increased levels of communication with the Access Team. As social services were not undertaking regular home visits during the pandemic the home visits made by our services flagged up issues which needed to be discussed with social services.

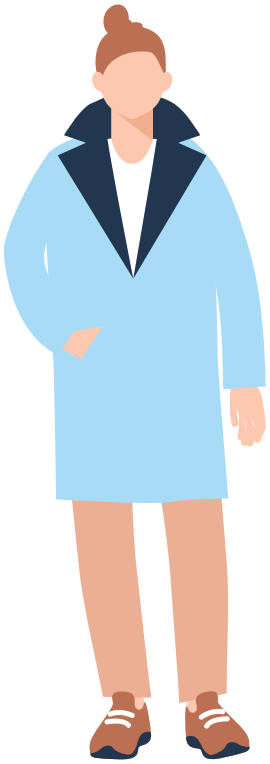
## Alzheimer's Society Wandsworth

Alzheimer's Society recently changed the way safeguarding is reported to local authority safeguarding teams. From 1st April 2021, our local dementia support and dementia adviser services now report safeguarding concerns to a national team. This national team manages the process and follows up concerns with the appropriate local authority team. To provide some local context, in the reporting period 01/04/2021 to 31/06/2021, in London Borough of Wandsworth, two safeguarding concerns were reported to the local authority. For London and the Southeast, for Quarter one of 2021/22, a total of 66 reports were made – 67% (44 cases) by Dementia support service and 33% (22) by a Dementia adviser. We are aware of the pressures and subsequent problems lockdown during the COVID-19 pandemic has created. Alzheimer's Society's service delivery has had to adapt with some of the clearer indications of any changes in safeguarding being an increase in reports of self-neglect as the main type of abuse being reported, with a heavy reliance on disclosures of abuse over observations.

## Central London Community Healthcare NHS Trust (CLCH)

CLCH provides community services across eleven London Boroughs, alongside the delivery of sexual health and respiratory services across Hertfordshire and since October 2019, adult community services in West Hertfordshire. Our services respond to the needs of our communities and champion the rights, choices, and safety of all service users. Our key achievements in 2020/21 were:

- Reviewed our Safeguarding business continuity plan.
- Daily safeguarding team meetings in place.
- Single point of contact for practitioners 7/7.
- Daily virtual drop-in sessions available re: case discussion/ supervision/advice.
- Safeguarding updates (e.g., domestic abuse) added to internal hub
- Safeguarding policies updated.
- Continued engagement with: CMARAP, MARAC and RWSAB sub-groups.
- Engaged with S42, S44, S49 safeguarding reviews.
- Audits on self-neglect and quality of safeguarding referrals to social services completed.
- Developed and promoted CLCH SAFER guidance re: making a referral to local authority.
- 2 cohorts of safeguarding/MCA champions graduated (20/21)
- Update days/supervision with all champions.
- Bespoke training to staff/ partners re: MCA and MSP
- Safeguarding training packages updated – interactive & linked to L2 booklet and training passport.
- Delivered 5 events during National Safeguarding Adults week 2020.
- Developed/cascaded 7-minute briefings re: learning from local and national investigations/reviews.



## Chelsea and Westminster NHS Foundation Trust

The Adult Safeguarding Team maintained relationships with partners through challenges emerging from redeployment and remote working. The continuity of support of Safeguarding adult's team was maintained. The team managed a quality round to sustain a focus and monitor safeguarding process across the Trust. The safeguarding team supported implementing revised Safeguarding functionality within the electronic clinical record.

The safeguarding team worked to develop and support our Adult Safeguarding Champions in the Emergency department to improve quality of information documented in referrals. Risks emerged within Palliative care in a context of limited or no visiting. Other issues identified in alerts included domestic abuse involving abuse by adult children to parents, alerts indicating severe self-neglect, and risks associated with substance misuse and mental health. Pressures on in-patient flows have impacted on planning transfer from hospital for some people.

## Community Safety – Richmond and Wandsworth Councils

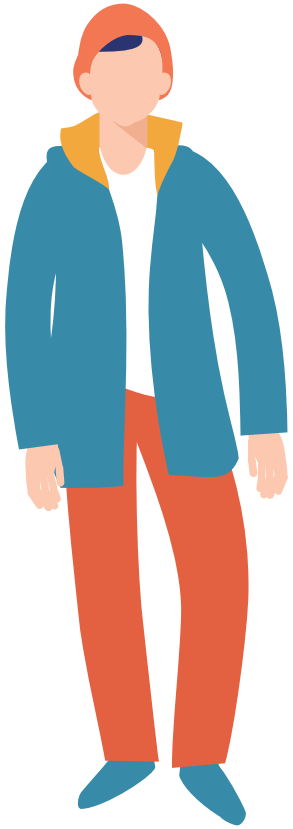
The Community Safety Service has seen an increase in risk management over 2020/21 in relation to preventing crime, reducing reoffending, serious violence, anti-social behaviour and violence against women and girls. The Integrated Offender Management (IOM) system managed a larger number of offenders in Wandsworth. There is an increased emphasis on harm caused to the community especially in relation to violence. In Wandsworth, a total of 12 high-risk individuals and areas were managed and there was a total of 7 in Richmond. The Community Multi-Agency Risk Assessment Conference managed 13 high risk cases in Richmond, and 25 in Wandsworth. There was a significant increase in Community Trigger applications with a total of 11 received in Richmond and 22 in Wandsworth. Community Safety also manage several third-party contracts around mentoring high risk violent perpetrators. All the actions described involve high risk multi management of individuals and areas with safeguarding at the heart of every case.

## Healthwatch Richmond

During an unusual year we have supported the Safeguarding Adults Board by:

- Supporting communications with over 100,000 people engaged with through our communications
- Feeding back intelligence from the community to identify potential abuse to the Board and to the Safeguarding team
- Connect community organisations to the Board
- Undertaking 225 DBS checks for volunteers supporting vulnerable people in the community
- Engaging with its committees.

## Hounslow and Richmond Community Healthcare (HRCH)



During this challenging year, HRCH teams (particularly Care Home Support, vaccination teams and Community Nursing), were supported with changes and challenges with their statutory responsibilities for adult safeguarding and consent. There was a focus on facilitating virtual multi-disciplinary professionals' meetings for patients with complex needs, including self-neglect, and offering advice and support for individual clinicians to ensure positive outcomes. 7-minute summaries and bite size bespoke learning resources, have been used to enable reflection and learning for busy teams. Safeguarding Week in November was used to share 1-page guides with links to useful resources and information for busy / redeployed staff to keep for reference. Adult Safeguarding training is progressing towards full compliance with the Adult Intercollegiate Document. MARAC referrals for domestic abuse have increased and processes to safely manage research and recording for adults and families were reviewed. Collaboration with Your HealthCare offers opportunities for further improvement.

## Housing and Regeneration Department – Richmond and Wandsworth Councils

Housing are committed to the priorities of the SAB and look for ways to help achieve these. The department participates constructively in all SAB events, relevant sub-groups, and multi-agency meetings to provide a housing perspective on issues and ensure policies and procedures reflect decisions made by the Board. The housing policy team has a dedicated adults safeguarding lead who advises housing staff on safeguarding matters, ensures training is completed and acts as a point of contact between Housing and other agencies. Adult safeguarding has been paramount in the pandemic, and we have also worked closely with the NHS and Age UK to facilitate the distribution of food parcels to the elderly and vulnerable in the borough, also linking up vulnerable residents with a befriending service and regularly checking in ourselves to ensure welfare. Furthermore, given that work has been remote this year we have facilitated the online adult safeguarding training of 143 officers.

## Kingston and Richmond Safeguarding Children Partnership

'Working Together to keep children's safety and wellbeing at the heart of everything we do'

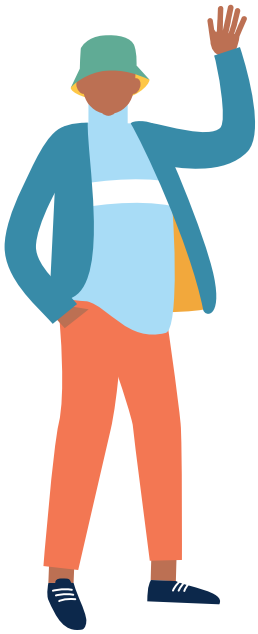
The pandemic immediately put incredible stress on local families and our workforce. As face to face work largely closed down, the partnership formed the COVID-19 planning group led by senior multi-agency partners from the CCG and the Single point of Access (SPA) from April 2020, moved to monthly in July 2020. The COVID-19 Planning Group met fortnightly to review the multi-agency safeguarding arrangements for vulnerable children in Kingston and Richmond, highlighting intelligence data from agencies and reviews of local services. This led to the distribution of voluntary sector support networks to schools and other agencies, so they could direct families for aid, and public Communications campaigns to keep the child in sight in the community, as referrals to Children's Social Care fell. There were over 90 multi-agency actions arising from the group.

## London Community Rehabilitation Company (LCRC) – South-West Area

LCRC entered into an Exceptional Delivery Model (EDM) in March 2020. The EDM saw us review the entire caseload and employ a blended approach to supervision based on risk prioritising face to face appointments for the riskiest including Domestic Abuse. We continued to work with key partners albeit in many cases via remote activities such as MS Teams meetings. This includes Multi-agency Risk Assessment Conference and Integrated Offender Management. Safeguarding training has continued throughout via the online learning platform "fuse". COVID-19 has impacted on safeguarding in that we have not been able to see all service users in person and not able to complete home visits (door stop visits have been an option), this does limit some safeguarding assessment activities.

## London Fire Brigade (LFB) - Richmond

Commitment to Safeguarding is part of our day-to-day interaction with the community that we serve. LFB's community safety activities in Richmond include being an active member of the local Safeguarding Adults Board. We have successfully engaged with our colleagues across the partnership over the last 12 months, especially during the COVID-19 pandemic. To make sure our residents and our co-NHS workers are kept safe during home visits we have provided over 120,000 Personal Protective Equipment kits to the local NHS trust. We continue to actively participate in the development of effective information sharing agreements and robust referral pathways, to ensure a multi-agency approach is adopted and always maintained.



We continue to carry out multi-agency joint visits to the most vulnerable and have an active partnership with telecare systems to install smoke detectors that raise the alarm in the first instance to telecare monitoring.

## London Fire Brigade (LFB) - Wandsworth

Commitment to Safeguarding is fully integrated into every aspect of the LFB's community safety activites in Wandsworth. We have successfully engaged with our colleagues across the partnership over the last 12 months, especially during the COVID-19 pandemic, to make sure our residents safety and wellbeing are at the forefront of everything we do. For example, operational crews assisted Wandsworth foodbank with their deliveries to vulnerable residents and participated in "Operation Christmas Cheer" which successfully ensured the delivery of welfare parcels to our older residents in the borough.We continue to actively participate in the development of effective information sharing agreements and robust referral pathways, to ensure a multi-agency approach is adopted and always maintained.

## Metropolitan Police South West Basic Command Unit (SW BCU)

SW BCU police continue to work closely with partners to improve our response to vulnerable people in our communities. We have recently developed a new cuckooing protocol, including clear referral pathways for police and other professionals and tactical options for officers, to better identify and support victims of cuckooing and target perpetrators. The SW BCU aims to professionalise Adult Abuse work: we have appointed a dedicated Detective Inspector to lead on Adult Abuse, who will look to strengthen our response and engagement, raise the adult abuse agenda within policing locally, develop a network of subject matter experts around adult abuse and embed learning from SARs. SW BCU continue to be fully engaged with the Safeguarding Adults Board executive and Safeguarding Adults Board sub-group meetings and other multi-agency panels including Multi-agency Risk Assessment Conference and Community Multi-agency Risk Assessment Conference .

## National Probation Service

The Covid-19 Pandemic has brought challenges to the delivery model of Probation and partners alike in achieving the aims of the NPS under exceptional circumstances. The National Probation Service has implemented Exceptional Delivery Models since the pandemic to ensure continuity of service with service users and partners whilst incorporating the lockdown tiers in place at the time.

The offices have remained opened, with face-to-face appointments provided to those identified as at risk and all assessments were reviewed. Offending behaviour programmes and Community Payback have been adapted in accordance with pandemic restrictions to continue to be delivered. The Courts have continued to operate throughout the pandemic with the NPS providing Pre-Sentence reports with support for sentences enforcement action.

The work with partnership agencies has continued including attendance and informing operational and strategic meetings such as Multi-agency Public Protection Arrangements (MAPPA) . Multi-agency Risk Assessment Conference, Integrated Offender Management and safeguarding.

## Richmond Carers Centre

Richmond Carers Centre maintains a holistic and integrated approach to safeguarding where safeguarding practices are embedded within all aspects of our work. All staff and volunteers are required to undertake safeguarding training as part of their induction, along with regular refreshers. Our adult safeguarding policy was updated in 2021. We liaise with our colleagues in social care to ensure appropriate safeguarding measures are taken so that carers and the people they care for are safe. We are on the membership for the RWSAB workshops. We adopted the Common Safeguarding Objective in 2019 and achieved green status.

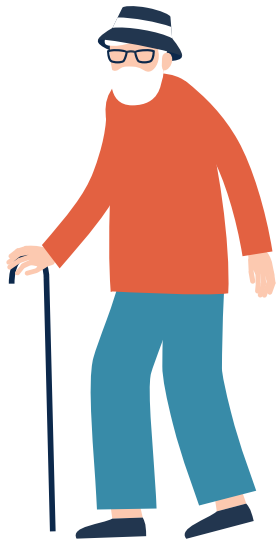
## Richmond Council for Voluntary Services (CVS)

The Covid-19 Pandemic and lockdown prompted more than 3,000 Richmond residents to register with our volunteer service to offer help to the local community. Many small groups started up, wanting to provide support to vulnerable people and it was vital that people understood what they had to do to keep people safe. We developed a series of resources to provide information to people about how to help and volunteer safely, 'Everybody needs a good neighbour', and to voluntary groups about how to recruit volunteers safely and limit the risk of harm.

We produced summary information about data protection and confidentiality, and keeping people safe online. We also sent out regular information relating to safeguarding and attended the Richmond Community Forum.

We continued to provide 1:1 support to an increasing number of groups that needed to develop or update their safeguarding policy and procedures.

## Richmond Housing Partnership (RHP)



RHP has a strong track record of partnership working with the SAB, the borough and partner agencies to safeguard our customers and keep people from harm and abuse. To ensure that safeguarding is embedded within the organisation and that it is every employee's responsibility to report safeguarding concerns, we have included safeguarding in our formal and informal performance management process. We have developed our own in-house e-learning training. We supported the national safeguarding week delivering workshops on Cuckooing, financial abuse and hoarding to raise awareness and how to report it. The pandemic has increased our focus on ensuring that vulnerable adults stay connected so that they can access services from RHP and other agencies. We have been proactive in engaging with those at risk of hoarding and self-neglect as well as those who are both victims and perpetrators of anti-social behaviour. Our approach was recently reinforced through a recent positive audit of safeguarding in RHP retirement housing schemes.

## Richmond Wellbeing Service

Richmond Wellbeing Service offers a person-centred approach to safeguarding and collaborates with local specialist providers to offer seamless service for adults who need safeguarding. The safeguarding needs of our service users are regularly assessed and reviewed while in treatment with us and a safeguarding intervention is provided as part of their psychological therapy treatment where appropriate. All clinical staff receive regular adult safeguarding supervision and training appropriate to their role. This year Richmond Wellbeing Service has focussed on the short- and longer-term impact of COVID-19 on service users and has created and adapted specific interventions to support service users impacted by COVID-19 and the pandemic.

## South West London and St. George's Mental Health Trust

Our staff have been working under exceptionally difficult circumstances and we have continued to adapt the way we deliver services and the way we work with stakeholders in response to guidance on Covid-19. Working arrangements for each service have been led by the needs of that service and delivering the best care to our patients.

There have been important quality improvement initiatives throughout the year. We are embedding the principles of Trauma Informed Care (TIC) across our services; and this provides over-arching support for key policy initiatives to promote our service user's wellbeing, including policies on Restrictive Practice, Domestic Violence & Abuse, and Sexual Safety.

The Domestic Violence & Abuse Working Group was commended for its work at the second Annual Conference in December. They also secured a new part-time post on a six-month contract to provide support to staff, service users and carers to manage the concerning increase of local and national reports of domestic abuse.

The Trust has also re-launched its policy requiring inpatient services to better manage staff and service user's sexual safety. We are supporting all our inpatient services to meet the National Sexual Safety Standards.

The Trust has remained fully open for business to look after the people who use our services, and their carers, friends, and family. We have made sure that staff at all levels have been supported with the often complex challenges of safeguarding adults at risk of abuse and neglect.

## South West London Clinical Commissioning Group (SWLCCG)

In October 2020 Dr Gloria Rowland was appointed as Chief Nurse and Executive Director of Quality (includes Adults and Children safeguarding) for SWLCCG and she took up post in January 2021. Dr Rowland brings a wealth of experience, with a strong passion for innovation and transforming healthcare for the benefit of the people of South West London. The Accountable Officer is the overall Executive Lead for Safeguarding in SWLCCG who delegates safeguarding responsibility to the Directors of Quality. Going forward, Dr Rowland will be the Executive Lead for Safeguarding in SWL Integrated Care Systems (ICS).

The London Region Safeguarding Sub cell was established during the Covid-19 pandemic. A safeguarding issues log was established in response to the large amount of information being shared during the weekly London Region Safeguarding Sub-cell meeting held since April 2020. Information has been shared by: the regional NHS England safeguarding team, Sustainability and Transformation plan (STP) system safeguarding leads, NHS England Specialist Commissioning, Chairs of the safeguarding professional networks, Public Health England , London Ambulance Service and London Nightingale Hospital. This report is also informed by an After-Action Review activity which took place in late May. The exception report highlights themes of hidden harms for the adults at risk and unseen population, virtual assessments, disengagement of vulnerable population, increased opportunities for abuse and neglect and care homes which was shared with our local authority to mitigate local risks. The CCG Designated Safeguarding Adults leads are part of that COVID-19 sub cell and have been sharing information with Richmond and Wandsworth SAB.

## South West London Clinical Commissioning Group – Richmond

The Designated Safeguarding Adults Lead for Richmond continued to contribute directly to the work of the RWSAB by attending all Sub-groups and chairing the Richmond Community Forum and the Communications and Engagement Sub-group. The Lead played a significant role in the running of the SWL Safeguarding Adults Leads' Forum, which includes Safeguarding Adults Leads across partner agencies in the six local authorities forming South-West London region and helps share information, good practice, brainstorming on issues and developing guidance like the Safeguarding Incidents Patient to Patient in Hospital Setting.

During the Covid-19 pandemic, safeguarding training to all primary care services in Richmond were provided together with the named Safeguarding Adults and Children GP leads for Richmond and have been a major contributor to enhancing safeguarding awareness and work in the Borough. The Richmond Designated Safeguarding Adults Lead also helped with complex cases in Care Homes and Continuing HealthCare (CHC) setting, with lessons learnt from these cases being shared nationally during the Safeguarding Adults National Networks (SANN) meeting to share good practice.

## South West London Clinical Commissioning Group – Wandsworth

Over the last year 2020/21, the Designated Safeguarding Adults lead for Wandsworth CCG has worked closely with RWSAB through attending all sub-groups (Workforce and Performance, SAR, Communication and Engagement) and chairing the Wandsworth Community Forum, which is attended by many stakeholders including the Wandsworth Carers Centre, Alzheimer's Society, Age UK Wandsworth, Housing, London Fire Brigade, Local Authority colleagues and commissioned providers. A lot of work involved communication through the Covid-19 pandemic to ensure that people are safe, that the public and professional colleagues had the right information, and that Safeguarding was continuing to operate as intended. The CCG also carried out a learning review ('Grace'), which was part of the Safeguarding Adults Review sub-group. Working closely with the Community Safety Partnership Board and being part of the Domestic Homicide Review (DHR) panel and the Counter-Terrorism, Channel Panel group.

During the Covid-19 pandemic, a lot of work was done together with our Primary Care colleagues in providing safeguarding training which includes domestic violence, safeguarding in a virtual setting for both Adults and Children to help GPs and other primary care professionals.

## St. George's University Hospital NHS Foundation Trust

The Safeguarding Adults Team continued to provide on-site support to clinicians throughout the Covid 19 pandemic response. The team comprised of a safeguarding adult lead and practitioner, an Mental Capacity Act (MCA) lead and practitioner, a Domestic Abuse lead and 2 members of our learning disability team. The team worked to support vulnerable adults coming into the hospital, including adults with learning disabilities who were unable to be accompanied by their family or carers. This meant increased front line working for Learning Disability team, who were crucial in maintaining focus on the needs and rights of this vulnerable group, and played an important role in communication with loved ones. The Safeguarding and MCA team offered advice and supervision to clinical staff, and worked with our local authority colleagues to implement new pathways and communication tools. The regular use of video conferencing to ensure that discussions could take place and information shared in a timely way was embraced and will continue.

## Trading Standards – Richmond and Wandsworth (part of the Regulatory Services Partnership)

The main effect of COVID-19 on the service was to divert resources to enforcement of the COVID-19 regulations and supporting Test and Trace. There was an increase in safety issues relating to facemasks and sanitisers especially early in 2020 and Brexit led to an increase in advice requests. Despite this, the team carried on their normal workload with restrictions and a reduction in face to face work. We have still received and investigated numerous reports about scams, doorstep criminals and rogue traders although predominantly logging intelligence. There has been a large rise over the last year in online scams.

Doorstep Crime is a priority area achieved over the last year through:

- Community online talks
- Organising ward-based patrols in some Boroughs
- Working with the banks, financial institutions, and the National Scams Hub
- Visiting identified victims where possible
- Prosecutions of rogue traders
- Recovering large sums of victim's money

## Wandsworth Carers Centre

We stopped face to face contact a week before the first lockdown. We then managed to get a paper newsletter out to Carers who were digitally excluded, to let them know the arrangements for accessing our services in the coming months. All other Carers received a digital newsletter. We instigated well-being calls, prioritising those we knew who were living in high pressure situations, and those digitally excluded, many of whom were older Carers. Counselling & peer support groups moved to telephone or online platforms where possible, with the facility to also call into the Zoom group via telephone. Where Carers were not able to access the support groups in this way, we arranged to carry out wellbeing calls at the time the group would usually meet and to share agreed updates to keep group members connected. Some dementia Carers reported difficulty in keeping the people with dementia occupied as day services had ceased. As a result, we organised online monthly activity sessions. Like other services we have continued to adapt in line with the government guidelines.

## Wandsworth Care Alliance (WCA)

We continue to comply with our local Safeguarding policy, which is in line with Wandsworth Council's policies and procedures of Safeguarding Adults and Children. We have had no Safeguarding Activities beyond the routine maintenance of policy and governance. WCA volunteers continue to sit on both the Adult and Children's Safeguarding boards.

## Wandsworth Safeguarding Children Partnership

To determine the harm that children and young people were experiencing during the COVID- 19 pandemic lockdown a group of senior managers across the partnership set up the COVID-19 Silver Group. The group met weekly to review the multi-agency safeguarding arrangements for vulnerable children and highlighted several emerging issues. Intelligence from agencies was presented through data and reviews of local services. The arrangements allowed for effective communication and sharing organisational risk assessments. Police and MASH continued to complete Operation Tea Rose domestic abuse disclosures throughout COVID-19 pandemic. There was an increase in referrals and through the scheme some children were offered places in schools ordinarily for vulnerable children. All schools (apart from 3 special schools) remained open throughout the pandemic for pupils of critical workers and vulnerable children. Police, Local Authority and Health offered face to face meetings with vulnerable families and the Multi Agency Safeguarding Hub (MASH).

## Your Healthcare (YH)

Last year witnessed unprecedented challenges for health and social care. Despite the difficulties, Your Healthcare continued to deliver services both face to face and with the introduction of virtual appointments. We saw a marked increase in reporting of self-neglect and domestic abuse as well as increased concerns regarding scamming. We are proud to say that our staff remained alert to the safeguarding principles and maintained our level of reporting in line with previous year. We worked closely with our partners to ensure support for those at risk of isolation, support welfare checks and maintain essential services.  This year has provided an opportunity to take a leap forward in the use of virtual communication, which has made multi-agency working more agile and responsive. As we return to a full service, we want to build on these new ways of working together whilst ensuring we make the most of being back in people's homes, building relationships and responding to concerns.

# 09

# PRIORITIES FOR 2021/23

## 1. Prevention and Early Intervention

- Promoting awareness of Adult Safeguarding.
- Strengthening collaboration and partnership working to prevent abuse and neglect.
- Gain assurance on the safety and effectiveness of safeguarding practice.
- Focus on Deprivation of Liberty Safeguards and the introduction of the Liberty Protection Safeguards.

## 2. Making Safeguarding Personal

- Engagement of experts by experience in delivering professional staff development events.
- Strengthening understanding and effective utilisation of the Mental Capacity Act to safeguard residents.
- Embed Making Safeguarding Personal in front line services across the partnership.

## 3. Learning lessons and shaping practice

- Obtain assurance that learning from SARs is embedded across the partnership.
- Improve effectiveness of transitional safeguarding arrangements through partnership collaboration.

The Business Plan 2021/22 can be found on our website: www.sabrichmondandwandsworth.org.uk/about-the-safeguarding-adults-board/#vision

Glossary of Safeguarding Adults Terms can be found on our website in the Annual Reports section.

# 10

# REPORTING A SAFEGUARDING CONCERN

## Richmond

**Phone**
020 8891 7971

**Out of hours**
020 8744 2442

**Email:** adultsocialservices@richmond.gov.uk

## Wandsworth

**Phone**
020 8871 7707

**Out of hours**
020 8871 6000

**Email:** accessteam@wandsworth.gov.uk

## Emergency

Call the Police or emergency services

999

Richmond and Wandsworth
Safeguarding Adults Board

## Questions about this Report

If you have any questions about this report, please email sab@richmondandwandsworth.gov.uk

## Remember, safeguarding is everyone's business