Richmond and Wandsworth
Safeguarding Adults Board

ANNUAL REPORT 2021 - 2022

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

I am delighted as the new Independent Chair appointed in October 2021 to introduce the 5th Annual Report of the Richmond and Wandsworth Safeguarding Adults Board (RWSAB) – for 2021/22. The previous Chair left in March 2021 and the business plan was set in line with the Vision and Strategic Plan.

I first want to pay tribute to all those residents, staff, service users and carers who were and still are, impacted by the COVID-19 Pandemic virus. The impact on all RWSAB partners' staff – particularly health staff, many volunteering to give vaccinations, and managing the distress of those needing hospital treatment – cannot be underestimated. Likewise, the support of Adult Social Care staff and Commissioning support to residential care homes and domiciliary care providers was vital to ensure the safety of residents. As I write in summer 2022, cases are rising again, and we know how important it is as a partnership to work together to protect those who are at risk of the effects of the virus.

Despite all these pressures all the RWSAB partners, local authority, health, police, fire and rescue service, housing, community groups and providers in both boroughs remained committed to ensuring the objectives of the business plan as far as possible could be completed. The achievements in relation to the Business Plan can be found on page 11 and the work of the Sub-groups is summarised in section 3.

Objectives that needed to be held over, partly due to varying COVID-19 restrictions impeding meetings, were effective engagement with People with Lived Experience and service users to help influence the business plan and priorities. This is now a key priority for 2022/23. This reflects recognising that whist the development of online meetings assisted many people to keep in contact, it is important to recognise digital exclusion is detrimental to those most at risk. The lessons from the overall impact of Covid-19 on health inequalities in disadvantaged communities also requires more consideration to promote awareness of safeguarding and working with Public Health.

Another objective affected – to provide support on safeguarding for Wandsworth Prison, needed to be reactivated and contact has now been established.

Due to restrictions on in-person meetings, the RWSAB Executive and the sub-groups embraced virtual meetings to maintain momentum and partnership working in assessing safeguarding concerns, such as Domestic Abuse, Social Isolation, Scams and Hoarding. The SAB Executive's role to be assured that the priorities were being progressed continued, and with my initial appointment as Interim reviewed progress and gaps.

A key concern with COVID was the reduced ability to closely monitor safeguarding situations, which came with reduced health and social care professional home visits, less fire safety visits, and impeded access for families in care homes. Since the easing of COVID restrictions in year, there has been an increase in safeguarding alerts, although those then subject to an investigation were not higher. Equally all these services have now begun to tackle the backlog and waiting lists to mitigate safeguarding risks.

The RWSAB takes seriously its responsibility to learn when the multi-agency partnership does not work well, and, despite the pandemic, followed through on four Safeguarding Adults Reviews (SARs) ('Robert' and 'Evelyn' for Richmond and 'Issy' and 'Daniel' for Wandsworth), and participated in two led by other boroughs ('Alice', done by Redbridge and 'Madeleine', completed by Croydon). The learning for both Richmond and Wandsworth related to holistic approaches to care, professional curiosity, the 18-25-year-olds care leavers and young people in transition, an emerging issue across London. New Transitions Protocols and Pathways have been developed in Wandsworth with the Wandsworth Children Services and in Richmond with Achieving for Children.

Learning events and masterclasses were successfully held, for all partners to consider themes such as Making Safeguarding Personal and Cuckooing, Professional Curiosity and Unconscious Bias, partnership working and sharing of information. A key challenge for this year is how to be assured of the learning being embedded and maintained in systems and professional practice.

The SAB Executive, through its SW CCG lead, was involved in the assurance by NHSE on the national findings in the NHS Safe and Wellbeing Reviews for people with learning disabilities placed in assessment units following a national CQC report highlighting failure in support after 3 people who died in a residential assessment unit out of London.

As Chair I participate in National and London Chairs' networks and help identify issues of relevance locally such as homelessness and substance misuse in Wandsworth and issues of social isolation and dementia support for Older people in Richmond. Many issues link in with the Community Safety Partnerships across both boroughs and more effective links are being established on joint priorities.

There are fundamental changes coming to how Health services are organised, commissioned and monitored, moving from Clinical Commissioning Groups (CCGs) to an Integrated Care System and Board across South-West London, which will work closely with Safeguarding Adults Boards to ensure safeguarding priorities are assured.

Any business plan has to be adaptive and from August 2021 with the Afghanistan Crisis and with the outbreak of the war in Ukraine February 2022 and arrival of refugees, support and safeguarding advice were provided to partners. The RWSAB Annual General Meeting, providing challenge and assurance between partners, also identified new areas to promote and prevent abuse set out in the business plan for 2022/2023.

Priorities for the RWSAB for 2022/2023 are:

- Increasing awareness of Adults Safeguarding amongst members of the public in Richmond and Wandsworth and effectively engaging with People with Lived Experience.
- Enhance understanding of Adult Safeguarding Across the Partnership.
- Develop effective partnership with Wandsworth Prison to support understanding of safeguarding.
- Reduce number of home fire accidents via improved awareness around home fire risk assessments and fire prevention interventions.
- Gain assurance that the safeguarding practice is in line with the Safeguarding Principles (Empowerment, Protection, Prevention, Proportionate, Partnerships, Accountable).
- Engagement of experts by experience in delivering professional staff development events.
- Engage people with lived experience to inform practice development.
- Facilitate implementing Mental Capacity Act in practice and prepare for the changes in the Liberty Protection Safeguards system.
- Obtain assurance that learning from SARs is embedded across the partnership.
- Learning lessons from the Local Government Association/ADASS Covid Insight Report.
- Collaborate with partners in the evolution of the Integrated Care System locally to ensure Safeguarding Adults remains a focus.
- Improve effectiveness of transitional safeguarding arrangements through partnership collaboration.

INTRODUCTION

The Care Act 2014 requires all local authorities to set up a Safeguarding Adults Board with key statutory partners including local Police and the local Clinical Commissioning Group. As such, a Safeguarding Adults Board is a group of organisations and communities working together in the best way possible, so that people are able to live their lives free from abuse or neglect.

Its core duties are to:

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

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

This report provides an overview of the work of the Richmond and Wandsworth Safeguarding Adults Board (RWSAB), our partners and our sub-groups from April 2021 to March 2022.

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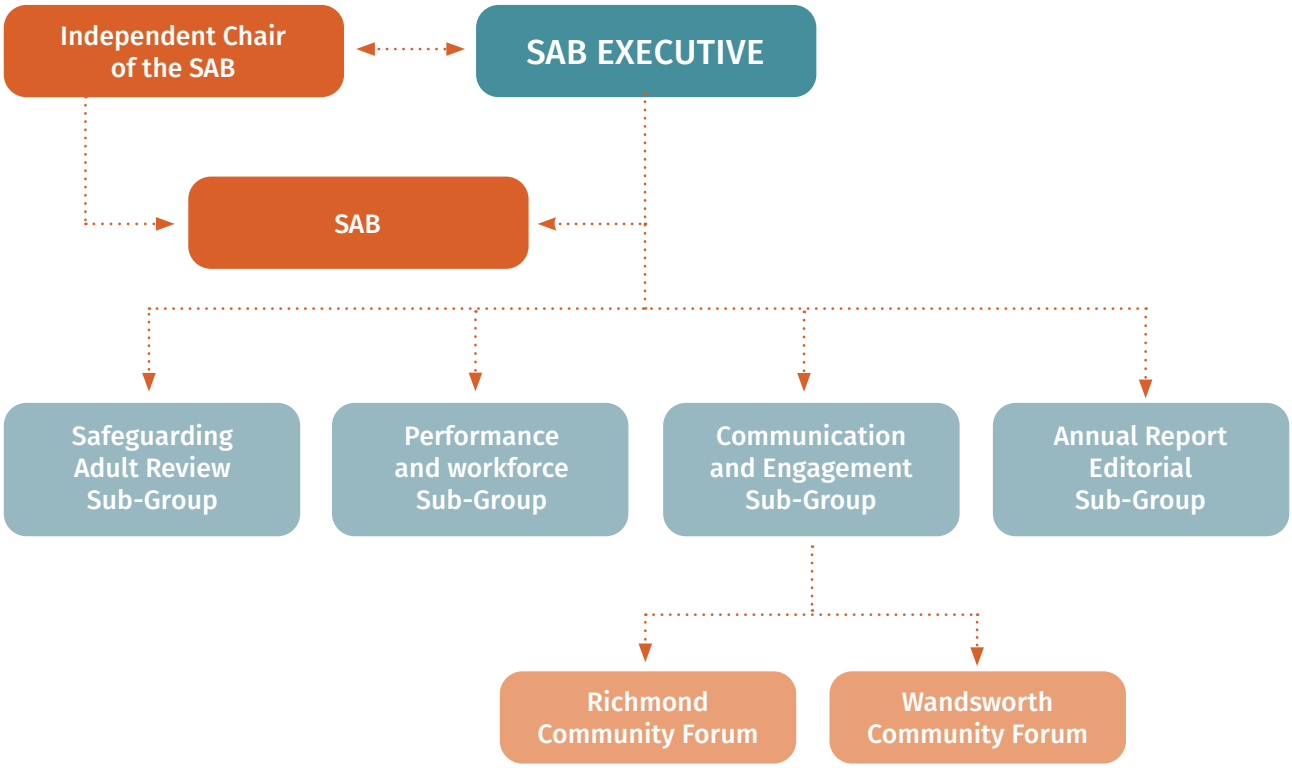
PURPOSE AND STRUCTURE

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

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

Structure of the RWSAB



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3. OVERVIEW OF ACTIVITIES AND ACHIEVEMENTS OF THE EXECUTIVE AND SUB-GROUPS

Supporting the Board, we have the Executive, which takes all strategic decisions and signs off reports and material produced by the sub-groups. The Executive is formed of senior manager representation from the three statutory partners – the Local Authority, the local Police Basic Command Unit and the Clinical Commissioning Group. Despite the challenges brought on by the second year of the Covid-19 Pandemic, the partners in the Executive and the three main sub-groups worked to complete as many of the priorities in the Business Plan as possible and help safeguarding efforts in Richmond and Wandsworth.

RWSAB Executive

- Met five times.
- Monitored and oversaw the RWSAB budget and risk log.
- Monitored and supported the continuous development of the sub-groups.
- Signed-off four completed Safeguarding Adults Reviews (Issy, Robert, Daniel and Evelyn), the learning from which is presented further on in the report.
- Continued developing good working relationships between strategic partners.
- Signed-off the previous year's Annual Report of RWSAB and presented it through all statutory partners' governance structures.
- Arranged the RWSAB Annual General Meeting

Safeguarding Adult Review (SAR) Sub-group

- Met six times and had three more Extended SAR Sub-groups.
- Considered five referrals.
- Recommended one SAR as meeting the mandatory criteria.
- Considered four SAR reports and action plans (Issy, Robert, Daniel and Evelyn).
- Reviewed and updated the SAR Protocol to include the SAR in Rapid Time methodology.
- Followed up on action plans from SARs, with a total of 75 actions from 12 SARs, 92% (69 actions) of which are now completed.
- Work on Transitions for young people 18-25 following a thematic review of SARs is progressing, with new Transitions Protocol and Transitions Pathway published in both Boroughs.
- Virtually Networked through London ADASS and London SAB.

Performance and Workforce Sub-group

- Met quarterly.
- Monitored performance via the Performance Dashboard.
- Organised masterclasses and training:
  - Mental Capacity Act, Making Safeguarding Personal & Self-neglect
  - Professional Curiosity and Unconscious Bias
  - Cuckooing
- Organised and led a successful Learning Event on Partnership Working and Information Sharing during National Safeguarding Adults Week Nov 2021.
- Collaborated with Merton SAB to offer attendance for RWSAB members to their 'What is a Safeguarding Adults Review' November 2021.
- Created a Making Safeguarding Personal factsheet and the Principles of engagement to improve communicating and working with people.
- Sent out the London Safeguarding Adults Partnership Assessment Tool (SAPAT) audit in October 2021, which provides opportunity for partners to demonstrate overall assurance of good safeguarding practice and any multi-agency issues.

Communication and Engagement Sub-group

- Met quarterly.
- Both Richmond Community Forum and Wandsworth Community Forum met quarterly.
- Had very good attendance and regular updates from partners on Safeguarding and other work during the continued pandemic.
- Delivered the regular 6 Newsletters, with articles from partners, training opportunities and updates.
- Kept the website up to date.
- Updated the Communication and Engagement Plan and started a Communication and Engagement Action Plan for 2022/23.
- Organised communications for National Safeguarding Adults Week 2021.
- Updated the Safeguarding Awareness presentation, which is now ready to be used at community events to raise awareness of Safeguarding in the general population.

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REVIEW OF ACHIEVEMENTS IN RELATION TO THE BUSINESS PLAN

Despite the significant impact of Covid-19 pandemic on agencies in the partnership, which included staffing issues, increase in demand for services (including increased numbers of safeguarding concerns, increase in demand for mental health services, domestic abuse and others) as well as directly dealing with the pandemic, the RWSAB ensured that all business plan actions were completed or substantially progressed. Some significant achievements in relation to the priorities in our Strategic Plan are:

Prevention and early intervention

- The Board arranged social media messages on financial scams, raising general awareness around Safeguarding for National Safeguarding Adults Week, articles in partner agencies' newsletters around self-neglect and reporting abuse.
- Masterclasses organised around Mental Capacity Act, Making Safeguarding Personal and Self-neglect, Professional Curiosity and Unconscious Bias, and two training sessions on Cuckooing.
- The Multi-agency Risk Assessment Framework was promoted extensively.

Making Safeguarding Personal

- National Safeguarding Adults Week Learning Event around partnership working and sharing of information, which featured a live case and interviews with staff from different agencies to highlight the real issues and challenges during a live case, as well as the importance of multi-agency meetings and sharing of appropriate information.
- Factsheets around Making Safeguarding Personal and Principles of Engagement were produced and promoted.
- Continued positive multi-agency forums including Wandsworth Community Multi-agency Risk Assessment Panel (CMARAP), the Richmond Vulnerable Adults Multi-agency panel (VAMA) and South West London Safeguarding Leads Forum.

Learning lessons and shaping practice

- The Safeguarding Adults Partnership Assessment Tool sent out in October 2021, covering period from April 2020 until September 2021, which provided good assurance of practice and learning from SARs, despite smaller response rate to previous years.
- The Safeguarding Adults Practice Awards have continued to highlight and awarded best practice across the partnership.
- Well-established 7-minute learning model for Safeguarding Adults Reviews (SARs) helping to improve sharing of learning, including from other-Borough SARs.
- Published the RWSAB Annual Report for 2020/21.
- Richmond and Wandsworth agencies submitted information for the LGA/ADASS Covid Insight report

The Business Plan 2022/23 can be found on our website:
www.sabrichmondandwandsworth.org.uk/about-the-safeguarding-adults-board/#vision

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

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RICHMOND AND WANDSWORTH PERFORMANCE INFORMATION

RICHMOND

Safeguarding in numbers – Safeguarding figures

Safeguarding Concerns and Enquiries[1]

In the past year, the number of concerns reported to London Borough of Richmond upon Thames (as the lead agency for Safeguarding Adults) increased by 9%, however this did not translate to an increase in enquiries, which decreased by 28% from the previous year, returning to the levels from 2019/20. Increased referral rates without corresponding increase in enquiries point both to a wider awareness around Safeguarding, as well as to less understanding of the referral criteria. Work is underway to understand the referrals in detail and address any potential single-agency issues in understanding of the criteria, as well as understand the Local Authority's response to referrals.

91% of Safeguarding Enquiries were completed, which is an increase from the previous year (87% in 2020/21). Enquiries not completed within the year were raised and logged close to the end of the year, taking their timelines for completion into the next financial year.

The percentage of enquiries relating to sex, age and ethnicity is in line with the Borough's Population (Richmond upon Thames has the largest proportion of 40+ population in London; over 80% are white and population is made up of 51% females and 49% males, with the proportion of females increasing with age).

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.

Concerns in 2021/22

1883

(1445 people)
9% Increase

9%

28%

Enquiries in 2021/22

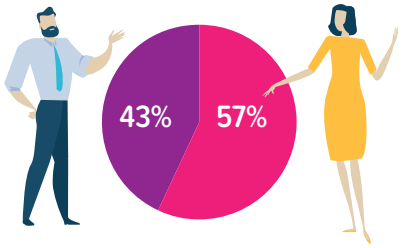
426

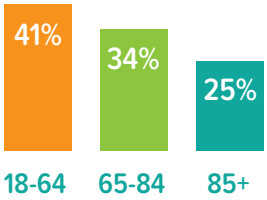
28% decrease
(593 in 2020/21)

CompletedEnquiries in 2021/22

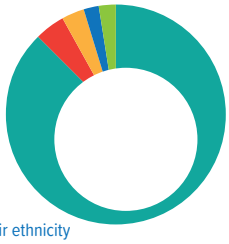
388

91% of enquiries completed
(compared to 87% in2020/21)





78% White
4% Asian
3% Black
2% Mixed
2% Other Ethnic Groups



41 people did not state their ethnicity

TYPES OF ABUSE

19% (107) Neglect

Financial/Material **17%** (96)

15.8% (89) Self-neglect

Physical **13.3%** (75)

42% (162) Known to Individual

15% (56) Care, health or other Professional

1% (5) Not known to Individual

58% (205) Own Home

21% (76) Care Home

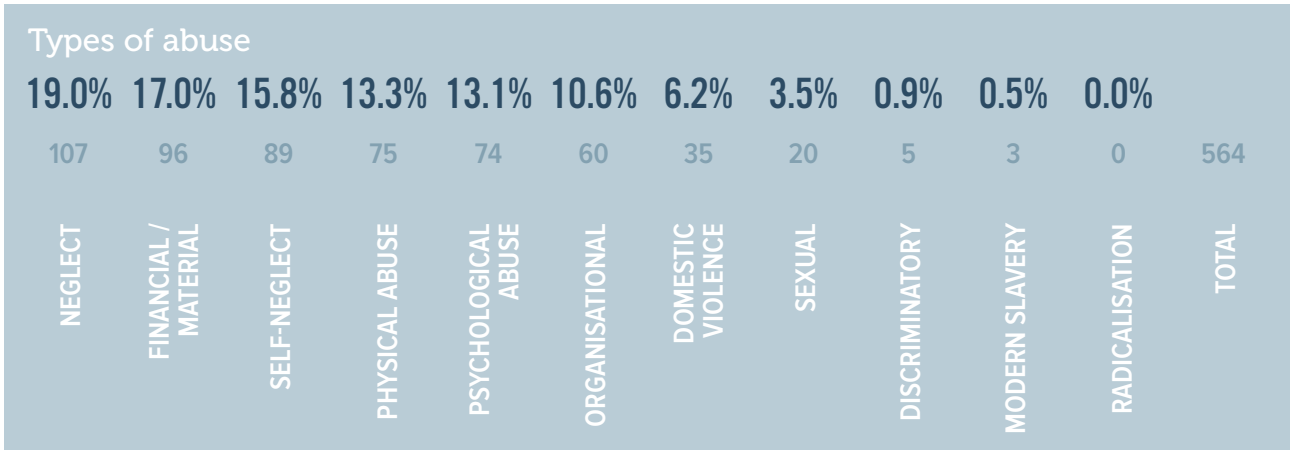
7% (25) In the community (excluding community services)

85.3% (331) Outcomes expressed

97.6% (323) Outcome fully or partially met (of those asked)

93% (361) Risk Reduced or removed

84.3% (327) Felt safer after safeguarding



The majority of abuse takes place in an individual's own home (58%), which is in line with the national and regional average as the majority of people live in their own home. Richmond upon Thames has a relatively large number of care homes, which reflects the second-highest place of abuse (21%).

Types of Abuse[2]

Neglect, Financial/Material Abuse and Self-neglect have been the highest reported types of abuse for the last 3 years. Domestic Abuse cases have stabilised and dropped back 59% to the levels from 2019/20 (before the Covid-19 Pandemic). Levels of Modern Slavery and Discriminatory abuse remain low, and there is an understanding that they are under-reported. We are working with partners to refresh the referral pathway and increase awareness on these types of abuse.

Making Safeguarding Personal

Making Safeguarding Personal (MSP) is a sector-led approach which aims to develop outcomes focus to safeguarding work and is required by all agencies undertaking safeguarding duties in terms of the Care Act 2014. This means all safeguarding activities should be person-led, outcomes focussed, supportive of involvement, choice and control, improve the quality of life for the person and promote well-being and safety.

As an important success measure of the 'Making Safeguarding Personal', the extent to which the person's desired outcomes are met is measured. Locally, 85.3% expressed desired outcomes, with almost 98% of people's outcomes being fully or partially met. In the cases where outcomes were not expressed or met, this is usually due to the person not engaging with the process or being unwell at the time of the enquiry.

Impact on Risk and sense of safety

London Borough of Richmond upon Thames have continued to ask individuals and/or their representatives if they feel safer because of the help from people dealing with the safeguarding concern. Out of 388 completed enquiries, 327 people (84.3%) have expressed they feel safer after the process, which is really positive feedback. In the remaining 15.7% of cases, due to the nature of the concern and the impact on the person, the feeling of safety remains the same.

Adult safeguarding aims to remove or reduce the risk to the adult. The impact of Safeguarding on risk is good with the risk removed or reduced in 93% of cases. Where the risk remains, this is usually the result of people choosing to live with risk and understanding the implications of it.

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

DoLS	20/21	%	21/22	%
Number of Requests Received	754		788	
Granted	494	65.5	488	61.9
Not Granted	227	30.1	238	30.2
Not yet signed off by Supervisory Body	33	4.4	62	7.9

Deprivation of Liberty Safeguards (DoLS)

In July 2018, the government published a Mental Capacity (Amendment) Bill, which passed into law in May 2019. This law will allow for the current Deprivation of Liberty Safeguards (DoLS) to be replaced with the Liberty Protection Safeguards (LPS). LPS will extend the safeguards to community-based settings, including the persons own home. Currently the Government are holding a consultation on LPS, but at present there is no implementation date. Additional information on Liberty Protection Safeguards can be sourced via the Government factsheets.

The total number of DoLS authorisations received in Richmond have increased by about 5%. The number of requests received but not yet authorised has also slightly increased, this is due to increased demand. All requested authorisations are reviewed and monitored to ensure that the most urgent are prioritised and there is a process in place to ensure renewals are addressed to minimise breaks in the authorisation. A summary of the number of Deprivation of Liberty Safeguards requests and authorisations in Richmond during 2021/22 is shown above.

Provider Quality

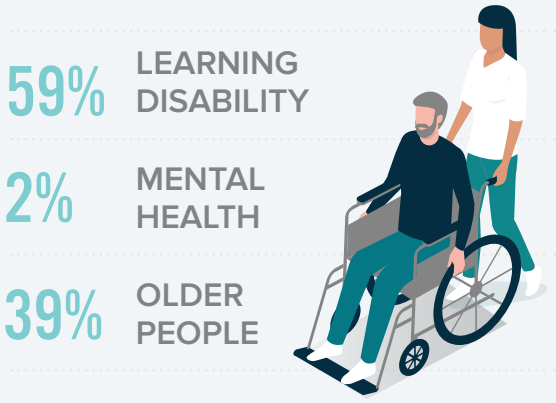
In Richmond there are 44 local Care Homes and 19 Community Services Providers registered with the care regulator the Care Quality Commission (CQC). 43 Care Homes (97.7%) are rated Good or Outstanding by the CQC and, following recommencement of regular CQC inspections, one home is rated Inadequate. An action plan and regular quality monitoring is in place to help improve this rating. 2 of the Community Services Providers require improvement and 17 (89%) are rated Good. This indicates that quality across the borough remains good.

INADEQUATE 2.3%

Care Homes CQC Rating (Richmond)	No	%
Outstanding	2	4.5%
Good	41	93.2%
Requires improvement	0	0%
Inadequate	1	2.3%
Total	44	

INADEQUATE 0%

Community Services CQC Rating (Richmond)	No	%
Outstanding	0	0%
Good	17	89%
Requires improvement	2	11%
Inadequate	0	0%
Total	19	



Care Home Type (Richmond)	No	%
Learning disabilities	26	59%
Mental health	1	2%
Older people	17	39%
Total	44	

Learning Disability Mortality Reviews (LeDeR) in Richmond

The national programme aimed at making improvements to the lives of people with learning disabilities is known as Learning Disability Mortality Reviews (LeDeR). It requires that reviews are carried out following the death of anyone with a learning disability. The purpose of the review is to identify whether there are any concerns or areas of learning to improve the health and quality of care for people with learning disabilities. These reviews are conducted by South-West London Clinical Commissioning Group (CCG) and the findings are reported to NHS England.

During 2021/22 Richmond CCG received a total of 9 death notifications for LeDeR. Lessons learnt include issues with the application of the Mental Capacity Act, which is not always recorded in detail during assessments.

The annual health check is seen as a key means to improve and maintain the health of people with learning disabilities and work is being done to promote uptake. It is available to anyone over the age of fourteen and on their GP's learning disability register. GP practices offer these annual health checks routinely.

The Do Not Attempt Cardio-Pulmonary Resuscitation notice (DNACPR) is a feature of advance care planning that has been used for many years but attracted some notoriety during the COVID-19 Pandemic when there was widespread concern that orders were being issued to groups of people rather than individuals. The Richmond LeDeR Steering Group recognised this as an area of concern and support was provided to the local Care Homes Learning Disability Teams.

There was significant hospice input to care at home and lessons were disseminated widely to ensure improvement in these areas. There were escalation plans, coordinate my care advanced planning and DNACPR input from Neuro Developmental Services – physio, Speech and language therapists (SALT), psychiatry. Annual Learning Disabilities health checks were undertaken at home as a reasonable adjustment.

Some examples of the good practice from the reviews were:

- A family was supported with discussions and decision making by the community care team.
- Good communication with professionals and care home manager.
- Excellent team working with primary and acute care facilitated a good death taking into account an individual's wishes.

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

WANDSWORTH

Safeguarding in numbers – Safeguarding figures

Safeguarding Concerns and Enquiries

The number of concerns reported to Wandsworth Council (as the lead agency for Safeguarding Adults) in the past year increased by 41%, however the number of enquiries decreased by 17% from the previous year, returning to the levels from 2019/20 (before the Covid-19 pandemic). Increased referral rates without corresponding increase in enquiries point both to a wider awareness around Safeguarding, as well as to less understanding of the referral criteria. Work is underway to understand the referrals in detail and address any potential single-agency issues in understanding the Local Authority's response to referrals.

88% of Safeguarding Enquiries were completed, which is a slight decrease from the previous year (91% in 2020/21), largely due to the increased volume of concerns needing to be screened and enquiries raised and logged close to the end of the year, taking their timelines for completion into the next financial year.

The percentage of enquiries relating to sex, age and ethnicity is in line with the Borough's Population (Wandsworth has one of the highest proportions of the 20–44-year-old population in London; around 30% of the residents are Black, Asian or Minority Ethnic and the population is made up of 59% females and 41% males, with the proportion of females increasing with age).

The majority of abuse takes place in an individual's own home (57%), which is in line with the national and regional average as the majority of people live in their own home. Wandsworth has a number of care homes and a number of hospitals in its territory, which reflect the second and third highest locations of abuse (14% and 12% respectively).

Concerns in 2021/22

3486

(2648 people)
41% Increase
(2478 in 2020/21)

41%

17%

Enquiries in 2021/22

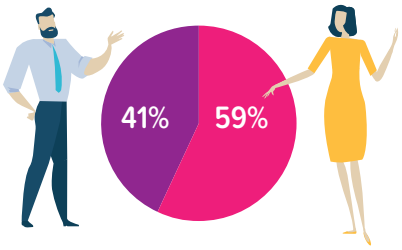
717

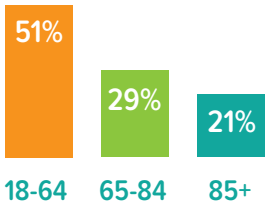
(654 people)
17% decrease
(886 in 2020/21)

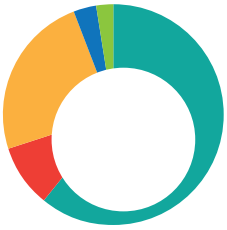
CompletedEnquiries in 2021/22

630

88% of enquiries completed
(compared to 91% in2020/21)







53% White
8% Asian
21% Black
3% Mixed
2% Other Ethnic Groups
67 people did not state their ethnicity

TYPES OF ABUSE

22.8% (212) Neglect

18% (167) Financial/Material

18% (167) Self-neglect

13.3% (124) Physical

33% (201) Known to Individual

6% (38) Care, health or other Professional

1% (7) Not known to Individual

57% (324) Own Home

14% (80) Care Home

12% (71) Hospital

89.2% (522) Expressed Desired Outcomes

95.9% (514) Outcome fully or partially met

91% (573) Risk Reduced or removed

80.6% (508) Felt safer after safeguarding

Types of abuse

NEGLECT	FINANCIAL / MATERIAL	SELF-NEGLECT	PHYSICAL ABUSE	PSYCHOLOGICAL ABUSE	DOMESTIC VIOLENCE	SEXUAL	ORGANISATIONAL	DISCRIMINATORY	MODERN SLAVERY	RADICALISATION	TOTAL
22.8%	18.0%	18.0%	13.3%	11.3%	8.7%	5.1%	2.4%	0.3%	0.2%	0.0%	
212	167	167	124	105	81	47	22	3	2	0	930

Types of Abuse[3]

Neglect, Financial/Material Abuse and Self-neglect are again the highest reported types of abuse for the year. Domestic Abuse cases remain high and comparable to last year. Levels of Modern Slavery and Discriminatory abuse remain low, and there is an understanding that they are under-reported. We are working with partners to refresh the referral pathway and increase awareness on these types of abuse.

Making Safeguarding Personal

Making Safeguarding Personal (MSP) is a sector-led approach which aims to develop outcomes focus to safeguarding work and is required by all agencies undertaking safeguarding duties in terms of the Care Act 2014. This means all safeguarding activities should be person-led, outcomes focussed, supportive of involvement, choice and control, improve the quality of life for the person and promote well-being and safety. As an important success measure of the 'Making Safeguarding Personal', the extent to which the person's desired outcomes are met is measured. Locally, 82.9% expressed desired outcomes, with almost 96% of people's outcomes being fully or partially met. In the cases where outcomes were not expressed or met, this is usually due to the person not engaging with the process or being unwell at the time of the enquiry.

Impact on Risk and sense of safety

London Borough of Wandsworth have continued to ask individuals and/or their representatives if they feel safer because of the help from people dealing with the safeguarding concern. Out of 630 completed enquiries, 508 people (80.6%) have expressed they feel safer after the process, which is really positive feedback. In the remaining cases, due to the nature of the concern and the impact on the person, the feeling of safety remains the same.

Adult safeguarding aims to remove or reduce the risk to the adult. The impact of Safeguarding on risk is very good with the risk removed or reduced in 91% of cases. Where the risk remains, this is usually the result of people choosing to live with risk and understanding the implications of it.

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

DoLS	20/21	%	21/22	%
Number of Requests Received	1080		1134	
Granted	673	62.3	667	58.8
Not Granted	332	30.7	368	32.5
Not yet signed off by Supervisory Body	75	6.9	99	8.7

Deprivation of Liberty Safeguards (DoLS)

In July 2018, the government published a Mental Capacity (Amendment) Bill, which passed into law in May 2019. This law will allow for the current Deprivation of Liberty Safeguards (DoLS) to be replaced with the Liberty Protection Safeguards (LPS). LPS will extend the safeguards to community-based settings, including the persons own home. Currently the Government are holding a consultation on LPS, but at present there is no implementation date. Additional information on Liberty Protection Safeguards can be sourced via the Government factsheets.

The total number of DoLS authorisations received in Wandsworth have increased by about 5%. The number of requests received but not yet authorised has also slightly increased, this is due to increased demand. All requested authorisations are monitored to ensure that the most urgent are prioritised and there is a process in place to ensure renewals are addressed to minimise breaks in the authorisation. A summary of the number of Deprivation of Liberty Safeguards requests and authorisations in Wandsworth during 2021/22 is shown above.

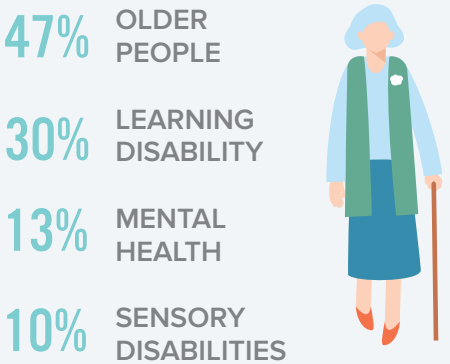
Provider Quality

There are 30 local Care Homes in Wandsworth, and 35 Community Services Providers which are registered with the care regulator the Care Quality Commission (CQC). All 30 Care Homes (100%) are rated Good or Outstanding by the CQC. 1 of the Community Services Providers requires improvement and 1 is rated Inadequate. Action plans and regular quality monitoring are in place to help improve this rating. 32 (92%) rated Good or Outstanding. This indicates that overall quality across the borough remains good.

Care Homes CQC Rating (Wandsworth)	No	%
Outstanding	2	6.7%
Good	28	93.3%
Requires improvement	0	0%
Total	30	

INADEQUATE 3% - UNRATED SERVICE 3%

Community Services CQC Rating (Wandsworth)	No	%
Outstanding	3	9%
Good	29	83%
Requires improvement	1	3%
Inadequate	1	3%
Unrated service	1	3%
Total	35	



Care Home Type (Wandsworth)	No	%
Older people	14	47%
Learning disabilities	9	30%
Mental health	4	13%
Sensory disabilities	3	10%
Total	30	

Learning Disability Mortality Reviews (LeDeR) in Wandsworth

The national programme aimed at making improvements to the lives of people with learning disabilities is known as Learning Disability Mortality Reviews (LeDeR). It requires that reviews are carried out following the death of anyone with a learning disability. The purpose of the review is to identify whether there are any concerns or areas of learning to improve the health and quality of care for people with learning disabilities. These reviews are conducted by South-West London Clinical Commissioning Group (CCG) and the findings are reported to NHS England.

During 2021/22 Wandsworth CCG received a total of 8 death notifications for the learning from deaths reviews (LeDeR)

The Wandsworth LeDeR Steering Group, which is chaired by the Designated Safeguarding Adults Lead on a quarterly basis, has members and stakeholders from various organisations and agencies such as Care Quality Commission (CQC), pharmacists, Consultant Psychiatrist in Learning Disability, provider leads, local authority learning disability teams, NHSE/I London Region LeDeR coordinator, learning disability liaison teams from providers, LeDeR reviewers, hospice and care home representatives and the Wandsworth CCG LD strategy partnership board. Cases are discussed and lessons are shared and disseminated across all agencies within SWL and beyond via newsletters and minutes of actions shared.

The annual health check is seen as a key means to improve and maintain the health of people with learning disabilities. It is available to anyone over the age of fourteen and on their GP's learning disability register. GP practices offer these annual health checks routinely.

The Do Not Attempt Cardio-Pulmonary Resuscitation notice (DNACPR) is a feature of advance care planning that has been used for many years but attracted some notoriety during the COVID-19 Pandemic when there was widespread concern that orders were being issued to groups of people rather than individuals. The Wandsworth LeDeR Steering Group recognised this as an area of concern and support was provided to the local Care Homes Learning Disability Teams.

There was significant hospice input to care at home and lessons were disseminated widely to ensure improvement in these areas. There were escalation plans, coordinate my care advanced planning and DNACPR input from Neuro Developmental Services – physio, Speech and language therapists (SALT), psychiatry. Annual Learning Disabilities health checks were undertaken at home as a reasonable adjustment.

Lessons learnt include issues with the application of the Mental Capacity Act, which is not always recorded in detail during assessments.

Some examples of the good practice from the reviews were:

- A family was supported with discussions and decision making by the community care team.
- Good communication with professionals and care home manager.
- Excellent team working with primary and acute care facilitated a good death taking into account an individual's wishes.

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

06

6. THE NATIONAL SAFE AND WELLBEING REVIEW PROGRAMME DECEMBER 2021

The National Safe and Wellbeing Review Programme was identified as part of the NHSE response to the Safeguarding Adult Review (SAR) concerning the deaths of three people at Cawston Park Hospital in Norfolk. The reviews were undertaken to check the safety and wellbeing of all people with a learning disability and autistic people (children, young people, and adults) who were being cared for in any mental health hospital, learning disability or autism inpatient setting funded by clinical commissioning groups (CCGs) or provider collaboratives on 31 October 2021.

The purpose of the National Review Programme was to:

- undertake a safe and wellbeing check for each person.
- to seek assurance that people are being properly cared for and are leading good lives in hospital.
- for commissioners to take immediate remedial action if a review shows that a person is not safe and well.
- to be carried out swiftly and at a point in time so that any key themes and learning can be identified.

The approach adopted for the Safe and Wellbeing Reviews was one that listens to and considers the views and information available from a range of sources including:

- The individual.
- Family and loved ones.
- Responsible clinicians and multi-disciplinary teams.

The approach also required reviewers to determine their level of confidence in the care provided and to identify actions and to feedback on these actions and the outcomes to the individual.

SWL CCG submitted data to NHSE on 34 people with a learning disability and/or autism who are in a mental health hospital setting funded by the CCG.

SWL CCG also established an oversight panel to scrutinise the reviews which included a range of senior clinical staff from across SWL and a core group of people with lived experience. All 34 reviews were signed off by the SWL oversight panel.

Regular updates on the progress of the reviews have been presented to the RWSAB Executive throughout this time, and a final report identifying opportunities for improvement is being completed and will be shared with all RWSAB partners in Summer 2022.

07

LEARNING FROM SAFEGUARDING ADULTS REVIEWS

Safeguarding Adults Review Referrals

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

Safeguarding Adults Review Referrals

	SAR Referrals received	Met criteria for SAR
Richmond	3	1
Wandsworth	2	0
TOTAL	**5**	**1**

Completed Safeguarding Adults Reviews

	Completed SARs
Richmond	2
Wandsworth	2
TOTAL	**4**

Richmond

Who was Robert?

Robert was 86-year-old at the time of his death in September 2020. He had a career in the arts and hospitality industries. Following a fall in July 2020, which resulted in a hospital admission, his family arranged for him to move into a residential care home. Shortly after he moved in, there was an unwitnessed incident between Robert and a fellow resident, James, and there was a further unwitnessed incident between them in early August 2020. Robert sustained a minor injury but did not need medical attention. On the same day as the second incident, Robert had a fall and was admitted to hospital. He was described as having increased confusion/delirium, which was attributed to a subdural bleed (possibly due to a fall), an infection and low sodium. He was treated for the infection and low sodium and returned to the care home with a plan for further intervention from the GP and the memory clinic. He was moved to a different unit in the care home to create distance between him and James. Within hours, James attacked Robert, who was subsequently admitted to hospital with an intercranial haemorrhage. The coroner has determined that pneumonia was the cause of death with an antecedent cause of a head injury.

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

Why was this SAR commissioned?

The RWSAB Executive agreed that Robert's case met the criteria for a mandatory SAR as there was evidence of abuse and agencies could have worked better together to safeguard him.

What were the findings from the review?

1. There are no agreed mechanisms for collaborative working and decision-making across the range of professionals who provide support to older people with dementia. As a result, the understanding of escalating risk is hindered by imprecise or incomplete communication about the situation.
2. All staff across health and social care need to have a shared understanding of the nature of dementia and skills in managing behaviours that challenge and of the level of expertise available in a residential care home.

What did we learn?

1. It is important to have access to relevant skills and understand the changing risks in the person when supporting people living with dementia. Regular multidisciplinary case discussions can help to achieve a more holistic understanding of care needs and risk management.
2. It is important that all stakeholders impacted by the structural changes within an organisation are aware of what to expect from the new delivery systems.
3. Providing care and support to people with dementia is complex because of the variation in individual symptoms and the growing number of physically strong and able people living with dementia. It is important for providers to have access to a range of skills and strategies for managing behaviours of people with dementia as well as access to specialist input such as that provided by Community Mental Health Teams.
4. Formally documented best interest decisions should be undertaken for all people who lack capacity to make decisions on where they live when they are permanently moving into a care home.
5. When the person alleged to have caused harm is also vulnerable, consideration should be made to have an Independent Mental Capacity Advocate at the Safeguarding Enquiry.
6. Established mechanisms for multi-agency reviews of the needs of care home residents who have dementia to identify any needed early interventions would ensure that changes are planned and crises avoided. Risk management and care planning to support the person and their family to understand changing needs is vital.

What did we do?

- As part of the Care Home Improvement Plan, which sets out to improve services within Care Homes, the specialist support commissioned by the Clinical Commissioning Group from the Mental Health Trust for Residential Care Homes with Dementia will be reviewed to ensure adequate provision.
- The learning from the SAR and the Multi-agency Risk Assessment Framework promoting mechanisms for multi-agency meetings were promoted with care homes in light of cases with dementia.
- The RWSAB wrote to the Care Quality Commission to highlight the need to specify training levels required by staff supporting people in residential care homes which offer dementia care.

Richmond

Who was Evelyn?

Evelyn was a 75-year-old Black British/ African-Caribbean woman who was a retired midwife. Evelyn had two sons, one of whom had a Lasting Power of Attorney for Evelyn's care and welfare. There were multiple concerns about how well Evelyn's health and care needs were being met by her family but attempts to intervene and to offer support were rejected. Evelyn was moved regularly by her family between three addresses in three different boroughs, seemingly to avoid contact with services and attended at least eight different hospitals, some of which were private, from which she was often discharged by her family against medical advice. Evelyn left the UK with one of her sons in March 2019 and died later in a care home on a Caribbean Island.

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

Why was this SAR commissioned?

The RWSAB Executive agreed that whilst it is not clear if Evelyn was suffering abuse or neglect, a discretionary SAR should be undertaken to examine how the system supports work across local authority boundaries with people who choose not to engage with public services.

What were the findings from the review?

1. The impact on Evelyn of decisions made on her behalf by her family was not recognised.
2. Frequent moves made it difficult, but there was still insufficient inter-agency communication and joint working to meet Evelyn's needs.
3. Safeguarding referrals were made but no action was taken.
4. There was insufficient engagement with Evelyn and there was insufficient professional curiosity or responsibility in exploring Evelyn's circumstances.

What did we learn?

1. Professionals should be careful when closing a safeguarding case because someone has moved out of area. If there are concerns about someone's safety, contact should be made with organisations that work across local authority or health areas, such as the ambulance service or the police, in case the person comes to their attention.
2. Professionals should consider and respond to the need of all family members in all assessments and interventions.
3. There should not be assumptions made that someone's family will always be a protective factor.
4. Consideration should always be given to a person's whole history of contacts with an agency. Professionals should look for repeating patterns and themes.
5. Important for professionals to check validity of any Lasting Powers of Attorney (or Deputyship) that a relative or representative claim to have as soon as possible, asking to see evidence that each page is stamped by the OPG (Office of the Public Guardian) or checking on the OPG website.
6. Consideration should always be given to the circumstances of people's refusal to accept services, in order to identify any additional needs or help needed or identify possible detrimental relationships.

What did we do?

- A Professional Curiosity and Unconscious Bias workshop was held for professionals, with good attendance from a variety of agencies.
- RWSAB noted for this case that locally, once the extent of the Safeguarding Concern was understood, there was diligent following up with family and engagement of partners across Borough boundaries.
- The RWSAB noted that the statutory guidance and the London Multi-agency Safeguarding Procedures focus on people who are residents in a single borough and it is difficult for practitioners to know when they should and shouldn't intervene. When people move around different areas, it is difficult for professionals to know this. This issue was discussed at a workshop in February 2020 during the Association of Directors of Adult Social Services' (ADASS) Safeguarding Conference. All partners recognise the importance of working across organisational and Borough boundaries. The importance of carefully considering safeguarding concerns was also highlighted to staff in Practitioners and Managers Forums.
- London Ambulance Services have introduced a system where they collate information and feed into Local Authorities where there are concerns for people with multiple calls or moving across boroughs.

Wandsworth

Who was Issy?

Issy was 26 years old at the time of her death in October 2020 from a heart attack following sepsis as a result of infected pressure ulcers. She was a white woman with an extremely rare, inherited disease that affects the muscles. In her case the condition was progressive, severely disabling, and life-threatening. As her condition progressed, Issy become increasingly bedbound, socially isolated and in pain. Her main carers were her parents. When the COVID-19 Pandemic impacted, she was regarded as 'clinically extremely vulnerable' and required to 'shield', to protect her from infection. This resulted in further isolation.

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

Why was this SAR commissioned?

The RWSAB Executive agreed that Issy's case met the criteria for a mandatory SAR as there was suspected neglect (and self-neglect) and there was multi-agency involvement in her support. The case also provided opportunity for learning on how organisations work with young people in transition, the adequacy of the support to family carers and the impact of COVID-19 on the level of support which was provided.

What were the findings from the review?

1. "Tunnel vision" amongst professionals is working to maintain a task focus in pressured work environments which increases the risk of staff inadvertently becoming desensitised to and dehumanising people drawing on health and care services.
2. Mental Capacity Act training has not achieved a base line understanding of the application of the Mental Capacity Act across agencies and professions.
3. Family carers needs and abilities are not fully and holistically explored with the consequence that carers are left feeling unsupported.

What did we learn?

1. It is important for Adults' and Children's Services to have a model for joint working on cases involving young people with complex needs, with coordinated community support and a recognised mechanism for sharing information and updating risk assessments.
2. Multi-agency hospital discharge meetings offer the opportunity for professionals from the acute and community health and social care networks to share planning for delivery of community care with the person and their family carers. These should be prioritised when discharging young people with complex needs and concerns about compliance with medication, appointments, or care.
3. Improve professionals' confidence in distinguishing between unwise decisions and where executive decision-making capacity is impaired due to factors such as depression, anxiety or isolation.
4. Self-neglect can manifest in a small change of engagement from the person, however it is still important to be picked up and progressed as Safeguarding.
5. Managing Direct Payments information needs to be simple and accessible. When surpluses are identified for repayment, this issue must be fully explored with the person and assurance gained that they understand how they can use their allocated funds flexibly to meet their needs.
6. Family carers may need practical and advocacy support, particularly when the needs of the person they are caring for are complex.
7. Parent carers need support and flexibility when their child reaches 18 and their role changes from being responsible for a 'child' to supporting an adult. Professionals need to be sensitive and supportive to parents and the young person. This issue of role needs to be explored as part of carers assessments and in the context of developing support plans for the young person which rely on input from a parent carer.

What did we do?

- Held a Joint Adults' and Children's Services Leadership meeting to discuss culture change and ways to improve collaborative working on complex cases.
- Created a joint Adults' and Children's Services "reflective space" to promote joint working and co-ordination of interventions, thereby improving the outcomes for people.
- Received assurance that the right agencies are involved and alert in discharge plans for young people with complex needs.
- Organised and delivered a 'Clinical and Practical application of Mental Capacity Act (MCA), Making Safeguarding Personal with Self-Neglect' masterclass to raise awareness about safeguarding in the context of self-neglect and the implications in terms of the MCA. The masterclass was attended by over 80 professionals and received excellent feedback.
- Individual Direct Payment requests are looked at in a case-by-case basis and the use of Direct Payments for unpaid carers is now incorporated in Team Meetings, Supervision and relevant training. The Carers Champions are also advocating this in their contact with unpaid carers.
- Transitions protocol and pathway have been updated and published. Working flexibly with the families is embedded within the pathway and protocol.

Wandsworth

Who was Daniel?

Daniel, a white British man, died at the age of 36 in August 2018. He had historical diagnoses of asthma, attention deficit hyperactivity disorder (ADHD), mild learning disability, and epilepsy and was believed to have suffered head injuries. Daniel was known to drink alcohol excessively, to a level of dependency. He suffered from depression and low mood, and had experienced trauma, loss, and bereavement in his life. Daniel's mother had died and in his 20's, he lost a partner who died after having a seizure at home. After a hospital admission Daniel was discharged into residential care, and from there into supported living. Over time Daniel began to disengage with services and with treatment. There were concerns about his ability to sustain his tenancy, use of alcohol, non-concordance with medication and the neglect of his room and himself. In August 2018, Daniel had an epileptic seizure at home and died from a brain haemorrhage

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

Why was this SAR commissioned?

The RWSAB Executive agreed that Daniel's case met the criteria for a mandatory SAR as he died, there is evidence of self-neglect, and agencies could have worked together better to safeguard him.

What were the findings from the review?

1. When faced with social needs, alcohol misuse, and the threat of homelessness, many social care methods follow a crisis intervention approach, focused on immediate practical solutions, which often fails to address underlying causes, or the impact of previous crises, historical traumas, or hidden vulnerabilities and health conditions.
2. In the formulation and assessment of need, there was insufficient weight given to developing and maintaining family and personal relationships as a step towards a good life for everyone. This increases the risk of a stand-off between the person and professionals about their safety, rather than jointly focusing on factors critical to their happiness.

What did we learn?

1. A sequential approach to multiple needs is standard across agencies – services focused on practical aspects of homelessness, and then alcohol use without tackling other vulnerabilities including childhood conditions, loss, bereavement and recent experiences of abuse and exploitation. Such an approach risks responding to symptoms and not causes, undermining the potential effectiveness of professionals' efforts.
2. The ambition of the Care Act is that social care makes a major contribution to everyone's wellbeing – going beyond simple assessment and service provision to meet practical or physical needs, embracing the vision of 'lives worth living', societal participation, and the creation of a 'good' life. The basic approaches of Adults Social Care assessment and formulation of need do not yet match this vision or support this ambition.
3. The issues of homelessness and alcohol addiction should be viewed through a perception that goes beyond immediate and practical. Systems that fail to identify and address the underlying causes and experiences of individuals, however complex, are well designed to improve an individual's immediate circumstances, and safety, and may provide a foundation for further work, but increase the risk that an individual will not be supported to tackle psychological outcomes, to learn from crises, and to develop future resilience.

What did we do?

- Considering whole life histories and trauma-informed practice is a repeating theme in a number of SARs, therefore the Board undertook training of professionals focused on improving skills in working in a trauma-informed way. The SAB also held a multi-agency workshop on working with Change Resistant Drinkers in 2020 led by Alcohol Change UK, which was very well received. More training provided by the same charity is being promoted locally and a masterclass on Substance Misuse and Self-neglect is planned for Autumn 2022.
- The RWSAB understands that practitioners are faced with an ongoing dilemma of achieving balance between involving the family members or informal carers as a supportive mechanism for vulnerable adults and on the other hand avoiding the voice of the person being overtaken. The Local Authority has worked to expand engagement with informal carers, working with local Carers Centres and Carers Groups to improve carers assessment rates. The RWSAB is working to increase awareness (via sharing and promoting the learning across the partnership) of the holistic view of a person's care, which includes their family life and relationships.

08

PARTNERS' CONTRIBUTIONS

Adult Social Care – Richmond and Wandsworth Councils

The year has presented a number of challenges including increased demands in Safeguarding concerns. Most safeguarding meetings with residents and their families are now held virtually and overall, we have seen better attendances from all parties including partner organisations. Face-to-face meetings are still available at request and home visits remain a priority. This new way of working has enabled us to be a more responsive service. Intelligence from partners regarding locally commissioned services is shared regularly and we have supported local care homes and agencies in continuing to deliver high quality services to local people. There has been more jointed up working with Childrens Services in raising the profile of family safeguarding and clearer pathways for young people in Transitions. Multi-agency working is paramount and the local authorities have taken a key role in supporting the local MARAC and MAPPA meetings and leading on Vulnerable Adults Multi-agency panels in both boroughs.

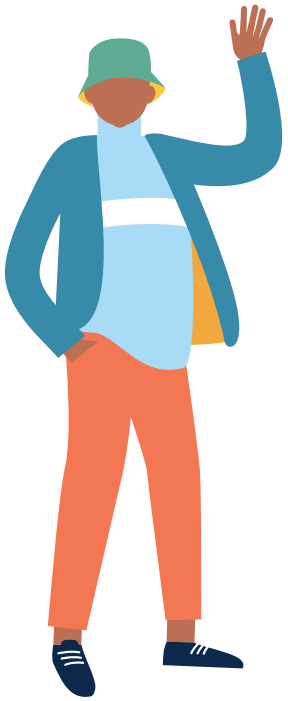
Age UK Wandsworth

Age UK Wandsworth continues to make safeguarding a priority and it remains the case that all new staff and volunteers must undergo safeguarding training as part of their induction. Volunteers who work on our Befriending Plus Service, which commenced in 2020, are also now required to complete an additional higher level safeguarding course after completing their first year of volunteering.

Alzheimer's Society Wandsworth

During the first part of 2021 we were still completing many of our assessments over the telephone, relying on the skill of the advisers to identify areas of concern. As the year progressed, we were able to open up our offer on face-to-face support. During the early part of 2022 we have been working on recruitment where there have been challenges on finding suitable applicants, however by August we will be back at full staffing levels.

We continue to work closely with our internal Safeguarding team when identifying a safeguarding concern and work to make safeguarding personal. All concerns continue to be logged on our internal reporting system 'RADAR' and reported to the Local Authority as appropriate. The Services Manager continues to attend the Adult Safeguarding Board meetings.



Central London Community Healthcare NHS Trust (CLCH)

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

Our key achievements in 2010/22 were:

- Well established 'duty' system to support staff accessing timely advice and support.
- Contributed to: Community Multi-Agency Risk Assessment Panel (CMARAP), Multi-Agency Risk Assessment Conference (MARAC) and RWSAB sub-groups.
- Engaged with S42, S44, S49 safeguarding reviews.
- Trust-wide audits on quality of safeguarding referrals to social services.
- Developed and promoted SAFER guidance when making a referral to local authority.
- 2 cohorts of safeguarding and Mental Capacity Act champions graduated (21-20), 2 network days for update and supervision with all champions.
- Delivered bespoke training to staff and partners re: Mental Capacity Act, Deprivation of Liberty Safeguards and Making Safeguarding Personal.
- Revised safeguarding training packages virtual with interactive software linked to L2 booklet and training passport.
- Delivered 5 events during National Safeguarding Adults week 2021 in partnership with RWSAB.
- 'Annual CLCH safeguarding conference: What really matters in safeguarding?' attended by 520 delegates.
- Developed and cascaded significant number of 7-minute briefings in response to internal investigations and also learning from local and national inquiries.

Chelsea and Westminster NHS Foundation Trust

The Adult Safeguarding Team have worked to maintain relationships with safeguarding partners during the post-pandemic period. This period has seen an increase in the overall number of safeguarding alerts made particularly from the emergency department. To support this increased level of activity and to improve the quality of alerts the team has worked to improve access to training for senior staff (Level 3). A key component of this training is a focus on utilising the improved safeguarding functionality within the electronic record.

Work is underway to enhance the referral process to include an integrated referral form with fewer steps for users to share risks externally. Again, in response to patterns evident in referrals, a project to enhance the understanding of familial abuse has been initiated that will help older people subject to abuse and neglect access protective services. The team is also working with the Trust's tissue viability team to improve focus on and use of the Pressure Ulcer Protocol that was designed to clarify when pressure damage can be an indicator of abuse or neglect.

The safeguarding team continued to work to support our Adult Safeguarding Champions in the Emergency department to improve quality of information documented in referrals.

Key themes in alerts raised continue to include significant self-neglect triggering conveyance to Emergency Departments, and risks associated with substance misuse and mental health. Pressures on in-patient flows have impacted on planning transfer from hospital for some people.

Community Safety – Richmond and Wandsworth Councils

The Community Safety Service and the Community Safety Partnership (CSP) lead on preventing and reducing: crime, reducing reoffending, serious violence, anti-social behaviour, violence against women and girls (VAWG), hate crime and safeguarding people from radicalisation. During 2021/2022 the Service has seen an increase in the risk being managed, both the prevalence and complexity of cases. There has been a marked increase in the numbers of victims/survivors and their children at the Domestic Abuse MARAC[4] which is under pressure. In 2021/22 in Wandsworth there were 648 cases with 662 children referred to the MARAC an average of 49 cases per meeting, compared to 20 to 25 cases in previous years. This has increased still further by 29% in 2022. In Richmond there have been 340 cases with 320 children with an average number of 28 cases per month.

Protections for victim/survivors of domestic abuse has been reinforced through the Domestic Abuse Act 2021 which puts a statutory duty on local authorities to provide support to those suffering and fleeing domestic abuse including priority status for housing and access to accommodation-based support. The Councils currently provide a range of specialist services for VAWG and launched a new VAWG strategy in 2021. The Integrated Offender Management (IOM) service in Wandsworth now manages a larger number of offenders (up to 100). The scheme now oversees higher harm offenders including those perpetrating domestic abuse. This is a new area of work, and it is essential that we hold perpetrators to account.

Serious violence continues to be a priority for the Community Safety Service and CSP, there is extensive work underway in Wandsworth through the Knife Crime Forum while Richmond has led reductions in street robbery and worked with Achieving for Children and Kingston Council to develop Project X. In relation to crime and anti-social behaviour, individuals are managed and supported through the Community MARAC. In Wandsworth there have been 26 high-risk individuals supported and 16 in Richmond. Work on Modern Day Slavery and Cuckooing will be invigorated in 2022/23 to enhance the safeguarding of vulnerable individuals. This work will be undertaken in collaboration with Adult Services and the Safeguarding Adults Board.

4 Domestic Abuse Multi-Agency Risk Assessment Conference - The purpose of the DA MARAC is the protection, safeguarding and support for those with the highest risk i.e. of imminently losing life and/or limb.

Healthwatch Richmond

Healthwatch Richmond sits on the Board and sub-groups as a critical friend. Our communications and expertise help to promote safeguarding messages and raise awareness amongst the community. Our staff work to the shared safeguarding objectives and make referrals as well as supporting members of the community to raise appropriate alerts.

Hounslow and Richmond Community Healthcare (HRCH)

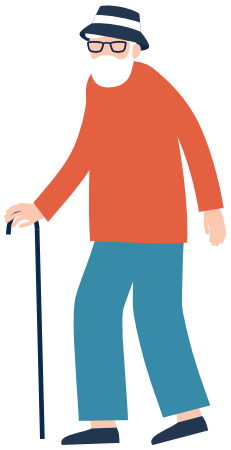
Despite another year of unique challenges, HRCH staff were supported to safeguard adults at risk and their families.

We welcomed the changes in legislation and guidance in response to rising levels of domestic abuse and reflected these in our policies and procedures, including use of Routine Enquiry.

Multi-disciplinary working remained key to assessing and addressing the balance between risks and rights for adults at risk. Readily available advice and support for staff with care quality and safeguarding concerns has been valued.

7-minute summaries and other focussed, bite-size learning and reflection was integrated into existing meetings or available on the extranet, to maximise impact and support the mandatory training programme.

Abuse, neglect and complex welfare concerns in people's homes remain a challenge for community healthcare and our partners – making it increasingly important to Make Safeguarding Personal, Think Family, raise awareness and share information respectfully.



Housing and Regeneration Department – Richmond and Wandsworth Councils

Housing are committed to the priorities of the RWSAB and look for ways to help achieve these. The department participates constructively in all RWSAB events, relevant sub-groups and multi-agency meetings to provide a housing perspective on issues and ensure policies and procedures reflect decisions made by the Board.

The housing policy team has a dedicated Safeguarding Action Plan setting out how housing staff are empowered on safeguarding matters, ensures training is completed and there are appropriate procedures in place. This includes a joint protocol mental health hospital discharges and improving how adults with needs can access housing. Richmond and Wandsworth Department gained Domestic Abuse Housing Alliance (DAHA) accreditation in 2021, recognising its robust responses to domestic abuse. 202 staff members undertook specialist courses in safeguarding adults and children during 2021/22.

Kingston and Richmond Safeguarding Children Partnership (KRSCP)

The KRSCP Business priorities of Contextual Safeguarding and Child Sexual Abuse Mental Health, and Parental Vulnerabilities & Early Help have been driven forward through the work of our sub-groups. We have disseminated the findings of Ulric Child Safeguarding Practice Review (CSPR) which highlighted the importance of the Think Family Approach and the role of Adults Services practitioners with regards to safeguarding children. As a response we worked jointly with our Adults Services colleagues to host a conference on Parental Mental Ill Health in February 2022.

The Family T CSPR has highlighted intrafamilial child sexual abuse, neglect, working with the needs of Learning Disabled adults as parents and understanding family history to effectively safeguard children and support families. We will be developing a plan to disseminate the learning from this review across the multi-agency partnership.

Our multi agency safeguarding training offer continues to be delivered online and we are working closely with Adults Services colleagues to ensure that training topics such as Prevent, Domestic Abuse and Parental are promoted across both Adults' and Children's Services.

We have been raising awareness about the impact of poverty on families in Kingston and Richmond especially highlighted in the current cost of living crisis.

Kingston Hospital Foundation Trust

Over the past year we have adopted hybrid training for staff to ensure a level of face to face as well as virtual sessions. This was to maximise staff completion of mandatory learning. Level 3 Adult Safeguarding Training is due to be rolled out in April 2022 and work is currently underway to establish staffing groups requiring the competency.

We had further expansion to our Learning Disability Liaison service due to a grant received from work our lead LD practitioner was completing with NHS England for the Reasonable Adjustment Flag Digital Project. This provided funding for a Band 6 Practitioner in a seconded post which we are hoping to make permanent in 2022/23, due to the excellent feedback we have had throughout the year. Kingston Hospital was invited to be a key stakeholder in the Supporting Complex Lives Programme which used a systems change approach via workshops to help change the support for rough sleepers in the borough. This work is ongoing into the next financial year.

London Fire Brigade (LFB) - Richmond

Richmond London Fire Brigade work in partnership to identify, refer and assist the most vulnerable – assistance given in fire safety visits, fire retardent bedding and equipment supplied, alongside linked smoke detection (Tunstall alarms) and arson proof letter boxes. Attendance at Vulnerable Adults Multi-agency Panel (VAMA) and other relevant RWSAB meetings. 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.

London Fire Brigade (LFB) - Wandsworth

Commitment to Safeguarding is fully integrated into every aspect of the LFB's community safety activities in Wandsworth. We have successfully engaged with our colleagues across the partnership over the last 12 months, to make sure our residents' safety and wellbeing are at the forefront of everything we do. One example being our online "fire awareness training" for approximately 60 Adult Social Services and Local Authority housing colleagues. We continue to actively participate in the development of effective information sharing agreements and robust referral pathways, to ensure a multi-agency approach is adopted and maintained at all times.

Metropolitan Police South West Basic Command Unit (SW BCU)

SW BCU police continues to work closely with partners to improve our response to vulnerable people in our communities. We are developing a new cuckooing protocol, including clear referral pathways for police and other professionals and tactical options for officers, to better identify and support victims of cuckooing and target perpetrators. The BCU aims to professionalise Adult Abuse work: we have appointed a dedicated Detective Inspector to lead on adult abuse, who will look to strengthen our response and engagement, raise the adult abuse agenda within policing locally, develop a network of subject matter experts around adult abuse and embed learning from Safeguarding Adults Reviews. We have revised our Multi-Agency Safeguarding Hub (MASH) referral process to make it easier to call a strategy meeting for improved working and risk assessment. SW BCU continue to be fully engaged with the RWSAB Executive and the sub-group meetings and other multi-agency panels including MARAC and CMARAC.

National Probation Service

In June 2021 the National Probation Service and Community Rehabilitation Companies (CRC) unified to become one organisation. The Probation Service has experienced severe staffing challenges since this time, alongside managing the ongoing changes required to embed new processes and policies and ensuring appropriate training is undertaken by staff to deliver effective offender management services. Delivery of services are therefore modified in line with available resources in different boroughs, with Kingston delivering under 'Red' regime and Wandsworth under 'Amber'.

In relation to safeguarding, we continue to implement mandatory training and encourage staff to access all available safeguarding training opportunities from local authorities and other bodies. We ensure adult safeguarding activity is addressed at all points of delivery, including Courts, custody and supervision in the community. Concerns about safeguarding are escalated for management through Multi-agency Public Protection Arrangements (MAPPA)[5] where necessary.

5 Multi-agency Public Protection Arrangements ensure the successful management of violent and sexual offenders.

Public Health, Richmond and Wandsworth Councils

The Public Health Quality Assurance (PHQA) process is the main safeguarding approach in the Division to provide assurance to the Director of Public Health that services are safe and effective. PHQA ensures issues are reported, mitigated, managed and where needed, escalated in a timely manner. It is reported at the internal commissioners PHQA meeting and Public Health Board.

The Safeguarding Identification and Reporting Pathway is embedded within service contracts, and commissioners share information and learning about safeguarding at the PHQA meeting.

Public Health have refreshed both suicide prevention strategies and are currently conducting comprehensive mental health needs assessments for both boroughs. The latter incorporates groups with increased vulnerability to mental health problems (e.g., homeless people, those who identify as LGBTQI+), the impact of COVID-19 on local populations and will make recommendations to inform service commissioning over the next five years.

Richmond Carers Centre

Richmond Carers Centre is committed to a holistic and integrated approach to safeguarding where safeguarding practices are embedded within all aspects of our work. All staff and volunteers, including trustees, are required to undertake safeguarding training as part of their induction, along with regular refreshers. Our adult safeguarding policy was reviewed in February 2022. We continue to liaise with our colleagues in Social Care to ensure appropriate safeguarding measures are taken so that carers and the people they care for are safe. We completed the annual self-assessment audit in October 2021, and along with Kingston and Richmond Safeguarding Children's Partnership completed Section 11 Audit in November 2021. We are currently enhancing our policy on DBS checks for staff and volunteers working with vulnerable children and adults. Safeguarding is a standing item on our board agenda and internally report quarterly on safeguarding alerts and referrals – keeping safeguarding visible.

Richmond Crime Prevention Outreach Committee (CPOC)

Richmond Crime Prevention Outreach Committee (CPOC) was formed through the RWSAB Richmond Community Forum. This committee is chaired by a long serving Met Police Volunteer and its membership is comprising of the Richmond Met Police Wards Inspector, the Cybercrime Units and the 'Prevent' team of the Police, Richmond Council, the SWL CCG Safeguarding Designate Nurse, the Richmond Safer Neighbourhood Board (SNB), Trading Standards, and Volunteers specialising in crime prevention and the safety of Richmond residents.

The committee focuses on discussing public information from its partner agencies and ensuring this is advertised widely in Richmond. During 2021/22 CPOC specifically recognised the rise in COVID vaccination scams. It also assisted in promoting scam information to residents, e.g., distributing scam booklets, giving presentations on scams and safety (live and via Zoom), and working with the SNB, the Police and NHS in manning stalls at local events.

Richmond Council for Voluntary Services (CVS)

Our work continues to focus on highlighting the importance of embedding appropriate safeguarding procedures within local voluntary and community groups. This includes promoting relevant safeguarding resources, facilitating learning and training opportunities and working with some new and existing groups on a 1:1 basis to develop or update their policies and procedures. We are a member of the Richmond Safeguarding Community Forum and have attended meetings regularly to share and collate information and learning relevant for the voluntary and community sector.

Richmond Housing Partnership (RHP)

We held a Safeguarding week to coincide with the National Safeguarding week and covered Cuckooing, Domestic Abuse and best practice in managing safeguarding records. RHP supports the work of the RWSAB and attends the meetings and sub-groups. We have a strong working partnership across multiple agencies to ensure that our vulnerable customers are kept safe from harm and neglect. We have adopted the RWSABs 7-minute learning as an area of best practice.

Richmond Wellbeing Service

Richmond Wellbeing Service offers a person-centred approach to safeguarding and collaborates with local specialist providers to offer seamless service for adults who need safeguarding. We have continued to provide a person-centred, integrated approach to safeguarding adults in the last year. Our clinical work keeps in mind safeguarding issues at every clinical contact. Richmond Wellbeing Service liaises closely with the local safeguarding team and refers to them when appropriate, alongside offering clinical treatment.

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

The Coronavirus pandemic placed critical and sustained pressure on all areas of the Trust. Despite challenges, we have continued to promote and prioritise the safeguarding adults agenda across the Trust. Our highlights for 2021/22 include:

- New co-produced 'Safeguarding Adults Policy' fully aligned with the principles of Trauma Informed Care and places the principles of making safeguarding personal (MSP) as a golden thread through all of our safeguarding work.
- Development of a bespoke safeguarding adults level 3 training package in collaboration with SLAM.
- Secondment of a Domestic Violence & Abuse Lead, focusing on improving practice around Routine Enquiry, referral pathways and reviewing requirements for mandatory Domestic violence and abuse (DVA) training plus co-location with Independent Domestic Violence Advisors (IDVA).
- Relaunched our co-produced 'sexual safety' policy and produced practice guidance, posters, leaflets and a training webinar.
- Successful appointment of new Safeguarding Adults and Prevent Lead following 3-month interim arrangements.

South-West London Clinical Commissioning Group (SWL CCG)

In 2021/22 SWL CCG have been preparing to transition smoothly to become an Integrated Care Board (ICB) to establish an Integrated Care System (ICS) across SWL to empower better joined up health and care as set out in the Health and Care Bill 2021. The four aims of an ICS are:

- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience, and access
- enhance productivity and value for money
- help the NHS support broader social and economic development.

Covid vaccination programme in SWL

SWL CCG rolled out the biggest vaccination programme in NHS history across South-West London. All individuals aged 12 and over eligible for a 1st or 2nd dose and all adults aged 16 and over wanting to book for a 1st, 2nd, 3rd dose or booster dose of the COVID-19 vaccination are able to book in for an appointment through the National Booking System or by calling 119. Since the start of the roll-out of COVID-19 vaccination across South-West London, the programme has administered 3,006,847 vaccine doses, the majority of which has been provided by local GPs and Community Pharmacists. As of 16th February 2022, 75.5% of SWL adults have had their first vaccination, 72.4% have had their second vaccination and 78.8% of those eligible, have received their booster. 72% of 16-17 years old and 59% of 12-15 years old have received their first vaccination. Getting to this point has been a significant achievement and reflects the enormous collective contribution from the South West London system including the CCG, NHS Trusts, PCNs, Community Pharmacies, Local Authorities, Police, Army, Voluntary Sector, faith and community groups and staff and local people as volunteers.

Richmond and Wandsworth Designated Safeguarding nurses were enlisted to interview candidates for the national Covid-19 mass vaccination delivery campaign and were involved in administering Covid vaccines in SWL in December 2021.

South West London Clinical Commissioning Group – Richmond

The Designated Safeguarding Adults Lead for Richmond contributes directly to the work of the RWSAB by chairing the Communications and Engagement Sub-group, and the Richmond Community Forum and attending the SAR sub-group and Performance and Workforce sub-group. The Director of Quality and the Safeguarding Designate facilitated and presented at the RWSAB Annual General Meeting. The Richmond Community Forum continued to be a very active forum during the pandemic with attendance from all statutory agencies, local providers, and voluntary organisations, the meetings were held virtually. The Forum delivered key communication and engagement activity to enable the SAB to achieve its strategic objectives, as outlined in its business plan. Each attendee provides an update on their organisation's local services, highlighting achievements and concerns which assists in providing assurance to the RWSAB of the local safeguarding agenda and understanding of local areas of concern in Richmond.

During the Covid-19 pandemic, safeguarding training to all primary care services in Richmond was provided together with the named Safeguarding Adults and Children GP leads for Richmond and this has been a major contributor to enhancing safeguarding awareness and work in the Borough.

The Richmond Designated Safeguarding Adults Lead also assisted with complex cases in Care Homes and Continuing HealthCare (CHC) settings, with lessons learnt from these cases being shared locally and nationally during the Safeguarding Adults National Networks (SANN) meeting to share good practice.

South West London Clinical Commissioning Group – Wandsworth

Over the last year 2021/22, the Designated Safeguarding Adults lead for Wandsworth CCG has worked closely with RWSAB through attending all sub-groups and chairing the Wandsworth Community Forum. The Wandsworth Community Forum continued to be a very active forum during the pandemic with attendance by a large number of stakeholders including the Wandsworth Carers Centre, Alzheimer's Society, Age UK Wandsworth, Housing, London Fire Brigade, Local Authority colleagues, representative from the HMP Wandsworth and commissioned providers. The Forum delivered key communication and engagement activity to enable the SAB to achieve its strategic objectives locally, as outlined in its business plan. Each attendee provides an update on their organisation's local services, highlighting achievements and concerns which assists in providing assurance to the RWSAB of the local safeguarding agenda and understanding of local areas of concern in Wandsworth.

Robust communication during the Covid19 pandemic highlighted for example the need to work collaboratively with housing colleagues to ensure that homeless people were offered accommodation in Richmond and Wandsworth. The Designated safeguarding adults lead in Wandsworth worked closely with the Community Safety Partnership Board as a member of the Domestic Homicide Review (DHR) panel and the Counter-Terrorism, Channel Panel to provide expert advice and support to these groups.

St. George's University Hospital NHS Foundation Trust (StGH)

The St. George's Hospital team have seen a 14% increase in safeguarding referrals over the past year (total of 1094), of which those relating to Wandsworth where alleged abuse took place is 431.

The team attend Community Multi-Agency Risk Assessment Panel, working with wider stakeholders to support these very vulnerable individuals.

We attend RWSAB Sub-Groups and are keen to improve our contribution to Safeguarding in Wandsworth by attending regular Safeguarding Adults Boards. We attend and contribute to neighbouring Boroughs SABs as well.

Absconding from Hospital remains high on our agenda. We work closely with the Mental Health Trust, Police and Local Authority to improve safety. Training is being offered to new Police recruits as part of their readiness to work.

We participate in investigating and contributing to enquiries where our standard/quality of care is a cause for concern (total 118 in 2021/22).

Compliance with Adult Safeguarding training internally is 90.5%.

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

In early 2021 Covid was still having a large impact on our workload and resources. The team were still responsible for enforcing the Covid Regulations and there was an increase in enquires for advice from businesses. However we still received and investigated numerous reports about scams, doorstep criminals and rogue traders. There has been a large rise over the last year in online scams, mostly concerning Covid Vaccines or Track and Trace. Doorstep Crime and Scams are a priority area achieved over the last year through:

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

Wandsworth Care Alliance (WCA)

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

Wandsworth Safeguarding Children Partnership (WSCP)

The last 12 months has seen the partnership grow from strength to strength with innovative ways of working being a key theme.

Wandsworth Childrens Services, with the support of partners, has launched the Family Safeguarding Approach based on 'think family', Wandsworth is the only London Authority to have implementing this so far.

We have reshaped how we learn from Child Safeguarding Reviews with new methodologies to produce shorter reports with a focus on wider systems learning.

As a partnership we have had activity focus on Neglect and Domestic abuse and providing training across the partnership in using tools - with the NSPCC GCP2 Neglect tool and Barnardo's DARAC tool.

We have launched a Safer Sleeping Guidance for babies and infants.

There are iterative challenges such as unknown impact of Covid-19 and identifying and increasing the number of children being privately fostered.

We have shown progress against our key priorities.

Your Healthcare (YH)

2021-22 saw a rise in the number of safeguarding alerts raised by practitioners, with the most prominent area of concern being neglect/self-neglect, whereas safeguarding cases concerning Your Healthcare services remained low. As part of the response to this YH is part of a project to review how the local multi-agency network responds to self-neglect concerns.

YH was also honoured to be awarded the "We see you, We hear you" National Safeguarding Board award for "Empowerment Champion". YH continues to be an active member of the RWSAB and its working sub-groups.

Though we prioritise face to face patient contact, YH has continued to use video conferencing to support faster multi agency communication and respond to patient need more effectively. YH also entered a partnership arrangement with HRCH which has resulted in shared learning and co-production of resources to assist our practitioners. This reduces duplication of effort whilst bringing more knowledge and resource to projects.

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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 Richmond and Wandsworth Design and Print. wdp@wandsworth.gov.uk CS1975 (9.22)