RICHMOND AND WANDSWORTH SAFEGUARDING ADULTS BOARD

Annual Report 2025-2026

Richmond and Wandsworth
Safeguarding Adults Board

Richmond and Wandsworth Safeguarding Adults Board

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EQUALITY STATEMENT

The Richmond and Wandsworth Safeguarding Adults Board is committed to promoting equality, diversity and inclusion in all aspects of its work.

We recognise that people's experiences of safeguarding, access to support and outcomes can be influenced by factors such as age, disability, ethnicity, sex, gender identity, sexual orientation, religion or belief, socio-economic circumstances and other aspects of identity.

We are committed to understanding and addressing inequalities, ensuring that safeguarding arrangements are fair, accessible and responsive to the diverse communities we serve. Through the analysis of safeguarding data, learning from reviews, engagement with communities and partnership working, we seek to identify and tackle barriers that may prevent people from receiving the support, protection and outcomes they need.

We believe that safeguarding is everyone's business and that every adult has the right to live a life free from abuse, neglect and exploitation, treated with dignity, respect and compassion.

FOREWORD FROM THE INDEPENDENT CHAIR OF THE RICHMOND AND WANDSWORTH SAFEGUARDING ADULTS BOARD

As I complete my first year as the Independent Chair, I am pleased to present the joint Richmond and Wandsworth Safeguarding Adults Board (RWSAB) Annual report 2025/26. This report reflects the continued strength of our partnerships and our shared commitment to ensuring that adults at risk are supported to live safe, independent, and fulfilling lives.

Richmond and Wandsworth Safeguarding Adults Board

Over this year the Board has made strong progress against our strategic priorities. We have built on the first year of our 5-year plan to highlight the 4 priority areas of: Prevention and Early Intervention; Making Safeguarding Personal; Quality Assurance and Embedding Learning, and Cross Sector Working. This was achieved through vibrant, engaging Community forums and Challenge Events, which have strengthened our engagement with the voluntary and community sector, built closer relationships with faith communities, and delivered a range of multi-agency training and development initiatives.

The Board has worked jointly across both boroughs while continuing to listen separately to Richmond and Wandsworth's voluntary sectors, helping better understand the distinct needs of each local population. The strength of the partnership in each borough was reflected in the Care Quality Commission inspections of both boroughs. Richmond and Wandsworth were both rated Good for adult social care, with CQC recognising effective partnership working, strong safeguarding arrangements, and safe pathways, systems and transitions. The findings highlighted the importance of coordinated working between adult social care, health, housing, police and voluntary sector partners to identify risk early, support safe discharge and transitions, and ensure people receive the right support at the right time. This external assurance reinforces the Board's view that strong, focused partnerships are central to maintaining safe systems and improving outcomes for adults with care and support needs.

This energetic and robust partnership has shown a strong shared commitment to Making Safeguarding Personal, keeping individuals at the centre of safeguarding practice. Performance data shows that safeguarding activity remains high, reflecting both increased awareness and continued demand across the system. At the same time, outcomes for individuals remain positive, with high levels of outcome achievement and risk reduction.

The Board has been working to ensure that learning from reviews and audits continues to drive improvements in practice. The SAB continues to review how learning is embedded and seeks opportunity to share learning from SARs through the SAR subgroup. We have also held a very well attended Master Class presented by Alex Ruck-Keene on the Mental Capacity Act which was both informative and practical.

As we look ahead, the Board remains focused on prevention, improving referral quality, and strengthening pathways. We are working closely with our SABs in South West London to ensure that pathways are consistent across the Health and Police areas. We are sharing learning from across the region and the UK that could be used to improve services to Richmond and Wandsworth residents with care and support needs.

I would like to formally recognise the hard work of everyone within the wider Safeguarding Adults family, from the frontline multi-agency statutory partners, to the Voluntary sector partners, to the unpaid carers, all of whom play a significant part in keeping the residents of Richmond and Wandsworth independent, heard and safe. My thanks go to the SAB Board Manager who has guided and helped me so much, and the SAB executive partners of Health, Police and Local Authority who have all brought energy, dedication, and commitment to safeguarding adults in Richmond and Wandsworth.

Fiona Martin
Independent Chair of Richmond and Wandsworth Safeguarding Adults Board from June 2025

Richmond and Wandsworth Safeguarding Adults Board

1 INTRODUCTION

The Care Act 2014 requires local authorities to establish a Safeguarding Adults Board (SAB) to ensure that arrangements are in place to protect adults with care and support needs from abuse and neglect.

The RWSAB brings together statutory partners, including the Local Authorities, Police and the Integrated Care Board, alongside a wide range of voluntary, community, and independent sector organisations.

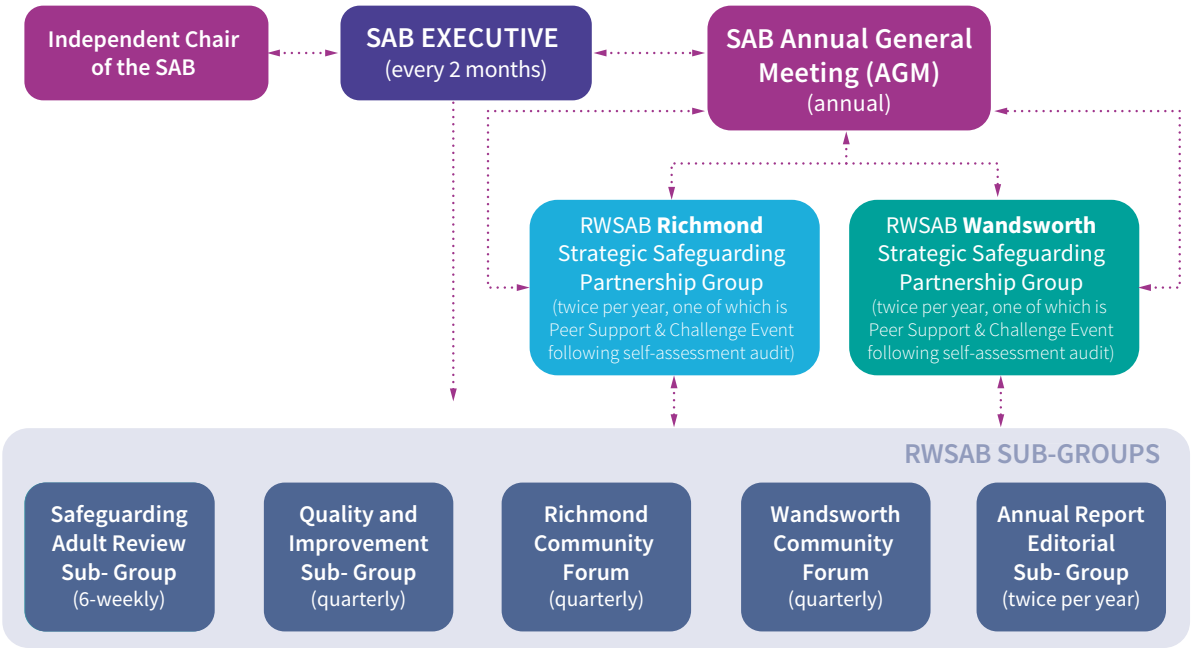
The Board works collaboratively to:

- Prevent abuse and neglect wherever possible
- Ensure timely and proportionate responses to safeguarding concerns
- Promote person-centred and outcome-focused safeguarding practice
- Seek assurance that safeguarding arrangements are effective and continuously improving

This report provides an overview of safeguarding performance across both boroughs, highlights the work of the Board and its sub-groups, and sets out priorities for the coming year.

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

Structure of the RWSAB



Richmond and Wandsworth Safeguarding Adults Board

2

WORK OF THE SAB EXECUTIVE, SUB-GROUPS AND FUTURE PRIORITIES

During 2025/26, the Richmond and Wandsworth Safeguarding Adults Board (RWSAB) continued to deliver its strategic priorities through the work of its Executive and sub-groups, providing oversight, assurance and operational leadership across safeguarding activity. The Board's Annual General Meeting in March 2026 provided an opportunity to reflect on progress and agree priorities for the year ahead.

RWSAB Stragegic Priorities 2024-2029

STRATEGIC PRIORITY 1
Prevention and early Intervention

Desired outcomes:

- Adults from local communities are aware of what abuse is and how to keep themselves and those they care for safe.
- Partners, service users, residents and carers recognise risk and are confident in how to report it.

STRATEGIC PRIORITY 2
Making Safeguarding Personal

Desired outcomes:

- People are listened to and have choice in shaping their safeguarding journey.
- Safeguarding practice is personal-centred, and outcomes focussed.
- The voice of Richmond and Wandsworth residents is being heard and acted upon.

STRATEGIC PRIORITY 3
Quality Assurance and Embedding Learning

Desired outcomes:

- We learn from when things go wrong, both locally and nationally, and take appropriate action to reduce risks
- We use learning to enhance prectice across the partnership
- The RWSAG has robust multi-agency safeguarding data which is used to inform planning and practice.

STRATEGIC PRIORITY 4
Cross-sector working

Desired outcomes:

- Maintain links with other strategic partnerships across shared priorities.
- Vulnerable young adults are transitioning safely into adult services, including preparing for adulthood workstreams in Richmond and Wandsworth.

Strategic Priority 1:
Prevention and Early Intervention

Achievements during 2025/26

The Board strengthened prevention and early intervention activity through a range of initiatives designed to improve awareness of safeguarding, support earlier identification of risk and strengthen community-based responses.

Key achievements included:

- Establishing a Voluntary and Community Sector Safeguarding Forum to improve awareness, confidence and early identification of safeguarding concerns within community organisations.
- Strengthening engagement with faith communities to extend the reach of safeguarding messages and improve culturally responsive support.
- Delivering vulnerability training to housing staff to support earlier recognition of abuse, self-neglect and emerging vulnerability.

Impact

The Board's prevention-focused work has increased opportunities for safeguarding concerns to be recognised earlier, helping partners build awareness, strengthen community resilience and improve access to support for adults at risk.

Priorities for 2026/27

The Board will continue to strengthen prevention and early intervention by:

- Developing tools and guidance for professionals and voluntary sector organisations.
- Improving safeguarding referral forms and referral pathways.
- Exploring innovative approaches to early intervention and prevention including community hubs.
- Using intelligence and community insight to target awareness-raising activity where safeguarding risks are greatest.

Strategic Priority 2:
Making Safeguarding Personal

Achievements during 2025/26

The Board continued to promote person-centred, outcome-focused safeguarding practice and supported practitioners to apply legal and ethical frameworks that place the adult at the centre of decision-making.

Key achievements included:

- Delivering a Mental Capacity Act masterclass to more than 150 practitioners, strengthening confidence in applying MCA principles within complex safeguarding situations.
- Supporting practitioners to develop greater understanding of capacity, best interests, proportionality, least restrictive practice and professional curiosity.
- Reinforcing relationship-based approaches through learning from safeguarding audits and reviews.

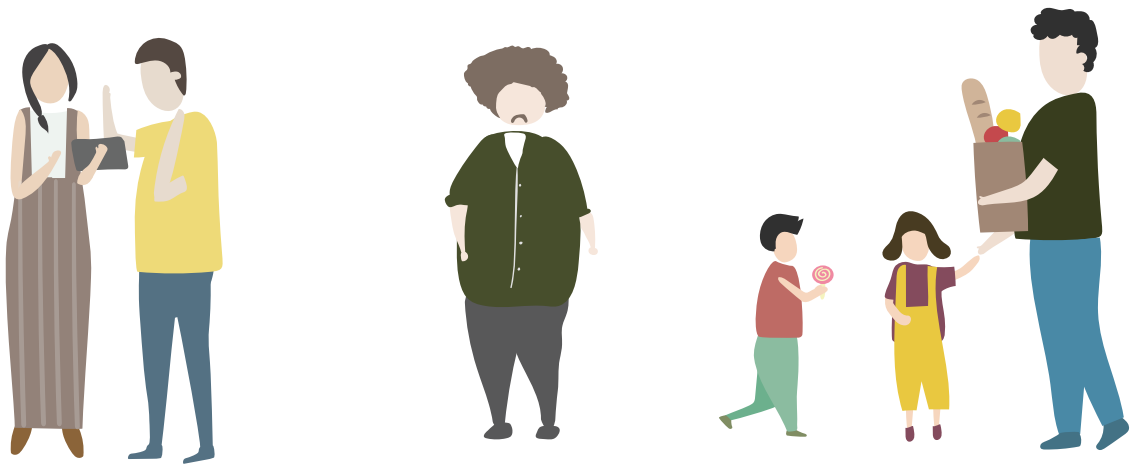
Impact

By promoting culturally competent, person-centred practice, the Board has supported a stronger focus on what matters to people, helping safeguarding responses better reflect individual circumstances, strengths and desired outcomes.

Priorities for 2026/27

The Board will further embed Making Safeguarding Personal by:

- Developing engagement tools to support inclusive and culturally competent practice.
- Improving responses and escalation routes to self-neglect.
- Strengthening transition pathways and joint working between children's and adults' services.
- Continuing to promote personalised, strengths-based safeguarding practice across partner agencies.



Strategic Priority 3:
Quality Assurance and Embedding Learning

Achievements during 2025/26

The Board strengthened its assurance arrangements and promoted continuous learning across the safeguarding partnership.

Key achievements included:

- Maintaining oversight and assurance of Safeguarding Adults Review recommendations and action plans.
- Completing a deep-dive audit into safeguarding referrals involving mental health and substance misuse.
- Using audit findings to identify learning and strengthen culturally competent and relationship-based practice.
- Sharing learning from Safeguarding Adults Reviews across South West London partnerships to support service improvement.

Impact

Through audits, review activity and continued oversight of Safeguarding Adults Review recommendations, the Board has strengthened its understanding of local safeguarding challenges and areas for improvement. This has enabled partners to share learning, identify emerging themes and support more informed safeguarding responses based on evidence, reflection and continuous improvement.

Priorities for 2026/27

The Board will continue to strengthen assurance and organisational learning by:

- Reviewing themes emerging from drug and alcohol-related deaths.
- Improving pathways for individuals who do not engage with drug and alcohol services.
- Strengthening data analysis and the use of evidence to inform safeguarding practice.
- Continuing to monitor the implementation and impact of learning from audits and reviews.

Richmond and Wandsworth Safeguarding Adults Board

Strategic Priority 4: Cross-sector Working

Achievements during 2025/26

The Board strengthened partnership working across sectors and increased opportunities for collaboration and shared learning.

Key achievements included:

- Enhancing collaboration with South West London safeguarding partnerships to share learning and strengthen practice.
- Supporting effective delivery through the work of Board sub-groups and partner agencies.
- Strengthening multi-agency working and collective ownership of safeguarding improvement activity.

Impact

Stronger partnership working has broadened engagement in safeguarding, improved collaboration across agencies and communities, and helped create a more connected safeguarding system across Richmond, Wandsworth and South West London.

Priorities for 2026/27

The Board will further strengthen cross-sector partnership working by:

- Improving consistency of safeguarding referral processes across South West London.
- Strengthening links with other strategic partnerships to influence shared priorities and support joint planning.
- Building on engagement with voluntary, community and faith organisations

Richmond and Wandsworth Safeguarding Adults Board

3 PREVENTION FRAMEWORK

The Prevention Framework represents a whole-system approach to preventing ill health, promoting positive health and wellbeing, and reducing health inequalities.

Adopted across both Richmond and Wandsworth, it reflects a shared commitment to embedding prevention across local policies, strategies and partnership activity, ensuring that action is taken earlier and closer to communities before needs, risks or inequalities escalate (see Figure X).

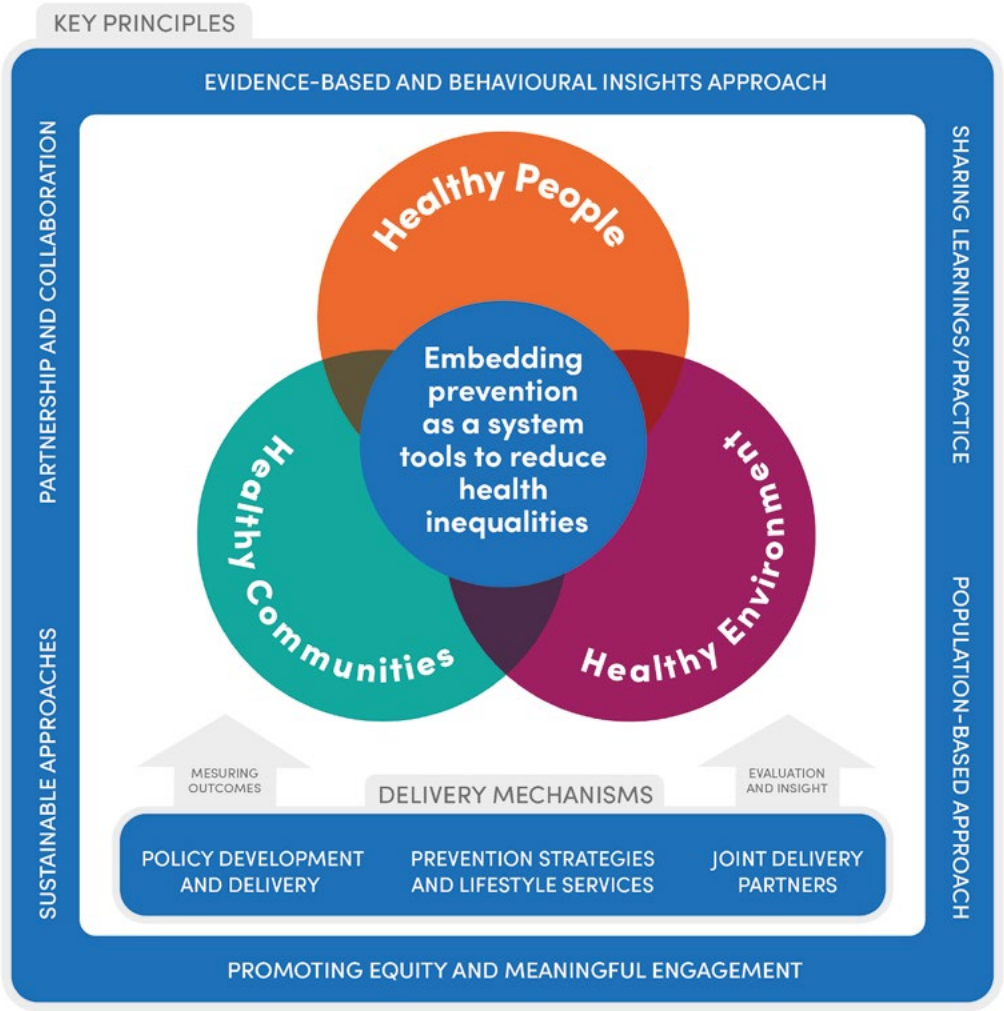
The Prevention Framework is central to the safeguarding agenda because many safeguarding risks are shaped by wider social, economic and environmental factors, including poor health, isolation, housing insecurity, poverty, discrimination and limited access to support. A preventative approach helps partners identify vulnerability earlier, strengthen protective factors and reduce the likelihood of abuse, neglect or self-neglect developing or escalating. Through a whole-system, place-based approach across people, communities and environments, the framework promotes early intervention, independence, community resilience and the use of local strengths and assets. This supports the safeguarding principle of prevention and reinforces the Safeguarding Adults Board's strategic role in promoting coordinated, multi-agency action to protect adults with care and support needs, reduce inequalities and improve long-term wellbeing.

Prevention is a core enabler of safeguarding, reducing the underlying risks that lead to abuse and neglect while supporting independence, resilience and earlier intervention across the system.

The framework recognises the importance of the wider determinants such as housing, crime, employment, education and income, on people's health and wellbeing. It will also stem the demand for health and social care services through promoting independence and self-care, using strengths and assets in the community thus delaying, preventing, or reducing the need for health and social care services

Richmond and Wandsworth Safeguarding Adults Board

Prevention Framework



Neighbourhood Health Planning and Safeguarding

Neighbourhood health planning provides an important opportunity to strengthen safeguarding by bringing partners together around local people, places and patterns of need. By integrating health, social care, housing, voluntary sector and community partners at neighbourhood level, these arrangements can improve the early identification of risk, strengthen information-sharing and enable more coordinated, place-based responses to vulnerability. This is particularly important where adults experience complex or overlapping risks linked to poor health, isolation, housing insecurity, mental ill health, substance misuse, self-neglect or wider social inequality. A neighbourhood approach supports trusted relationships, shared local intelligence and proportionate early intervention before concerns escalate. This directly supports the safeguarding principle of prevention and reinforces the Safeguarding Adults Board's role in promoting multi-agency action to reduce risk, address inequalities and protect adults with care and support needs.

Richmond and Wandsworth Safeguarding Adults Board

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RICHMOND AND WANDSWORTH PERFORMANCE INFORMATION

Richmond

Case study
Safeguarding in practice

(names and details may be changed to preserve the anonymity of the people involved)

The Multi-agency supported Sarah, a 62-year-old woman with multiple long term health conditions who lived in a care setting when concerns were raised by emergency services about potential neglect and acts of omission by her provider.

At the time, Sarah was not able to take part in safeguarding discussions herself, so a family member spoke on her behalf. This ensured that her wishes, as well as the family's perspective, were central to the process.

Partners came together to carry out a safeguarding enquiry. Through open and constructive conversations, the professionals involved identified areas where care could be strengthened. Rather than focusing on individual fault, the emphasis was on understanding what could be improved and how agencies could work together to make this happen.

What did the multi-agency do?

A range of changes were put in place, including clearer care planning, improved staff training, stronger management oversight and better communication and record keeping. These actions have helped to create a safer and more consistent approach to delivering care.

Richmond and Wandsworth Safeguarding Adults Board

Case study
continued

Feedback – the impact on the person and their family

The family member remained closely involved throughout. They shared

> "I felt that my views were listened to during the meeting and conversations. I was given the opportunity to share my perspective, and my concerns were acknowledged and taken seriously."

They also reported that

> "the information provided was clear and explained in a way that was easy to understand,"

enabling them to follow the discussions and ask questions where needed.

This case shows the value of partnership working, listening to families, and taking a learning approach to safeguarding to improve outcomes for people.

Concerns received in 2025/26

2328

1% increase
(2297 in 2024/25)

Enquiries in 2025/26

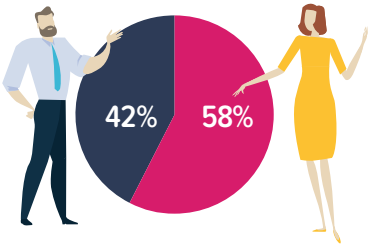
571

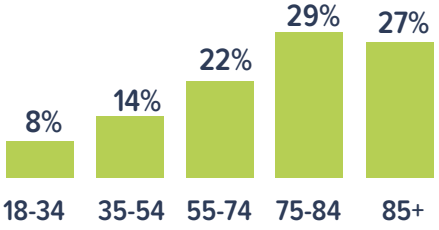
3% decrease
(588 in 2024/25)

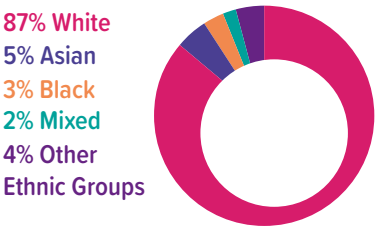
Conversion from concerns to enquiries

25%

26% in 2024/25







1 person did not state their ethnicity

TYPES OF ABUSE

28% (203)
Self-neglect

26% (188)
Neglect

15% (108)
Financial/material

66% (380)
Own Home

16% (94)
Care Home Residential and Nursing

5% (28)
In the community
(excluding community services)

31% (178)
Known to Individual

9% (55)
Care, health or other Professional

2% (12)
Not known to individual or no person alleged to have caused harm

99% (532)
Risk Reduced or removed

74% (425)
Expressed Desired Outcomes

99% (421)
Outcome fully or partially achieved

77% (447)
Felt as safe as they wanted to after safeguarding

99%
Support from advocate, family or friend

Richmond and Wandsworth Safeguarding Adults Board

Safeguarding Concerns and Enquiries[1]

In 2025/26, Richmond received 2,328 safeguarding concerns, a slight increase from 2,297 in 2024/25. Safeguarding enquiries decreased marginally to 571, compared with 588 the previous year. The conversion rate remained broadly stable at 25%, although this continues to sit below the national average of 32%. Work is ongoing with partners and through internal Local Authority processes to support the consistent application of safeguarding criteria and improve referral quality. Care providers and the voluntary sector remained the largest sources of safeguarding concerns at 23%, followed by police at 13% and hospitals at 12%. Following joint work with London and local MASH teams, police referrals reduced by 4%, while supporting a more appropriate referral profile. Referrals from members of the public increased to 11%, indicating growing community awareness of safeguarding and confidence in raising concerns.

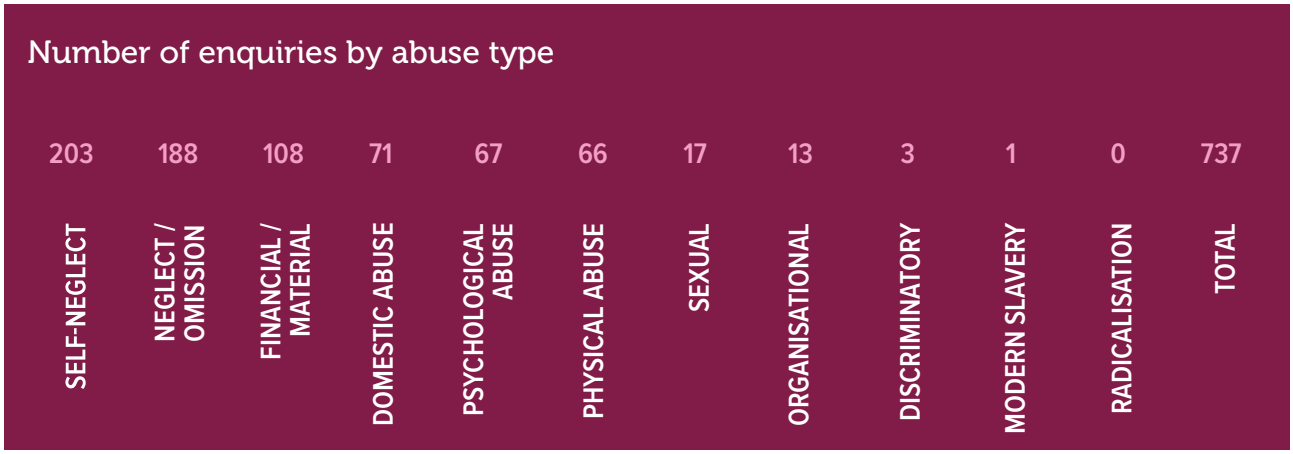
The profile of safeguarding enquiries by gender, age and ethnicity broadly reflects the characteristics of adults with care and support needs in Richmond and is consistent with national safeguarding patterns, where enquiries are more commonly associated with older adults. However, safeguarding activity is higher among people aged 65 and over, with this group accounting for 70% of enquiries compared with 54% of adults aged 65 and over on Council care records. This suggests that older adults remain more likely to be involved in safeguarding enquiries, reflecting the increased risks associated with frailty, cognitive decline, dementia, physical support needs and reliance on others for care. Ethnicity is closely aligned with the care records population.

There is a slightly higher proportion of females in safeguarding enquiries, with 58% female and 42% male, compared with 53% female and 47% male among adults with care and support needs in Richmond. This may be linked to the higher proportion of women in older age groups.

In terms of where abuse takes place, the majority occurs in people's own homes (66%), reflecting the fact that most residents live in their own home. This is also consistent with national and regional patterns. Richmond upon Thames has 41 care facilities, and good awareness among these providers of their responsibility to report safeguarding concerns is reflected in residential and nursing care homes being the second most common location of abuse, at 16%.

The support needs of people involved in safeguarding enquiries show that physical support remains the most common primary need in Richmond, accounting for just over half of enquiries at 54%. This was followed by social support at 14%, highlighting the importance of recognising wider social factors such as isolation, limited support networks, carer stress and increased vulnerability to abuse and neglect. People with mental health needs and people with a learning disability each accounted for 10% of enquiries. This profile reflects the higher level of safeguarding activity among older adults and people who may be more reliant on others, including unpaid carers, for day-to-day care and support. It also demonstrates the complexity of overlapping needs, where physical health, mental health, learning disability, cognitive impairment, caring arrangements and social vulnerability may intersect. Safeguarding responses therefore need to remain holistic, person-centred

1 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.



and informed by the interaction between multiple needs, risks, protective factors and carer circumstances.

Types of Abuse[2]

Self-neglect increased significantly to 28%, making it the most frequently recorded type of abuse in Richmond. This reflects continued local focus on identifying and responding to self-neglect and is consistent with wider safeguarding learning where self-neglect remains a prominent and complex area of practice. This sits within a significant programme of work undertaken across the borough over several years to improve responses to self-neglect and hoarding, including the use of a multi-agency self-neglect and hoarding panel to support shared risk management, coordinated intervention and earlier escalation where needed. In Richmond, neglect and acts of omission also remained one of the most common forms of abuse at 25%. Financial or material abuse increased notably to 15%, nearly doubling from 8% in 2024/25, reflecting increased awareness and the wider national context of scams and financial exploitation affecting adults at risk. The Board will also continue to strengthen work with the Community Safety Partnership to improve the identification of domestic abuse, support earlier intervention and ensure safeguarding responses are aligned with wider domestic abuse and VAWG priorities.

Making Safeguarding Personal

Making Safeguarding Personal (MSP) is central to effective safeguarding practice because it keeps the person's voice, wishes and lived experience at the heart of decisions about their safety and wellbeing. Under the Care Act 2014, safeguarding should not be something that is done to people, but with them. This means understanding what matters to the person, supporting informed choices and ensuring responses are proportionate, respectful and focused on outcomes that are meaningful to them.

Richmond's MSP performance compares positively with the national emphasis on person-centred safeguarding. In 2025/26, 74% of people were able to express their desired outcomes, and 99% of those outcomes were fully or partially achieved. This demonstrates strong local practice in supporting people to define what they want from safeguarding and in working with them to achieve safer, more personalised outcomes. These results should also be viewed alongside the complexity of safeguarding work, where not all outcomes will be achievable, particularly where a person chooses not to participate or is too unwell at the time of the enquiry.

2 A single enquiry may consider more than one type of abuse – hence there are more Types of abuse than safeguarding enquiries.

For people who lacked capacity to make relevant safeguarding decisions, support from an advocate, family member or friend was provided in almost all cases. This provides assurance that statutory requirements are being met and that people who may have difficulty expressing their views are still supported to have their rights, wishes and interests represented within the safeguarding process.

Impact on risk and sense of safety

Richmond continues to seek feedback from people and their representatives about whether safeguarding support has helped them feel safer. Of the 579 completed enquiries, 447 people (77%) reported feeling as safe as they wanted to. This is an important measure of impact because it reflects the person's own view of safety, rather than relying only on professional judgement. Only one person reported not feeling safe at all; this case continues to be closely monitored to ensure risk management arrangements remain effective.

Reducing or removing risk remains a core purpose of adult safeguarding. In Richmond, risk was reduced or removed in 99% of cases, demonstrating strong practice in supporting safer outcomes for adults with care and support needs. Where risk remained, this was usually because the person had made an informed choice to accept a level of risk. This reflects the importance of balancing safety with choice, control and independence, in line with Making Safeguarding Personal and the principles of the Care Act 2014.

Deprivation of Liberty Safeguards (DoLS)

The Deprivation of Liberty Safeguards (DoLS) protect people who lack capacity to consent to care or treatment arrangements that may restrict their freedom. They ensure any restrictions are necessary, in the person's best interests and properly authorised.

- Granted authorisations reduced slightly and accounted for 55% of total DoLS activity. This change largely reflects the increase in overall DoLS activity during the year.

1. Not granted decisions reduced slightly and represented 27% of activity. Hospital DoLS cases continue to be triaged because hospital restrictions are often urgent and time-limited, with capacity, treatment needs and discharge plans changing quickly. This ensures authorisations are progressed where required to protect people's rights, while avoiding unnecessary authorisations where circumstances change or less restrictive arrangements are possible.

Richmond DoLS	24/25	%	25/27	%	Change 2024/25 to 2025/26	
Granted	582	63%	525	55%	-57	-10%
Not Granted	258	28%	257	27%	-1	0%
Not yet signed off by Supervisory Body	87	9%	171	18%	84	97%
Total Number of Requests Received	927		953			

2. At year end, 18% of activity was awaiting supervisory sign-off. This largely reflected completed assessments that were ready for final authorisation, with the increase linked to year-end timing and administrative processing rather than delays in completing the core assessment work.

Community DoL

Community Deprivation of Liberty (Community DoL) applies where a person who lacks capacity may be subject to significant restrictions in a domestic or community setting, and Court of Protection authorisation may be needed to ensure the arrangements are lawful, necessary and in the person's best interests.

Before the Supreme Court judgment on 2 June 2026, which changes how deprivation of liberty is defined in law and overturns the long-standing Cheshire West decision, Richmond had 30 Community DoL cases authorised or being progressed. These cases will now be reviewed in line with the new legal position. The focus will be on confirming whether Court of Protection authorisation is still required, identifying less restrictive arrangements where possible, and ensuring people's rights, wishes and best interests remain central. While Community DoL applications are expected to reduce, there may be an increase in Section 16 welfare applications where wider best-interests decisions are needed.

Provider Quality

Richmond continues to benefit from a stable and generally high-quality local care market, with most regulated services rated positively by the Care Quality Commission (CQC). There are 41 care homes and 30 care-at-home providers registered with the CQC. Of the care homes, 38 (93%) are rated Good and one is rated Outstanding, demonstrating strong levels of quality, safety and consistency across residential and nursing care in the borough. Two care homes are currently rated as Requires Improvement; both have improvement action plans in place and are subject to regular monitoring by the Local Authority's Quality Assurance Team to ensure progress is sustained and risks are addressed promptly. Among care-at-home providers, 20 (67%) are rated Good, while ten providers are not yet rated by the CQC, largely due to new registrations and the time required for inspection. The Local Authority does not place people with unrated

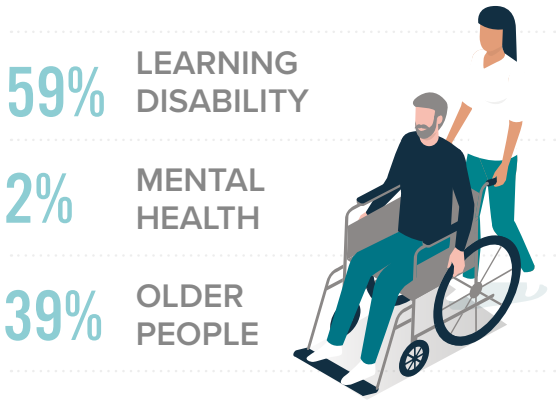
INADEQUATE 0%

Care-at-homes Services CQC Rating (Richmond)	No	%
Outstanding	0	0%
Good	20	67%
Requires improvement	0	0%
Inadequate	0	0%
Not yet rated	10	33%
Total	30	

services. Overall, provider quality in Richmond remains positive, supported by active oversight, constructive engagement with providers and a continued focus on safe, effective, person-centred care for residents.

INADEQUATE 0%

Care Homes CQC Rating (Richmond)	No	%
Outstanding	1	2%
Good	38	93%
Requires improvement	2	5%
Inadequate	0	0%
Total	41	



Care Home Type (Richmond)	No	%
Older people	16	39%
Learning disabilities	24	59%
Mental health	1	2%
Total	41	

Wandsworth

Case study
Safeguarding in practice

(names and details may be changed to preserve the anonymity of the people involved)

Mr Jones is a 59-year-old man living in Wandsworth with Bipolar Disorder and Diabetes.

He was known to the Mental Health Social Care Team, who had arranged support to address self-neglect. Soon after it began, concerns were raised that he was not engaging with the Care provider, and a safeguarding concern was raised.

The Local Authority led several safeguarding meetings with Mr Jones, his family and professionals. These identified concerns about his finances, outstanding home repairs, gaps in his care and missed health reviews.

What did the multi-agency do?

The network agreed a safety plan to reduce risk. Mr Jones' care support was increased, including support with shopping to help him follow a diabetic diet. London Fire Brigade installed smoke, heat and CO2 monitors in his home. His family began applying for Lasting Power of Attorney to help manage his finances and arrange repairs, while health partners worked together to review his physical and mental health needs.

The safeguarding remained open for over a year while these actions were completed, with regular review meetings to monitor risk.

Feedback – the impact on the person and their family

Mr Jones' sister said the family

> "felt listened to, not only as Mr Jones' relatives, but that our professional knowledge and lived experiences were also acknowledged and respected by the team,"

making them feel valued in decision-making.

She also said the Social Worker leading the safeguarding showed dedication and empathy, helping Mr Jones feel heard and valued, and thanked everyone involved for supporting his wellbeing.

As a result of the safeguarding and the actions taken, the network agreed that the overall risk to Mr Jones had reduced.

9%

Concerns received in 2025/26

3525

9% decrease

(3885 in 2024/25)

17%

Enquiries in 2025/26

927

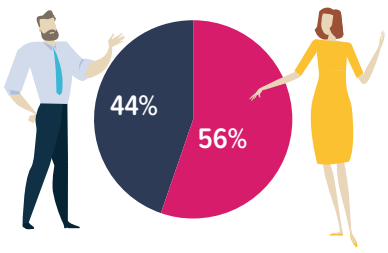
17% decrease

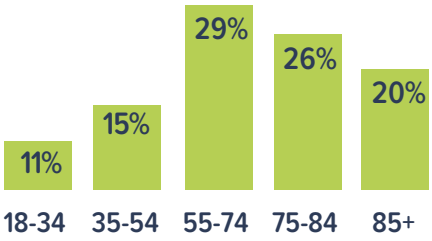
(1117 in 2024/25)

Conversion from concerns to enquiries

26%

29% in 2024/25





60% White
11% Asian
22% Black
4% Mixed
4% Other Ethnic Groups

7 people did not state their ethnicity

TYPES OF ABUSE

27% (340) Self-neglect

24% (300) Neglect

15% (181) Financial/Material

59% (551) Own Home

16% (151) Care Home Nursing and residential

10% (97) Hospital

32% (303) Known to Individual

9% (84) Care, health or other Professional

3% (27) Not known to individual or no person alleged to have caused harm

98% (874) Risk Reduced or removed

72% (672) Expressed Desired Outcomes

99.7% (670) Outcome fully or partially achieved

74% (699) Felt as safe as they wanted to after safeguarding

98% Support from advocate, family or friend

Safeguarding Concerns and Enquiries

In 2025/26, Wandsworth received 3,525 safeguarding concerns, down from 3,885 in 2024/25. Safeguarding enquiries also decreased, from 1,117 to 927, with the conversion rate falling from 29% to 26%. This remains below the national average of 32%. Work continues with partners, and through internal Local Authority processes, to support consistent application of safeguarding criteria and improve referral quality. Care providers and the voluntary sector submitted the highest proportion of concerns (20%), followed by hospitals (19%) and police (11%). Following joint work with London and local MASH teams, police referrals reduced by 4%, supporting a more appropriate referral profile.

The profile of safeguarding enquiries by gender, age and ethnicity broadly reflects the characteristics of adults with care and support needs in Richmond and is consistent with national safeguarding patterns, where enquiries are more commonly associated with older adults. However, safeguarding activity is slightly higher among people aged 65 and over with this group accounting for 63% of enquiries, compared with 52% of adults aged 65 and over on Council care records. This suggests that older adults remain more likely to be involved in safeguarding enquiries, reflecting the increased risks associated with frailty, cognitive decline, dementia, physical support needs and reliance on others for care. Ethnicity is broadly aligned with the borough population. There is a slightly higher proportion of females in safeguarding enquiries, with 56% female and 44% male, compared with 52% female and 48% male among adults with care and support needs in Wandsworth. This may be linked to the higher proportion of women in older age groups.

The majority of abuse in Wandsworth took place in people's own homes (59%), which reflects where most residents live and is consistent with national and regional patterns. Residential and nursing care homes were the next most common location, accounting for 16% of completed safeguarding enquiries. This is likely to reflect both the borough's 24 care facilities and providers' awareness of their responsibility to report safeguarding concerns. Hospital settings accounted for a further 10% of completed enquiries, reflecting Wandsworth's local hospital presence.

The support needs of people involved in safeguarding enquiries in Wandsworth show a more varied profile. Physical support remained the most common primary need, accounting for 41% of enquiries, while social support accounted for a further 20%. This highlights the importance of recognising wider social factors such as isolation, limited support networks, carer stress and increased vulnerability to abuse and neglect. Mental health needs were identified in 17% of enquiries, and people with a learning disability accounted for 10%. Overall, this profile shows that safeguarding responses in Wandsworth need to address a broad range of needs and risks, particularly where physical health, mental health, learning disability, social vulnerability and caring arrangements intersect. Responses therefore need to remain holistic, person-centred and informed by the interaction between multiple needs, risks, protective factors and carer circumstances.

Types of Abuse[3]

Self-neglect remained the most common type of abuse in Wandsworth at 27%, continuing the upward trend seen in recent years. This reflects the ongoing local focus on recognising and responding to self-neglect and aligns with wider safeguarding learning that identifies

3 A single enquiry may consider more than one type of abuse – hence there are more Types of abuse than safeguarding enquiries.

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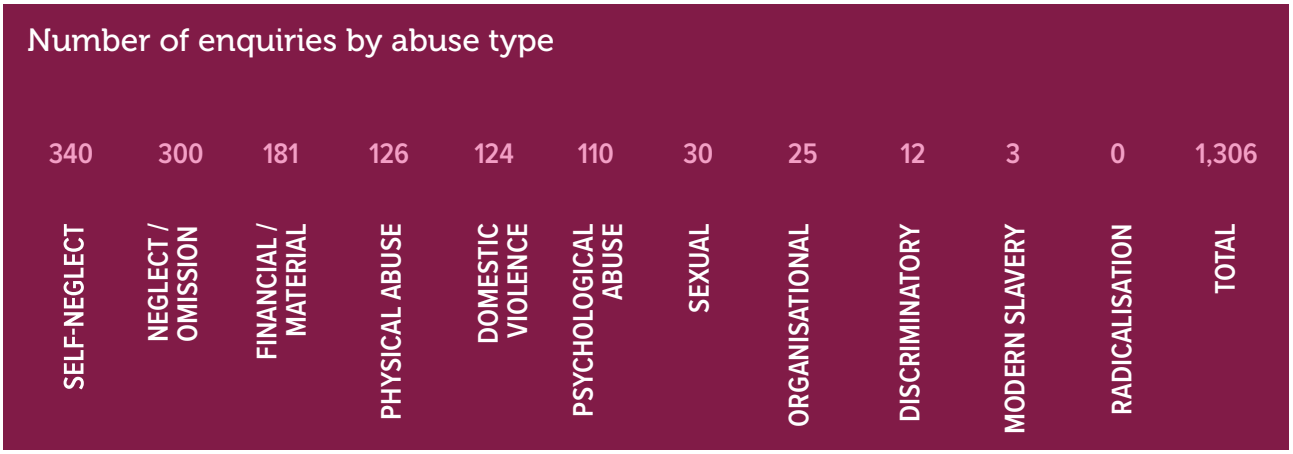


it as a complex and prominent area of practice. Over several years, the borough has developed a significant programme of work to strengthen responses to self-neglect and hoarding, including the use of a multi-agency panel to support shared risk management, coordinated intervention and earlier escalation where needed. Nationally, neglect and acts of omission remain the most common type of abuse in concluded safeguarding enquiries. This was also one of the most common abuse types in Wandsworth, accounting for 24%, a slight increase on the previous year. Financial abuse also remained significant at 14.5%, reflecting the wider national picture of scams and financial exploitation affecting adults at risk. The profile also highlights the importance of recognising the links between psychological abuse, mental health and domestic abuse, and of strengthening closer working with VAWG partners to support earlier identification, coordinated risk management and trauma-informed responses.

Making Safeguarding Personal

Making Safeguarding Personal (MSP) is central to effective safeguarding practice because it keeps the person's voice, wishes and lived experience at the heart of decisions about their safety and wellbeing. Under the Care Act 2014, safeguarding should not be something that is done to people, but with them. This means understanding what matters to the person, supporting informed choices, and ensuring responses are proportionate, respectful, and focused on outcomes that are meaningful to them.

Wandsworth's MSP performance compares positively with the national emphasis on person-centred safeguarding. In 2025/26, 72% of people were able to express their desired outcomes, and 99.7% of those outcomes were fully or partially achieved. This demonstrates strong local practice in supporting people to define what they want from safeguarding and in working with them to achieve safer, more personalised outcomes. These results should also be viewed alongside the complexity of safeguarding work, where not all outcomes will be achievable, particularly where a person chooses not to participate or is too unwell at the time of the enquiry.

Where people lacked capacity to make relevant safeguarding decisions, support from an advocate, family member or friend was provided in almost all cases. This gives assurance that statutory duties are being met and that people who may find it difficult to express their views are supported to have their rights, wishes and interests represented throughout the safeguarding process.

Impact on Risk and sense of safety

The London Borough of Wandsworth has consistently sought feedback from individuals and their representatives about whether safeguarding support has helped them feel safer. Of the 940 completed enquiries, 699 (74%) reported feeling as safe as they wanted to. This is an important measure of impact because it reflects the person's own view of safety, rather than relying only on professional judgement. Only one person reported not feeling safe at all, and this is monitored closely to ensure risk management is effective.

Reducing or removing risk remains a core purpose of adult safeguarding. In Wandsworth, risk was reduced or removed in 98% of cases, demonstrating strong practice in supporting safer outcomes for adults with care and support needs. Where risk remained, this was usually because the person had made an informed choice to accept a level of risk and understood the potential consequences. This reflects the importance of balancing safety with choice, control and independence, in line with Making Safeguarding Personal and the principles of the Care Act 2014.

Deprivation of Liberty Safeguards (DoLS)

The Deprivation of Liberty Safeguards (DoLS) protect people who lack capacity to consent to care or treatment arrangements that may restrict their freedom. They ensure any restrictions are necessary, in the person's best interests and properly authorised.

- Granted authorisations decreased by 1% and accounted for 55% of total DoLS activity. This reduction should be viewed in the context of an overall increase in DoLS activity during the year.

1. Not granted decisions reduced marginally by 0.34%. Hospital DoLS cases continue to be triaged because restrictions in hospital are often urgent and time-limited, with capacity, treatment needs and discharge plans changing quickly. This helps ensure authorisations are progressed where needed to protect people's rights, while avoiding unnecessary authorisations where circumstances change or less restrictive options become available.
2. At year end, 18% of activity was awaiting supervisory sign-off. This mainly related to completed assessments ready for final authorisation, with the increase linked to year-end timing and administrative processing rather than delays in completing the core assessment work.

Wandsworth DoLS	24/25	%	25/26	%	Change 2024/25 to 2025/26	
Granted	788	53%	730	48%	-58	-7.4%
Not Granted	590	39%	588	38%	-2	0.34%
Not yet signed off by Supervisory Body	120	8%	212	14%	92	77%
Total Number of Requests Received	1498		1530			

Community DoL

Community Deprivation of Liberty (Community DoL) applies where a person who lacks capacity may be subject to significant restrictions in a domestic or community setting, and Court of Protection authorisation may be needed to ensure the arrangements are lawful, necessary and in the person's best interests.

Before the Supreme Court judgment on 2 June 2026, which changes how deprivation of liberty is defined in law and overturns the long-standing Cheshire West decision, Wandsworth had 35 Community DoL cases authorised or being progressed. These cases will now be reviewed in line with the new legal position. The focus will be on confirming whether Court of Protection authorisation is still required, identifying less restrictive arrangements where possible, and ensuring people's rights, wishes and best interests remain central. While Community DoL applications are expected to reduce, there may be an increase in Section 16 welfare applications where wider best-interest decisions are needed.

Provider Quality

Wandsworth continues to have a strong local care market, with the majority of regulated provision rated positively by the Care Quality Commission (CQC). There are 24 Care Homes and 45 Care-at-home Service Providers registered with the CQC. Of the Care Homes, two (8%) are rated Outstanding and 20 (83%) are rated Good, meaning that 92% of care homes in the borough are rated highly. This demonstrates a great standard of residential and nursing care provision across Wandsworth. Two Care Homes are currently rated as Requires Improvement; both are subject to improvement action plans and regular monitoring by the Local Authority's Quality Assurance Team. Among Care-at-

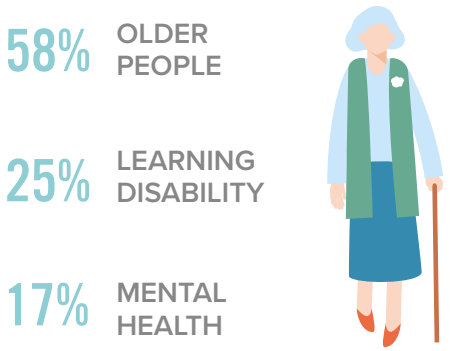
home Service Providers, two are rated Outstanding and 30 (67%) are rated Good. A further 13 services are not yet rated by the CQC, largely due to new registrations and the time required for inspection. The Local Authority does not place people with unrated services. Overall, the quality of Care Home and Homecare provision in Wandsworth remains very good, supported by active quality oversight, partnership working and a continued focus on safe, effective and person-centred care for residents.

INADEQUATE 0%

Care Homes CQC Rating (Wandsworth)	No	%
Outstanding	2	8%
Good	20	83%
Requires improvement	2	8%
Inadequate	0	0%
Not yet rated	0	0%
Total	24	

INADEQUATE 0% - UNRATED SERVICE 29%

Care-at-home Services CQC Rating (Wandsworth)	No	%
Outstanding	2	4%
Good	30	67%
Requires improvement	0	0%
Inadequate	0	0%
Unrated service	13	29%
Total	45	



Care Home Type (Wandsworth)	No	%
Older people	14	58%
Learning disabilities	6	25%
Mental health	4	17%
Total	24	

Richmond and Wandsworth Safeguarding Adults Board

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LEARNING FROM LIVES AND DEATHS OF PEOPLE WITH A LEARNING DISABILITY AND AUTISTIC PEOPLE IN RICHMOND AND WANDSWORTH

This section provides an overview of reported deaths, demographic information and findings from LeDeR reviews for people with a learning disability and/or autism in Richmond and Wandsworth, undertaken by the South West London LeDeR Team during 2025/26.

LeDeR is a service improvement programme, not an investigation into a person's death. Its purpose is to review the care and treatment people received before and during the final stage of life, recognising good practice and identifying learning for providers through local LeDeR Steering Group meetings.

We would like to thank family members, friends, health and social care staff, and others who contributed to LeDeR reviews by sharing their experiences of the life and death of a loved one or someone in their care.

Richmond LeDeR Data 2025/26

During 2025/26, the South-West London Integrated Care Board (ICB) LeDeR Team received seven notifications of deaths of people with a learning disability who were residents of the London Borough of Richmond.

Two reviews have been completed to date. These related to two woman that died in hospital. The recorded cause of death included pneumonia in two cases both cases was multi-organ failure.

Wandsworth LeDeR Data 2025/26

During 2025/26, the South-West London ICB LeDeR Team received 16 notifications relating to the deaths of people with a learning disability who were residents of Wandsworth.

Four reviews have been completed to date. These related to three woman and one man, all of whom died in hospital. The recording causes of death included pneumonia, while the remaining two deaths resulted from a gastric bleed or perforation.

Themes

Positive Practice

- Effective implementation of reasonable adjustments within hospital settings to support the needs of people with a learning disability.
- Continuity and consistency of GP care, which enabled strong therapeutic relationships to develop and supported the anticipation of changing needs and proactive care planning.
- High-quality end-of-life care, including timely and sensitive discussions with families regarding prognosis, treatment options, and ceilings of care.

Key Learning

- The importance of listening to individuals and those who know them well to reduce the risk of diagnostic overshadowing and ensure timely identification of health concerns.
- The need to strengthen processes for transferring learning disability diagnoses between GP practices to ensure continuity of care, access to annual health checks, and timely involvement of specialist learning disability services.
- The importance of proactive follow-up by clinicians when appointments are missed, to reduce the risk of unmet health needs and disengagement from services.

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

Richmond and Wandsworth Safeguarding Adults Board

6 LEARNING FROM SAFEGUARDING ADULT REVIEWS

Safeguarding Adult Review Referrals

During the year, four Safeguarding Adult Reviews (SARs) referrals were considered (all from Wandsworth), one of which met the criteria for a mandatory SAR.

Richmond

- ☑ **0** SAR Referrals received
- ☑ **0** Met the criteria for SAR
- ☑ **0** SARs completed in year

Wandsworth

- ☑ **4** SAR Referrals received
- ☑ **1** Met the criteria for SAR
- ☑ **1** SARs completed in year

‘Hope’ (Wandsworth)

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

Who was Hope?

Hope was a 66-year-old Black British Caribbean woman living alone with long-term physical and mental health needs, including diabetes, chronic illness and anxiety. She experienced self-neglect, increasing isolation, and declining health over several years. Hope often did not engage with services – missing appointments and limiting contact to telephone or at the doorway. There was prolonged non-access to her home, with no professional entering the property for several years, meaning her living conditions were not seen. Multiple agencies were involved, but no single agency had a full picture of risk. Her situation involved cumulative risk over time rather than a single crisis, with deterioration in health, environment and engagement.

Hope valued her independence and privacy and experienced significant anxiety that shaped how she interacted with the world. People who knew her described her as polite, articulate, and able to form warm connections when she felt safe. Her home was central to her sense of safety and autonomy. Over time, her anxiety about intrusion and change increased, and she became more cautious about allowing others into her personal space. This preference for privacy was closely tied to her identity and autonomy.

Hope’s life included periods of isolation, but also moments of connection with professionals who tried to engage her respectfully and at her pace. Understanding her wishes, fears and need for safety is key to understanding how safeguarding responses were experienced by her, and why proportionate, relationship-based approaches mattered. This review does not reduce Hope’s life to her vulnerabilities. She lived independently for many years, managed her own home, and engaged with services on her own terms. At the same time, her isolation, declining health and difficulty engaging with support meant that no single agency held a complete picture of her lived experience. Understanding this context is essential to making sense of practitioners’ decisions and the system responses explored in the sections that follow.

Why was this SAR commissioned?

The RWSAB Executive agreed that Hope’s case met the criteria for a mandatory SAR on the grounds that the adult had care and support needs; there is evidence suggesting agencies could have worked better together and individually, and signs of considerable self-neglect were uncovered after Hope died.

continued over the page

Richmond and Wandsworth Safeguarding Adults Board

What were the findings from the review?

1. Prolonged invisibility and non-access meant that self-neglect and environmental risk were normalised rather than escalated.
2. A narrow and episodic focus on mental capacity, combined with anxiety and non-engagement, constrained professional curiosity and safeguarding escalation.
3. Thresholds and escalation processes did not sufficiently respond to cumulative self-neglect, prolonged non-engagement, and systemic invisibility.
4. Housing oversight and assurance were not sufficiently integrated into safeguarding responses, contributing to prolonged invisibility and unmanaged environmental risk.
5. The absence of structured learning, review, and challenge mechanisms limited the system's ability to disrupt drift.

What will we do?

- Embed prompts within safeguarding and panel processes to identify and escalate prolonged non access.
- Deliver multi agency learning on executive functioning and cumulative risk.
- Reinforce housing involvement in safeguarding enquiries and escalation routes.
- Introduce equity prompts and audit self-neglect cases by protected characteristic..

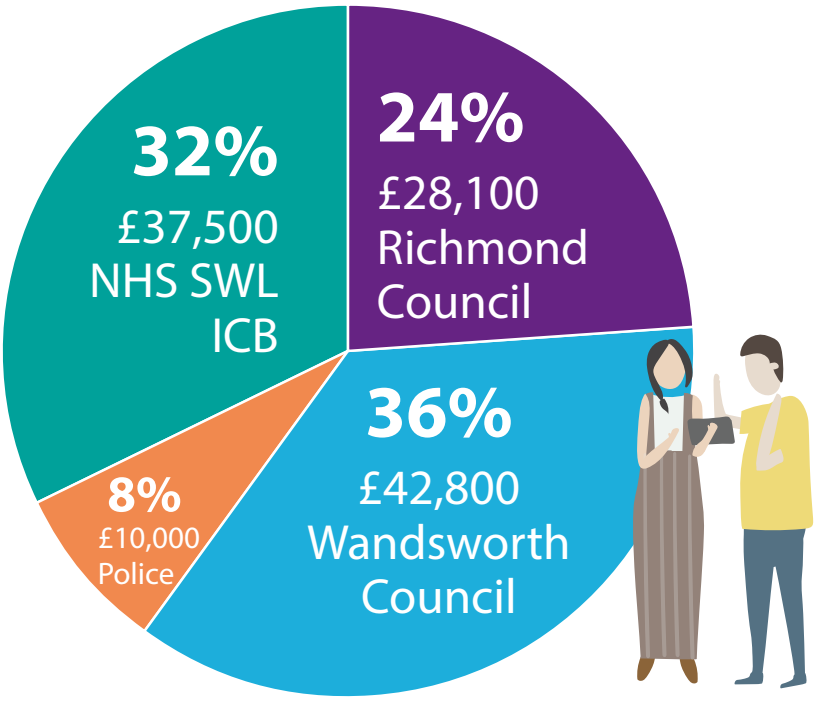
7

FINANCIAL SUMMARY

Although Richmond and Wandsworth Councils hold primary responsibility for Safeguarding Adults, key statutory partners are anticipated to equitably contribute to the partnership's resources. This contribution is essential to ensure effective safeguarding practices and responses.

As shown in the chart above, Richmond and Wandsworth Councils provided 60% of RWSAB funding. The South-West London Integrated Care Board and the Metropolitan Police also made direct financial contributions. The newly announced uplift from the Metropolitan Police, alongside ongoing discussions with the ICB, shows positive progress towards a more equitable funding arrangement across RWSAB's three statutory partners. Section 9 below outlines partners' wider non-financial contributions to safeguarding activity across Richmond and Wandsworth.

Who gave money to the RWSAB?



Richmond and Wandsworth Safeguarding Adults Board

8 PARTNERS' CONTRIBUTIONS

While Richmond and Wandsworth Councils are responsible for safeguarding adults in their respective boroughs, all partners contribute to our strategy. This section describes how the partners have worked towards achieving the strategic plan and improving Safeguarding arrangements in Richmond and Wandsworth.

HEALTH, CARE AND POLICE STATUTORY SAB PARTNERS

Adult Social Care – covering Richmond and Wandsworth Councils

During 2025/26, Adult Social Care continued to provide strong strategic leadership and operational delivery in support of the Richmond and Wandsworth Safeguarding Adults Board's statutory priorities, despite sustained system pressures and increasing complexity of need. The Councils played a key role in prevention and early intervention by strengthening cost-of-living support, developing the Carers Charter, improving support pathways, and maintaining robust transition arrangements between children's and adults' services. This work helped to identify risk earlier, support adults and carers before needs escalated, and ensure people experienced more joined-up support at key points of change.

Adult Social Care also led whole-system improvements to safeguarding responses, promoting proportionate, timely and person-centred interventions while keeping Making Safeguarding Personal central to practice. Progress included strengthening front-door decision-making, improving the quality and consistency of safeguarding referrals, and developing more confident responses to self-neglect, mental capacity, coercion, non-engagement, and complex risk. This activity was informed by learning from

Safeguarding Adults Reviews, partnership audits and multi-agency reflection, helping to translate learning into practical improvements for frontline practice.

Adult Social Care played a central role in quality assurance, governance, and the coordination of multi-agency safeguarding arrangements across both boroughs. This included supporting the Board's core functions through a significant funding contribution, providing professional leadership to sub-groups and assurance activity, and working closely with health, police, housing, and voluntary sector partners to strengthen shared ownership of safeguarding improvement. Through this leadership, Adult Social Care helped to drive continuous improvement, embed system learning and maintain a clear focus on safe, inclusive, and outcome-focused safeguarding practice.

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

Throughout 2025/26, SW BCU continued to prioritise safeguarding through early identification of vulnerability, strengthened multi-agency working and improved governance across public protection. Building on arrangements established previously through MASH terms of reference, dedicated mental health oversight and regular safeguarding learning, the BCU has continued to focus on putting the right resource and partnership response around adults at risk at the earliest opportunity.

In relation to prevention and early intervention, the BCU maintained a strong focus on vulnerability, domestic abuse, stalking and missing persons. During 2025/26, domestic abuse offences increased by 13% across SW BCU, while stalking also rose, reinforcing the need for prompt safeguarding responses, early risk assessment and close supervision of repeat and high-risk cases. At the same time, missing person volumes reduced significantly by 44% through improved risk management, triage and partnership resolution. Stalking awareness training launched in April 2025, alongside improved tracking has supported early identification and more consistent recording of stalking-related risk.

For making safeguarding personal, the BCU has continued to strengthen victim-centred practice through oversight of Victims' Code of Practice compliance and improved identification of priority victims. The SW BCU ended the year with positive increases in identified priority victims and victim update compliance measures, helping to ensure victims are better informed and supported. This sits alongside continued local oversight of safeguarding performance by senior leaders and public protection managers.

In respect of quality assurance and embedding learning, SW BCU has continued to use management oversight, organisational learning and partnership review processes to identify issues, improve practice and address data quality concerns. Learning from safeguarding reviews continues to be shared across the BCU, while Connect-related recording issues and outcome accuracy have remained an area of focus for supervision and assurance.

For cross-sector working, the BCU has maintained established links with Adult Social Care, mental health services and safeguarding partnerships, including continued police representation at safeguarding board and review forums. This partnership approach remains essential to safeguarding adults effectively, particularly where risk is complex, repeat or spans mental ill health, domestic abuse, exploitation or hate crime.

South-West London Integrated Care Board (SWL ICB) – Richmond and Wandsworth

In March 2025 the government announced that changes would be made to the purpose and function of ICBs with the release of the ICB Blueprint. This shifts the focus of the ICB to look at key functions to: understand local need (assess population needs to address inequalities and improve quality and performance); develop a long-term strategy (have a clear long-term health plan for the local population); develop the payer function (to ensure that what is purchased delivers outcomes). As part of this plan ICBs were required to make significant savings of 50% nationally in running costs, for SWL ICB the amount is 58%. SWL ICB has designed new structures, supported by a clustering arrangement with South East London ICB, and has undertaken a consultation as part of this process. These proposed changes will be delivered in 2026-27 and so will be reported in the next annual report. The likely impact for safeguarding will be a reduction in designate capacity for the ICB. For 2025-26, NHS South West London ICB continued to demonstrate strong strategic leadership and system-wide engagement in adult safeguarding. The Chief Nursing Officer (CNO) delegates safeguarding responsibilities to the Directors of Quality, who act as senior leaders and Executive members of the Richmond and Wandsworth Safeguarding Adults Board (RWSAB), with one Director also serving as the Senior Responsible Officer (SRO) for safeguarding across the ICB. The Designated Safeguarding Adults Professional for Richmond and Wandsworth remains an active contributor across RWSAB sub-groups and chairs the Wandsworth Community Forum, ensuring effective connectivity between system partners.

1) ICB Achievements Over the Last Year in Relation to Safeguarding Adults

During 25-26, the ICB has supported delivery of joint safeguarding priorities through targeted training for GP practices, including sessions on self-neglect and hoarding (aligned to the new framework), training on financial abuse, strategic support around mental capacity and transitions, supporting complex CHC case management and oversight of health trusts; both in public and private sector. Richmond and Wandsworth designate has worked with the named GP to provide Safeguarding training in the area of Financial Abuse – this was delivered to the mental health trust , acute care providers and due to be presented at the GP forum.

The Safeguarding Adults Team has also continued to lead the Learning from Lives and Deaths Programme (LeDeR), bringing together partners from across South West London, including learning disability community teams, acute trusts, mental health services, and local authorities. This collaborative work aims to

review mortality data, identify key themes, and ensure that learning is translated into meaningful action. A central focus remains on improving outcomes and maintaining the needs of autistic people and individuals with a learning disability as a priority within the health system.

A significant area of achievement has been the continued strengthening of the Richmond and Wandsworth Safeguarding Adults Boards (SABs), including the completion of the Annual General Meeting in March 2026 and the development of strategic priorities around Prevention, Making Safeguarding Personal, cross-sector collaboration and Quality Assurance. The partnership identified key areas for improvement and has proactively responded through the establishment of Task and Finish Groups, simplification of referral pathways and development of clearer guidance for practitioners managing complex safeguarding concerns. Particular focus has been placed on improving responses to self-neglect, homelessness, mental health, substance misuse and non-engagement.

Another key achievement has been strengthening multi-agency safeguarding coordination and quality assurance across provider services. Designated safeguarding leadership has continued to support provider risk panels, care governance boards and safeguarding oversight arrangements across Richmond and Wandsworth. This has included close liaison with the Care Quality Commission (CQC), Continuing Healthcare (CHC), Local Authority teams and provider organisations where safeguarding concerns have arisen. Oversight has included concerns relating to learning disability services, medication management, environmental safety, governance and supervision within care settings, ensuring robust escalation and coordinated multi-agency responses.

The ICB has also maintained strong oversight of complex provider and hospital safeguarding arrangements. This has included safeguarding support to organisations such as St George's University Hospitals NHS Foundation Trust and Royal Hospital for Neuro-disability, including attendance at safeguarding committees, safeguarding audits, supervision support and expert advice around complex Court of Protection applications. Work has also included aligning safeguarding governance structures across acute provider collaboratives and supporting safeguarding leadership during workforce gaps.

Significant progress has also been made in relation to domestic abuse and serious violence prevention. The Designated Safeguarding Lead continues to attend Community Safety Partnership meetings to strengthen the connection between safeguarding, crime prevention and public protection across the boroughs. Domestic abuse services across Wandsworth continue to provide enhanced Independent Domestic Violence Advocate (IDVA) and Independent Sexual Violence Advocate (ISVA) support pathways, including specialist provision around economic abuse and individuals with No Recourse to Public Funds. The ICB has a dedicated Domestic Abuse and Sexual Violence (DASV) Lead within the Safeguarding Adults Team. The postholder actively contributes to national workstreams addressing key agendas, including Violence Against Women and Girls (VAWG) and sexual safety. The DASV Lead also represents the ICB at national forums, including the Crossing Pathways network, co-chaired by Standing Together Against Domestic Abuse in partnership with NHS colleagues. The ICB, alongside its provider organisations, is a signatory to the Sexual Safety Charter and

has published the first iteration of its Sexual Misconduct Policy, demonstrating a clear commitment to promoting safe and respectful environments for both patients and staff.

The ICB has also demonstrated strong leadership in relation to safeguarding reviews and system learning. Current work includes oversight of ongoing Safeguarding Adults Reviews (SARs) and Domestic Homicide Reviews (DHRs) across Richmond and Wandsworth. Themes emerging from these reviews include homelessness, trauma, domestic abuse, mental health, cumulative harm, suicide, information-sharing and multi-agency coordination. Learning from reviews is actively being disseminated across agencies, including emerging work around domestic abuse and menopause awareness within healthcare settings and GP forums.

The ICB continues to engage with NHS England around national learning, and the Rand W designate inputs into the national archive of SARs CSPR and DHR – themes emerging are reviewed at a quarterly panel.

A modern Slavery task and finish group has been set up across Richmond and Wandsworth , where the ICB will continue to contribute to system wide analysis and subsequent improvement programme.

Overall, the last year has demonstrated a strong commitment across Richmond and Wandsworth to improving safeguarding systems, strengthening partnership responses and embedding a culture of learning, prevention and collaborative practice across health and social care systems.

2) Key Challenges

Over the past year, the Integrated Care Board (ICB) Safeguarding Adults Team has operated within a context of organisational uncertainty, particularly in relation to proposed workforce reductions across the ICB. This has had a direct impact on safeguarding capacity for both adults and children's services.

3) Priorities and Plans for the Coming Year

The ICB will continue to work collaboratively with the Richmond and Wandsworth Safeguarding Adults Board, recognising the ICB's statutory duty to support effective safeguarding arrangements across South West London. Key priorities for the coming year include:

Strengthening Safeguarding Assurance and Governance – Continue supporting the Board and partners to gain assurance regarding safeguarding practice across providers, with a focus on quality, learning from reviews, provider concerns and safeguarding outcomes. A focus on internal governance arrangement as structures change will also be a key area of focus.

Embedding Learning into Practice – Continue to ensure learning from Safeguarding Adults Reviews (SARs), Domestic Homicide Reviews (DHRs) and other relevant reviews and serious

incidents is translated into measurable improvements in practice.

Prevention and Early Intervention – Support the board with the focus around early intervention and prevention via training and raising awareness across the health landscape.

Enhancing Multi-Agency Collaboration – Continue to strengthen partnership working across health, adult social care, housing, community safety and voluntary sector organisations to improve coordinated responses to domestic abuse, self-neglect, exploitation and complex safeguarding cases.

Workforce Development and Practice Improvement – Support safeguarding workforce development through training, reflective practice and partnership learning, with emphasis on trauma-informed approaches, Making Safeguarding Personal, mental capacity and complex risk management.

Provider Oversight and Quality Assurance – Continue strengthening oversight of safeguarding concerns within commissioned providers, care homes and supported living services through Provider Risk Panels, governance processes and safeguarding audits.

Advancing the Domestic Abuse and VAWG Agenda – Continue supporting the implementation of the Sexual Safety Charter and wider Violence Against Women and Girls (VAWG) priorities, including dissemination of learning from DHRs and strengthening healthcare responses to domestic abuse and complex trauma.

HEALTH PARTNERS

Central London Community Healthcare NHS Trust (CLCH)

During 2025/26, CLCH Wandsworth continued to strengthen safeguarding practice through partnership working, workforce development, quality assurance, and embedding learning.

1. Prevention and Early Intervention

CLCH Wandsworth has continued to promote early identification and management of safeguarding concerns through regular meetings with the Wandsworth Local Authority Safeguarding Lead and attendance at the RWSAB Self-Neglect and Hoarding Panel.

Fortnightly safeguarding huddles were introduced across community nursing and therapy services to facilitate early discussion of emerging risks, support decision-making, and enable timely intervention. Pressure Ulcer Prevention (PUP) safeguarding training has also supported practitioners to identify and respond appropriately to safeguarding concerns at an earlier stage.

2. Making Safeguarding Personal

Practitioners have been supported to

adopt a person-centred approach through safeguarding supervision, reflective discussions, and learning opportunities focused on the Mental Capacity Act (MCA). An MCA audit was completed during 2025/26, identifying strengths and areas for improvement in capacity assessments, best interest decision-making, and documentation. Findings informed policy updates, targeted learning, and the establishment of an MCA Community of Practice to improve consistency and strengthen application of MCA principles. A continued focus has been placed on MSP, ensuring that the adult's voice and desired outcomes remain central to safeguarding interventions and decision-making.

3. Quality Assurance and Embedding Learning

Training compliance for Level 3 Safeguarding and MCA remained above 92% throughout the year. Learning was embedded through safeguarding journal clubs, safeguarding supervision, audits, and the CLCH Safeguarding Conference, attended by over 650 delegates. Journal club sessions covered key safeguarding themes including no access to adults at risk, restrictive practice, and escalation in complex safeguarding cases, supporting practitioner confidence and professional curiosity. The conference showcased learning from complex safeguarding cases and examples of good practice. In addition, a webinar on managing difficult conversations was delivered, drawing on learning from Safeguarding Adult Reviews and reinforcing professional challenge, escalation, and reflective practice.

4. Cross-Sector Working

CLCH Wandsworth has maintained strong partnership working with Adult Social Care, the Safeguarding Adults Board, and wider multi-agency partners. Participation in safeguarding panels, promotion of multi-agency MCA and domestic abuse training, and improved information sharing with social care and care providers have strengthened collaborative safeguarding responses. These arrangements have supported coordinated risk management, improved referral quality, and enhanced protection for adults at risk.

Kingston and Richmond NHS Foundation Trust (KRFT)

1. Prevention and early intervention

Adult Safeguarding has been working closely with the Hospital IDVA service to intervene early where domestic abuse is disclosed or reported

We referred to the Kingston Hospital Carers Liaison Service to help prevent / support unpaid carer burnout

Close Liaison with the Kingston Hospital Discharge Hub helped avoid potential unsafe discharges, abuse and neglect

The Safeguarding Adults team are core members of the Richmond Locality Multi-Disciplinary Teams (MDTs) and have consistently advised and supported colleagues across health and social care with complex or stuck cases to avoid Safeguarding where this is appropriate.

We continue to monitor and administrate Deprivation of Liberty in all KRFT Wards.

2. Making Safeguarding Personal

Flagged in the Safeguarding Level 3B training offer across the Trust.

We have been represented with NHSE to help develop the future Safeguarding learning offer.

3. Quality assurance and embedding learning

The service has produced 7-minute summaries and multimedia clips for key Safeguarding related messages to share with staff.

We have undertaken a review and merge of all Safeguarding policies and guidelines.

Daily screening of Datix incident reports has enabled Safeguarding issues to be followed up and learning identified for service lines.

4. Cross-sector working

Participation in the Modern Slavery network, the London Mental Capacity Act and Deprivation of Liberty Safeguards Forum, Richmond Multi-Agency Risk Assessment Conference (MARAC) and Channel Panel have enabled us to work through relationships, share information securely and contribute to safeguarding our patients across the Trust.

Chelsea and Westminster NHS Foundation Trust

Safeguarding activities and contribution to SAB priorities (2025/26)

During 2025/26, Chelsea and Westminster Hospital NHS Foundation Trust continued to strengthen its adult safeguarding arrangements, with a clear focus on prevention, partnership working and embedding learning across clinical services. The Trust Safeguarding Adults Team provided expert leadership and operational oversight across acute, community and specialist services, ensuring compliance with the Care Act 2014 and local multi agency policy.

Prevention and early intervention were prioritised through early identification of safeguarding risks at the front door, including neglect, self neglect, domestic abuse, modern slavery and exploitation. Safeguarding advice and escalation pathways were embedded into clinical practice through targeted support to wards and teams, enabling timely referrals to Adult Social Care and other partner agencies and reducing the risk of escalation.

The Trust actively promoted Making Safeguarding Personal (MSP) by supporting practitioners to focus on individual outcomes, voice and lived experience. This included case discussions, supervision and reflective practice that emphasised proportionality, least restrictive interventions and shared decision making, particularly for people with learning disabilities, mental health needs or complex social circumstances.

In relation to quality assurance and embedding learning, the Trust contributed to safeguarding audits, Safeguarding Adult Reviews (SARs) and learning dissemination. Learning themes were shared through internal briefings, training sessions and policy review activity, supporting continuous improvement and alignment with system wide expectations. Training compliance for Levels 1–3 adult safeguarding continued to be monitored and strengthened, with Level 3 training contributing to improved confidence in recognising and responding to abuse and neglect.

Cross sector working remained a core strength. The Trust engaged actively with the Safeguarding Adults Board, Adult Social Care, the Integrated Care Board, police and voluntary sector partners through strategy meetings, complex case discussions and multi agency forums. This collaborative approach supported shared oversight of risk, effective information sharing and a coordinated system response to safeguarding concerns.

South-West London and St. George's Mental Health Trust (SWLSTG)

Over the past year, there has again been increased activity for Prevent, including a rise in requests for Trust staff to attend board and subgroup meetings. While this reflects strengthened engagement, it has created resource pressures for SWLSTG staff in supporting SAB activity, which has been challenging to manage.

As of August 2025, Adult Safeguarding Level 3 Training became an annual requirement rather than 3 yearly ensuring staff are having a minimal level of training and refreshers each year.

- Safeguarding Annual Conference took place on 05.06.2025 which was a great success with 196 attendees.
- Domestic Abuse Conference took place on 05.12.2025 for internal & external colleagues in recognition of the 16 Days of Activism, with 200 attendees

Trust Safeguarding Adults Fundamental Standards of Care updated in January 2026, reinforcing the golden thread of safeguarding across the Trust by clearly defining the minimum standards required to protect adults at risk and ensuring these expectations are embedded consistently throughout all services.

Safeguarding Decision-Tool was reviewed and updated in collaboration with Richmond and Wandsworth.

Safeguarding Team in collaboration with the MCA Advisor created a self-neglect toolkit to rollout to the Trust.

The Safeguarding Team with the support of the Physical Health Team have improved response to valid consent & refusal to physical health treatment considering MCA principles, also strengthening our partnership with MCA Leads at general hospitals. A new MCA FSOC is being developed by MH law colleagues.

All safeguarding policies and strategic projects are developed in line with co-production principles, embedding the voices of people with lived experience throughout decision-making and practice.

SWLSTG Involvement Team offers paid and voluntary roles to people with lived experience, conducted a survey with in-patients on adult acute wards to gather their views on safety. Findings informed ward-level action plans ensuring service user feedback directly drives improvements.

St. George's University Hospital NHS Foundation Trust (part of GESH – St George's, Epsom and St Helier University Hospitals and Health Group)

Prevention & Early Intervention

Adult Safeguarding posters are displayed across the Trust, providing clear contact details, including the names and telephone numbers of the safeguarding team. For more complex safeguarding cases, a designated member of the safeguarding team is assigned as a key point of contact for the patient or their representative. This individual provides continuity of care.

The safeguarding team maintains a visible and accessible presence across all Trust sites, supporting staff and promoting a culture of safety and vigilance. Learning is reinforced using local case studies and case discussions in training and supervision.

A new level 3 adults safeguarding training package has been developed and actioned with positive feedback. Case studies utilised within the adult's level 3 package are a way to share learning from SARS.

In your shoes a domestic abuse sims package has been rolled out across GESH with community partners invited, this won a GESH hospital award for innovation and is incredibly well received.

Key safeguarding messages and updates are shared through multiple communication channels and with bespoke training sessions tailored to specific teams or services.

Regular touchpoint meetings with directors of nursing from the divisions enables a clearer safeguarding communication channel with enhanced governance and oversite on safeguarding and MCA/DoLS.

Integration across children's, adults, maternity and learning disability teams has strengthened over the last twelve months and this has led to increased communication and multi-disciplinary working. A whole safeguarding team meeting was held to aid integration and to look at work plans for the coming year,

Increased visibility of the Safeguarding Team has resulted in:

- Increased staff engagement and early consultation with the safeguarding team.
- Improved accessibility and responsiveness to frontline concerns.
- Improved quality and quantity of safeguarding referrals.

Making Safeguarding Personal

Comprehensive workforce training and sustained awareness-raising among staff and service users remain core components of safeguarding work. All staff have access to mandatory safeguarding training tailored to their role and aligned with the Intercollegiate Adult Safeguarding: Roles and Competencies Framework.

An MCA/DoLS audit has been carried out with several key recommendations over the last quarter. A working group will be set up to address the recommendations and provide action plans and time scales to ensure the recommendations have been carried out.

Extensive work with complex marginalised patients to enable them to access hospital services has been undertaken over the past 12

months which has led to the co -production of a cancer pathway for potential court of protection cases this includes step by step guidance on MCA, the best interest process and reasonable adjustments that can be undertaken to enhance the potential for people with mental health illness, learning disabilities and dementia/ cognitive impairment the ability to access cancer treatment in a timely way.

Bespoke care pathways have been established across Trust sites for people with learning disabilities. The learning disability team are a visible resource providing holistic care across the GESH group and aligning data to enable ongoing quality improvement work.

Quality Assurance and Embedding Learning

Workforce Engagement and Education - GESH adult safeguarding level 3 alongside is delivered alongside bespoke training. The clear emphasis over the last twelve months has been the re-introduction of adults safeguarding level 3 training with a clear emphasis on improving uptake and understanding.

The safeguarding team regularly shares audit outcomes and learning with SAB sub-groups and disseminates regionally coordinated training through newsletters, bulletins, and supervision forums. This ensures safeguarding remains a live, evolving area of practice across the workforce. Policies in relation to safeguarding, MCA, domestic abuse have been renewed and updated and are now GESH-wide policies.

Cross-sector working

The Trust plays an active role in local and regional safeguarding activities, such as:

- Multi-Agency Adults High Risk Panel:
- Southwest London Protocol on Pressure Ulcers, Medication and Falls:
- Learning from Safeguarding Adult Reviews:
- Neglect and hoarding panel.

The Trust's Safeguarding Workplan is closely aligned with the priorities set out in the SAB Strategic Plan. This alignment is maintained through regular attendance and active participation in SAB sub-groups.

The safeguarding team contributes directly to shared improvement activities, including Discharge Audit and use of the Discharge Checklist, both presented to SSAB and followed by implementation of local actions to improve safe discharges.

Your Healthcare (YH)

1. Prevention and Early Intervention

Your Healthcare (YH) frontline services, with the support of the YH safeguarding team work to identify risks early, respond to concerns, and support preventative interventions.

YH continues to participate in local high-risk panels, enabling prioritisation of referrals for clinical input where this supports risk reduction and safety netting.

The safeguarding team also monitors cases involving self-neglect and where the safeguarding process has not resulted in risk mitigation, we ensure referral to Self-Neglect and Hoarding Panel where additional multi-agency oversight can benefit.

Routine domestic abuse enquiry questions were introduced across services during 2024-25. A 2025 audit showed 73% compliance, with training planned to improve this further. Work also began in early 2026 to implement guidance on non-fatal strangulation and increase early identification and response.

2. Making Safeguarding Personal

YH's safeguarding approach focuses on providing timely, person-centred support that reflects individual risks and circumstances.

Through close working with frontline teams and multi-agency partners, safeguarding interventions and support plans are tailored to the needs of the individual.

The continued focus on domestic abuse enquiry and monitoring of complex self-neglect cases supports earlier identification of need and coordinated support for those at greatest risk.

3. Quality Assurance and Embedding Learning

YH has strengthened its systems for monitoring safeguarding activity and embedding learning into practice.

Improvements to the incident reporting system now allow actions arising from safeguarding concerns, incidents, and pre-safeguarding activity to be tracked and monitored to completion.

A structured process has also been introduced to review learning from national guidance, legislative updates, and local Safeguarding Adult Reviews (SARs).

4. Cross-Sector Working

Partnership working remains central to YH's safeguarding approach.

Participation in local high-risk panels and collaboration with agencies and representation on high-risk panels support coordinated responses for individuals with complex or high-risk needs. The arrangements strengthen information sharing, joint decision-making, and early intervention across organisations.

YH also continues to align safeguarding practice with national guidance, local safeguarding priorities, and multi-agency learning.

Richmond and Wandsworth Safeguarding Adults Board

VOLUNTARY SECTOR PARTNERS

Age UK Richmond

Age UK Richmond provide Safeguarding training to all our staff, volunteers and third party providers. During the year we undertook a review of the training we provide to volunteers and have looked to make it simpler and more accessible focusing on the key Safeguarding information that will help them in their roles. Managers also complete Safeguarding for Manager's training.

We maintain Safeguarding Adults and Safeguarding Children policies which are regularly reviewed and kept updated. We share our policies where it is useful to help other local charities.

We are keen that all staff, volunteers, third party providers and older people themselves feel able to report signs of abuse. This year, we have worked with adult social care to help staff feel more confident in being able to discuss individual concerns anonymously if required, especially if they are unsure if a Safeguarding referral is needed.

We use staff and services meetings to review how cases have been handled, and where improvement can be made.

Age UK Wandsworth

Age UK Wandsworth remains committed to being a partner in the RWSAB and participate in the Wandsworth Community Forum.

We completed the yearly self-assessment questionnaire and engage in relevant learning and development events.

All of our volunteers, trustees and staff must complete an online safeguarding training course as part of the recruitment process, and we provide guidance on how to recognise and report abuse, making referrals where appropriate. All of our staff who complete home visits complete mandatory Safeguarding Children training and line managers also complete Safeguarding for Managers and Safeguarding Leads training. Age UK Wandsworth have two Senior staff at each of our sites designated as Safeagurding Leads and this is diesplayed clearly on posters in each site to make this clear to all visitors and staff who they can report their concerns to.

Online safeguarding training is renewed annually as are the organisations Safeguarding policies. Staff training on Age UK Wandsworth Safueguarding policies and procedure is carried out annually by an Executve Team member with the Senior Leadership Team members who then hold additional refresher training with their respective teams.

Safeguarding is a standing agenda item at all of our staff meetings along with the Operations and Sub-Committee and Full Trustee meetings. All staff are regularly encouraged to raise any concerns, no matter how small, as soon as possible.

RWSAB Safeguarding Newsletters and relevant updates are shared with all of our staff and also volunteers when appropriate.

Alzheimer's Society – Richmond and Wandsworth

Through safeguarding training (undertaken annually) enables strengthened early identification of safeguarding concerns enabling actions to be taken and reducing the need for crisis intervention.

Using professional curiosity when speaking to individuals, to gather information to mitigate situations where possible.

Embedding a person-centred approach, ensuring individuals views, wishes and desired outcome are central to decision making. this ensures options/support/intervention are the least restrictive.

Using our internal safeguarding team to support and escalate when needed.

Carrying out random audits on case work to ensure safeguarding is being recognised and no missed opportunities have arisen.

Working collaboratively across the boroughs with ASC sharing information where appropriate, working on joint home visits to support people affected by dementia.

Richmond Council for Voluntary Services (CVS)

Richmond CVS is the commissioned infrastructure organisation for the borough supporting the voluntary and community sector (VCS) in all aspects of their activity. Our primary function, relating to safeguarding adults at risk, is to promote an environment where not for profit organisations and their governance structures understand their responsibilities, have effective policies and procedures in place, feel confident in their knowledge and updated in their learning, and know how to respond where there is a concern.

We continue to support the principle that "Safeguarding is everybody's business" regardless of the type of charitable activity delivered and we recognise and support the prevention role of the sector and the benefit of intervening early. This year we have worked with 16 groups on a 1.1 basis to develop or update adult at risk safeguarding policies and procedures and to answer queries relating to DBS check eligibility and implementation. The groups operate across a wide range of activity such as neighbourhood care groups, surplus food provision, bereavement and counselling, and sports groups. Through our network we promote training opportunities, and legal updates such as the safeguarding implications of The Renters Rights Act. We also highlight the range of resources available to residents, linking agencies to support available such as cost-of-living grants and equipment.

Richmond CVS chairs the Richmond Safeguarding Adults Board Community Forum which includes our main social housing provider, health and social care colleagues, the DWP, Met police volunteers and Richmond Healthwatch. Working closely with the RWSAB we raise awareness of the safeguarding risks we are seeing at a community level and promote early intervention. We focus on improving practice, and have highlighted the challenges of supporting residents in the community who present with multiple vulnerabilities with a particular focus on self-neglect. Topics have included "What constitutes a good safeguarding referral" and strengthening the feedback loop when a

safeguarding referral has been made. We are currently working on how we can improve the data presentation to this group so that exceptions and concerns are highlighted and there is opportunity for action-based improvement.

In response to VCS request we have established a Safeguarding Adults VCS Forum facilitated by safeguarding professionals from across the partnership. The aim of the facilitated forum is to create a safe and nurturing environment, where VCS staff and volunteers can share their experiences, and advice and learning is shared to support them to respond appropriately and to improve the safeguarding referral process. The VCS is often the first point of contact for residents where safeguarding risks can be identified early. It is critical that staff and volunteers feel confident and well supported to enable positive engagement and improved outcomes for local residents. We hope that this forum will help to foster this.

Healthwatch Richmond

Following the government's announced intention to abolish Healthwatch, this period marks a transitional phase that, assuming it passes, will ultimately end our independent insight and constructive challenge to the Safeguarding Adults Board (SAB).

Whilst we remain operational, we are deeply committed to our shared safeguarding goals. All staff and volunteers continue to be trained and supported to identify and report concerns, empowering community members to recognise and raise safeguarding alerts.

We have actively worked to influence both the incoming legislation – which transfers our role to Integrated Care Boards (ICBs) and Local Authorities – and local implementation plans. Our focus is to ensure as strong and independent a patient voice as possible remains to inform safeguarding practice.

Regrettably, managing this significant organisational change has impacted on our capacity to engage with safeguarding initiatives. It has also constrained our promotional support; we were unable to publish our Guide to Local Services or distribute printed materials across Richmond. The impending loss of this communications channel, and the unique voice we bring, underscores the importance of the Board's work to raise awareness and engage the community, which is now more critical than ever.

Wandsworth Care Alliance (WCA) and Healthwatch Wandsworth

Safeguarding Activity Summary 2025/26

Throughout 2025/26, our organisation has maintained a proactive and person-centred approach to safeguarding, aligning closely with the SAB priorities.

1. Prevention and Early Intervention

We have strengthened early identification of safeguarding concerns through regular staff training, awareness sessions, and clear reporting pathways.

2. Making Safeguarding Personal (MSP)

As a non-frontline organisation, we support the embedding of Making Safeguarding Personal principles through our policies, guidance, and partnership work. We promote a culture that encourages services to involve individuals in decisions about their care and safeguarding outcomes. Through influencing practice standards, sharing learning, and contributing to multi-agency discussions, we help ensure that person-centred approaches remain central, with a focus on outcomes that reflect what matters most to individuals.

3. Quality Assurance and Embedding Learning

We implemented regular audits, and policies were reviewed by the Board, as they are annually or by exception. We have kept abreast of any Safeguarding updates and included them in our policies. Additionally, learning from safeguarding incidents and reviews has been systematically shared across the team, informing service improvements and strengthening accountability. Safeguarding training is provided to all staff and volunteers upon induction. We support each other through co-reflection to provide mutual support, share knowledge and reflect on our practise to ensure the best outcome for the communities we support, as well as the wellbeing of employees.

4. Cross-Sector Working

We have continued to work collaboratively with partner agencies, including health, social care, and community organisations. Participation in multi-agency meetings and information sharing has strengthened coordination to improve outcomes for individuals at risk.

Overall, our safeguarding approach remains focused on prevention, partnership, and person-centred outcomes, ensuring we contribute positively to the SAB priorities.

Richmond and Wandsworth Safeguarding Adults Board

Richmond Carers Centre

1. Prevention & Early Intervention

- All staff and volunteers have comprehensive safeguarding training in induction and continued access to professional development opportunities. Staff are trained to support carers with minimising the risk of abuse and signpost to support services/referrals where needed to avoid escalation of concerns. All signposts and referrals are recorded and reported quarterly.
- RCC runs a counselling service for unpaid carers, where there has been a request for support around more complex emotional needs. Volunteers supporting the counselling service are required to complete mandatory safeguarding training and are BACP registered.
- RCC runs a bi-monthly Dementia Carers Information and Support Session in partnership with Richmond Memory Assessment Service. This session is for carers caring for someone with a new diagnosis of Dementia within the past two years. This session aims to support carers with early intervention, prevent escalation and how to manage challenging behaviour.

2. Making Safeguarding Personal

- Training opportunities are regularly shared with staff and records kept updated.
- RCC has recently updated its Code of Conduct for Adult Carers Service Users that also references when confidentiality needs to be broken if there is a concern about safeguarding, how they can be supported and where to go for information/legislation.

3. Quality Assurance and Embedding Learning

- Safeguarding policy review started in March 2026. This has involved working with outside organisations such as Richmond CVS for additional support and guidance to ensure quality.
- This policy is reviewed annually. The policy is shared on RCC website and there are signs within the centre to inform carers of who the Designated Safeguarding Leads are and how to contact them. The policy review this year has also seen the introduction of the PiPoT guidance as an appendix and identifies organisational leads.
- Internal safeguarding audit was conducted by a Trustee (nominated safeguarding lead on Board) and Senior Leadership Team in March 2026. The focus this year was to look across the organisation at staff understanding of safeguarding policies and procedures. The results showed that we have comprehensive training, policies and procedures in place. Going forward, this internal audit will be conducted on a biennial basis.

4. Cross-sector working

- RCC has provided induction sessions for a range of health and social care staff regarding the services available and highlighted common presenting safeguarding themes that unpaid carers may experience.
- RCC has a programme of professional awareness sessions targeting health, social care and voluntary sector teams to improve carer awareness and promote RCC's offer to carers.
- RCC attends bi-monthly Carers Champions meetings and has good working relationships with those working within Adult Social Care.

Wandsworth Carers Centre

Safeguarding remains a priority within the organisation and is a standing item on the agenda of both staff team meetings and board meetings.

All staff and volunteers are required to attend safeguarding training and to regularly update the training. This is monitored through supervision meetings and a training table recording attendance and dates. In line with our policy and procedures staff and volunteers always have access to a senior member of staff should any safeguarding queries or issues arise.

Interviews for staff and volunteers examines the candidates understanding of confidentiality and how this interacts with safeguarding priorities thus allowing us to identify any training awareness needs.

In June 2025 members of the Safeguarding team attended an Asian Carers peer support meeting to talk about safeguarding and the safeguarding board. This was a popular topic and well received by the Carers.

The CEO is a member of the Wandsworth Community Forum, is the safeguarding lead and has attended the DSL training level 3.

Our Safeguarding Adults policy was reviewed and updated in October 2025.

OTHER PARTNERS

Community Safety – Richmond and Wandsworth Councils

1. Prevention and early intervention

- DA & VAWG – Prevention and early intervention form key aspects of the VAWG Strategies for both boroughs. With Prevention before a key finding from the Wandsworth Task and Finish Group in 2026 that spoke to 355 people across four months. Recommendations as follows:

  a) To enhance the reach and visibility of Wandsworth's existing VAWG prevention offer in schools, exploring options to deliver interventions co-produced with young people and aligned with best practice regionally and nationally. This could be supported through measures such as creating a video co-produced with young people focusing on shared responsibility and allyship and considering opportunities to commission specialist service(s).

  b) To ensure a robust systems approach across statutory agencies, voluntary and community organisations and communities, to VAWG prevention and early identification by increasing visibility and sharing of best practice whilst identifying ways to address priority areas for further development. This could be supported through measures such as promoting partnership engagement in the VAWG Strategic Delivery Group, emphasising with partners the importance of sustaining key programmes like the

IRIS-i in GP practices, and exploring options to support senior management and committee oversight related to trauma-informed domestic abuse case management in Housing.

c) Maintain ongoing engagement with survivors, including renewed focus on seldom-heard communities, to ensure their voices inform the continuous improvement of service delivery and support available. This could be supported through measures such as exploring opportunities to commission specialist 'by and for' organisations and identifying tailored outreach strategies.

- Counter Terrorism – the Council chair the statutory Channel Panel which provides those who have been identified as at risk of radicalisation through prevention and bespoke early intervention work.
- Serious Violence and Reducing Reoffending – working with Wandsworth Children's, we attend the Youth Justice Board and Marve+. With Richmond Children's Services, there is a Youth Justice Board and a Vulnerable Adolescents Supported into Adulthood. There are also Community Multi Agency Risk Assessment Conferences separately in both boroughs.

  ASB Case Reviews also happen in both boroughs

  We also support different Forums: Violence Against Women and Girls, Serious Violence,
- Anti-Social Behaviour – there are many professional meetings, Rough sleeper's forum and Problem Solving Plans.

2. Making Safeguarding Personal

- DA & VAWG – The Councils commission a specialist advocacy service to provide safeguarding support to victim survivors of DA, each support plan is tailored to the needs of the service user. We have bolstered this by accessing grant funding for NRPF survivors.
- Moreover, the Council has utilised grant funding to ensure support to seldom heard communities and those more at risk of so-called honour-based abuse is bespoke during crucial safeguarding panels such as the Multi Agency Risk Assessment Panel.
- Counter Terrorism – the Channel Panel provides personalised support plans through an independent intervention provider through the Home Office to those identified at risk of radicalisation.
- Serious Violence and Reducing Reoffending – Wandsworth Bereavement Service to offer immediate counselling and therapeutic support to victims, witnesses, loved ones of serious violence incidents or where the community has been impacted.
- Anti-Social Behaviour – Victim centred approach e.g. ASB Case Review, new cuckooing steering group under the ASB Strategic Board.

3. Quality assurance and embedding learning

- DA & VAWG – CS continue to deliver on the statutory responsibility to conduct Domestic Abuse Related Death Reviews DARDRs and embed the learning which is monitored through the Strategic Delivery Group. There is a robust QA process in place through the governance structures in Community Safety – all priority areas are accountable to the Statutory Community Safety Partnership and are publicly

scrutinised by the Health Overview and Scrutiny Committee.

- Counter Terrorism - There is a robust QA process in place through the governance structures in Community Safety – all priority areas are accountable to the Statutory Community Safety Partnership and are publicly scrutinised by the Health Overview and Scrutiny Committee
- Anti-social Behaviour, Serious Violence – Review of risk assessments across multi agency meetings and problem-solving plans, partner training on upcoming legislative changes with the Crime and Policing Bill 2025 and robust governance across the cross-borough Strategic Delivery groups and sub-groups under the Community Safety Partnership.

4. Cross-sector working

- DA & VAWG – The local VAWG strategies are partnership approach and have been created through cross-sector partnership with many agencies. Attendance at the Strategic Delivery Groups is high from all core partners, we have great engagement with the voluntary community sector through the VAWG Community Forum.
- Counter Terrorism – The Council are well linked in with the Police regarding CT work and have an effective partnership approach monitored through a governance structure including Strategic Delivery Group accountable to the Community Safety Partnership. There is an emerging area of work with Prevent and Martyn's Law which has a Council-wide Task and Finish group to implement and ensure compliance.
- Anti-Social Behaviour , Serious Violence, Reducing Reoffending – there are strong Community Safety Strategies in place. We work with operational partners such as: Met Police, Probation Services. London Fire Service, HMP Wandsworth, Integrated Care Board, Registered Social Landlords, Children Services, Adult Social Care, Public Health, Community and Voluntary Sector. There are Critical Incident Process following an incident.

Department for Work and Pensions (DWP)

DWP makes safeguarding personal by placing the individual's wishes, circumstances and lived experience at the centre of all safeguarding activity. Staff take time to listen, build trust and understand what matters to each customer, using trauma informed and strengths based approaches to support choice, control and dignity. Where risks are identified, DWP works collaboratively with the individual and partner agencies to agree proportionate, practical actions that reduce harm while promoting independence, wellbeing and inclusion rather than a one size fits all response.

DWP continuously takes learning from its most serious cases. To achieve this, DWP has implemented systems where it can consistently act on feedback, ensuring that when it learns that its customers' experiences have fallen below expectations, it uses this learning to make changes that improve its services. One of the ways in which DWP looks to learn when things have gone wrong, is by completing Internal Process Reviews (IPRs) which help identify where improvements could be made across its many services.

All SARs are referred for an IPR and learning from these serious cases is now published on Gov.uk. Advanced Customer Support - Learning and improving from serious cases

Learning cases from 2024-2025 will be published in the coming months.

From a DWP perspective, cross sector working is essential to delivering safe, effective and inclusive support for vulnerable adults. DWP works collaboratively with local authorities, health services, housing providers, police and the voluntary and community sector to share insight, identify risk early and coordinate proportionate responses. By pooling expertise and aligning interventions, DWP helps ensure customers experience joined up support rather than fragmented services, enabling safeguarding, welfare and wellbeing needs to be addressed holistically and in a way that promotes stability, dignity and long term independence.

London Fire Brigade (LFB)

Richmond

London Fire Brigade, Richmond borough, work in partnership to identify, refer and assist the most vulnerable – assistance given in Home Fire Safety Visits (these are now prioritised and streamlined to target those at most risk), fire retardant bedding and equipment supplied, alongside linked smoke detection (Tunstall alarms) and arson proof letter boxes. Attendance at Self-Neglect and Hoarding Panel and other relevant RWSAB meetings, including Multi Agency Risk Assessment Framework. Providing training to frontline care staff in fire safety awareness and risks associated with clients. Setting up priority initiatives within the borough around Dementia, Alzheimer, Bluebird Care. Giving advice where appropriate to partners in the borough. Engagement with Age UK and more awareness of the assistance that LFB can give to those who are vulnerable. We have also assisted in evidence gathering and reporting on self-neglect (hoarding) and attended court to assist in de cluttering and making safe by assisting in expert witness testimony. Further works continue with 'safespace' initiative and prevention of future deaths working with RCDAS.

Wandsworth

During 2025/26, London Fire Brigade in Wandsworth Borough contributed to safeguarding activity through risk based prevention, early intervention and multi agency working, aligned to the priorities of the Wandsworth Safeguarding Adults Board.

Safeguarding prevention was delivered primarily through targeted Home Fire Safety Visits, prioritised towards adults most vulnerable to fire due to factors such as impaired mobility, cognitive impairment, mental health concerns, substance misuse or self neglect. Interventions included the installation of linked smoke detection and telecare systems (including Tunstall alarms), the provision of fire retardant bedding and protective equipment, and the fitting of arson resistant letterboxes where appropriate.

London Fire Brigade supported Making Safeguarding Personal by adopting a proportionate and person centred approach, ensuring interventions were tailored to individual need and aimed at supporting residents to remain safe within their own homes.

The Brigade maintained regular engagement with local safeguarding arrangements through

attendance at Vulnerable Adults Multi Agency Panels and other relevant risk management forums, supporting information sharing and coordinated responses. Fire safety awareness training was delivered to frontline care and support staff, alongside targeted engagement with services supporting people living with Dementia and Alzheimer's, and domiciliary care providers including Bluebird Care. Ongoing engagement with Age UK Wandsworth supported awareness of available fire safety interventions.

London Fire Brigade also supported safeguarding responses in cases of self neglect and hoarding, contributing to evidence gathering & professional reports. Partnership work continued through the Safe Space initiative and Prevention of Future Deaths processes, working with WCDAS and other partners to reduce risk and prevent serious harm.

National Probation Service

The Probation Service has worked to address the following Safeguarding Adults Risks:

- Domestic Abuse – Continued MARAC representation at both operational and strategic levels, working alongside local authority and other partners to safeguard victims of domestic abuse.
- Substance Misuse – Implementation of drug testing within the Probation Service for people on probation subject to Drug Rehabilitation Requirements to support enforcement and compliance with Court ordered requirements. Contribution to Drug and Alcohol Related Death Reviews.
- Homelessness – Continued coordination of resettlement panels to bring together Probation, local authority, housing providers and prison in prioritising accommodation arrangements on day of release.
- Mental Health – Provision of commissioned mental health service (Together) for Integrated Offender Management.
- Neurodiversity – Provision of commissioned service (3SC) for Integrated Offender Management.

Much of these services have been ongoing throughout the year; helping to provide stability and support to People on Probation with safeguarding risks.

The Hounslow, Kingston and Richmond PDU continue to operate significantly below target operational staffing levels (at around 65% of staff in post). Therefore, whilst the teams continue to facilitate and support arrangements to safeguard adults, there is continued pressure on the system.

The Wandsworth, Merton and Sutton PDU continue to operate significantly below target operational staffing levels (at around 68% of staff in post). As above, this places continued pressure on the system.

There is a Sentencing Act currently being operationalised throughout 2026, which provides the Courts with new sentencing guidelines to suspend short custodial sentences (thereby increasing the number of people subject to Suspended Sentence Orders rather than an immediate custodial sentence). This will reduce the negative impact short custodial sentences can have on the individual, which can have additional impact on individuals with adult safeguarding risks. However, this will also mean that multi-agency partnerships working between local community agencies will be even

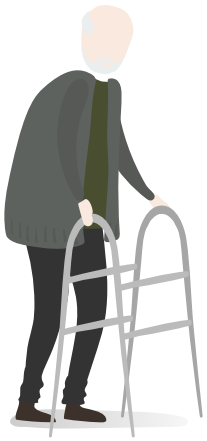
more essential to manage risks posed in the community.

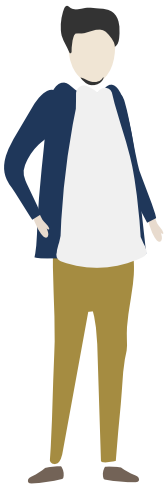
Probation staff have engaged in Quality Practice Hubs throughout 20205/2026 to focus on core aspects of Probation work that intersects with adult safeguarding risks. This has enhanced a focus on core aspects of the job and is delivered to front-line practitioners on a regular monthly basis. This has fed in to a Quality Improvement Plan for the Unit which is being delivered. Regular audit, local and national, are undertaken to track how learning is embedded and demonstrated.

Wandsworth Prison

Over the last year, HMP Wandsworth has focused on embedding adult safeguarding processes across the establishment, ensuring that safeguarding is recognised as a core responsibility for all staff. A key area of development has been the implementation and promotion of safeguarding referral pathways, providing staff with clear mechanisms to raise concerns regarding prisoners who may be vulnerable due to age, disability, mental ill health, self-neglect, exploitation or other safeguarding risks. Alongside this, significant work has been undertaken to increase staff awareness through training and engagement sessions, helping colleagues to identify indicators of abuse, neglect and vulnerability, understand their safeguarding responsibilities, and take appropriate action when concerns arise.

This work has strengthened the prison's links with the local Adult Safeguarding Community Board and supports a multi-agency approach to protecting vulnerable adults in custody. By working closely with safeguarding partners, HMP Wandsworth has sought to align its safeguarding arrangements with community-based best practice, ensuring that prisoners are included within wider safeguarding frameworks. The relationship with the Adult Safeguarding Community Board provides opportunities for shared learning, improved information sharing and collaborative problem-solving, particularly for individuals with complex needs who move between custody and the community. This partnership reinforces the principles of prevention, protection and accountability, while supporting the continued development of safeguarding practice within the prison.





Housing and Regeneration Department – serving Richmond and Wandsworth Councils

Housing are committed to the priorities of the SAB and facillitate these through their strategies and processes. The department aims to participate constructively in SAB events, relevant sub-groups and multiagency meetings to provide a housing perspective on issues and ensure policies and procedures reflect decisions made in addressing Safeguarding issues and meeting the needs of vulnerable residents and share/dissiminate information and update across teams.

Officers are all trained in making safeguarding referrals as well as additional training, guidance in ASC/mental health capacity upon being recruited as part of their induction. Regular refreshers are circulated as and when reqiured.

This year, Prevention and Solutions will be undertaking outreach work within St Georges hospital to provide early advice and prevent homelessness prior to them attending our offices at crisis point. Outreach work will also mean greater collaboration with partners to focus on the best outcomes for residents as well as delivery of support.

This year, we have renewed our push to ensure that the we understand the vulnerability profile A vulnerability project was approved as part of the Housing Improvement Transformation plan. Part of these strands include training all front line staff in the new and revised Hoarding procedures and Vulnerable Residents procedures. In addition, residents have been identified and targeted to ensure that organisation is compliant with the new residential Personal Emeergency and Evactuation Plans.

Richmond Housing Partnership (RHP)

We work alongside a wide range of partner agencies to ensure vulnerable customers receive effective support. Our frontline presence means we can identify risks early and contribute to the wider safeguarding system, including the Safeguarding Adult Board, where we play an active role.

Safeguarding is embedded across our organisation. All operational colleagues receive mandatory training, supported by real case examples such as hoarding, cuckooing, isolation and anti social behaviour. This strengthens our ability to recognise concerns and work with partners to respond quickly and appropriately. Learning outcomes from case studies highlighted prevention and acting before abuse takes place, and the power of partnerships.

During National Safeguarding Week 2025, we held workshops for all employees on modern slavery, reflecting emerging safeguarding themes. Ahead of National Safeguarding Week, we refreshed our safeguarding policy to reflect current practice and our commitment to strong partnership working.

Our day to day contact with customers gives us valuable insight into the lived experience of vulnerable adults. Through joint risk assessments with the police, adult social care, mental health teams and voluntary organisations, we help reduce harm and ensure people receive the right support at the right time.

We continue to increase our visibility in communities through door knocking, local hubs and targeted outreach. Our winter warmer initiative is now in its 7th year and we contacted all customers over 80 and visited those over 90, checking safety, heating, repairs and access to services, and escalating concerns where needed.

Kingston and Richmond Safeguarding Children Partnership (KRSCP)

During 2025-26 KRSCP has continued to work working collaboratively with our partners on a wide range of safeguarding activities can see progress against our priorities for 2024-26 which have been:

1. Child Sexual Abuse & Exploitation

2. Neglect

3. Adolescent/Transitional Safeguarding & Serious Youth Violence

4. Implementation of Working Together and associated guidance

These priorities have been highlighted through the activities of all our subgroups & broader workstreams.

We have been working throughout the year to implement Working Together to Safeguard Children 2023 Guidance and have continued to hold engagement events with faith, voluntary, community and sport sectors in Kingston and Richmond. We have continued to deliver our multi agency safeguarding training programme to disseminate and embed learning across the partnership.

Significant progress was made across all priority areas. This includes a CSA deep dive and action plan, development of a regional neglect strategy & multi agency audit on neglect, enhanced focus on youth violence and transitional safeguarding. guidance.

Cross-cutting work has strengthened safeguarding practice, with a growing emphasis on the voice of children and young people, and a renewed commitment to equality, diversity and inclusion (EDI) through training and co-produced initiatives.

Robust audit, inspection, and learning activity—including a variety of safeguarding training sessions and widespread e-learning participation—has supported continuous improvement.

The work on Neglect has continued with the launch of the Love, Care & Child Neglect Toolkit in October 2025 and focussed Neglect Thinkspace sessions from March 2026.

Learning from local reviews has been disseminated and integrated into our multi-agency safeguarding training programme and the following key themes have been identified:

- Child Sexual abuse & Exploitation
- Cultural Competency
- Voice of the Child
- SEND & Neglect
- Safeguarding in Early Years settings
- Online harms
- Self-harm & suicide

Looking ahead, the partnership has identified Online Harms, Protecting Babies and Cultural Competency as our business priorities for 2026-2029.

Wandsworth Safeguarding Children Partnership (WSCP)

Safeguarding activities and contribution to SAB priorities (2025/26)

During 2025/26, WSCP strengthened its multi-agency safeguarding approach through key strategic priorities aligned to prevention, personalised practice, continuous learning, and partnership working, while also developing closer alignment with the Safeguarding Adults Board (SAB).

Prevention and early intervention

The partnership progressed the Families First Social Care Reforms, establishing multi-agency working groups with strong engagement from local partners to support earlier, more coordinated intervention with families. A new Children Not in School subgroup was created to better understand this cohort through improved data analysis and to develop a more targeted, multi-agency response to reduce vulnerability and risk.

Making Safeguarding Personal

WSCP continued to embed anti-racist practice (ARP) across safeguarding systems, delivering against its ARP Action Plan informed by the "It's Silent" report. Independent Scrutiny has further strengthened this work through a focused review, ensuring that lived experiences and partner feedback shape improvements and promote equitable outcomes for children and families.

Quality assurance and embedding learning

The partnership maintained a strong focus on thematic learning priorities, including Child Sexual Abuse (CSA), Online Harms, and working with fathers. Multi-agency conferences and learning events were delivered to raise awareness, improve professional practice, and embed learning across the workforce. Ongoing quality assurance activity, including audit and scrutiny, ensured that findings and recommendations were translated into practice improvements.

Cross-sector working and forward planning

Effective collaboration remained central to WSCP activity, with strengthened links across statutory and voluntary sectors. Engagement with the SAB, including participation in peer challenge events, has supported shared learning and forward planning. This has enabled both partnerships to work more collaboratively and in parallel on aligned priorities, strengthening system-wide responses to safeguarding and promoting a more integrated approach across children's and adults' services.

Richmond and Wandsworth Safeguarding Adults Board

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

We continue to work closely with the National Scams Hub team, visiting residents suspected of being caught up with scam companies to provide advice and if necessary, intervention. As well as proactively responding to issues brought to our attention via partners such as the police and adult social services. Working in partnership to establish the best way to safeguard the resident concerned.

To help encourage prevention, our programme of talks to community groups empowering residents with knowledge and skills to spot and avoid scams continues. Last year we reached over 250 local residents.

Richmond and Wandsworth Safeguarding Adults Board

REPORTING A SAFEGUARDING CONCERN

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Emergency

Call the Police or emergency services

999

Questions about this report

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

Remember, safeguarding is everyone's business!

Richmond and Wandsworth
Safeguarding Adults Board

Designed and produced by wdp@wandsworth.gov.uk CS1975 (7.26)