Lambeth Safeguarding Adults Board Annual Report 2022-23

Safeguarding Adults in Lambeth

Contents

INTRODUCTION FROM OUR CHAIR

As the Independent Chair of the Lambeth Safeguarding Adults Board, I am incredibly proud of our amazing partnership. We have not shied away from the difficult things we need to do to address the growing vulnerability in our borough. We have had to work differently and reimagine our support pathways as we protect those who need us to work together and share our approaches. We have done this through growing our understanding of our communities, growing our understanding of each other, and sharing our data and resources. This annual report sets out the impact we have made for our communities by working differently together.

We have been supported to deliver this challenging work by a superb team at the Council who have helped our partnership to organise ourselves, perform strongly and keep our ambition high. They have helped us to both define and to keep focussed on delivering our priority actions. Making safeguarding personal and better understanding the nuances and drivers across our diverse communities has been a core focus for us. So, too has been supporting and understanding our teams of incredible staff. As a partnership we deliver an enormous amount of support for our diverse communities, and we could not achieve this impact without the professionalism, energy and resilience of the staff who work in each of our organisations. This has been a particularly challenging year, with a real growth in the volume and complexity of need. Again, this year I use the word resilience hesitantly, as we know our staff should not have to overcome personal wellbeing challenges and deliver under pressures of volume.

I hope you enjoy the breadth of impact we have shared in this report, and I look forward to another high impactful year ahead.

SAFEGUARDING ADULTS IN LAMBETH

Safeguarding adults is about protecting someone's right to live in safety, free from abuse and neglect. It is also about preventing the abuse of adults who might be unable to protect themselves because of their disabilities or care needs. **We all have a role to play.**

We want to ensure that all Lambeth residents, health and social care staff and other professionals working in the borough have access to information about Safeguarding Adults that helps them understand what this looks like and what steps we can take to support adults who may be at risk of or experiencing abuse or neglect. The Care Act 2014 states that safeguarding duties apply to an adult who:

- has needs for care and support (whether or not the local authority is meeting any of those need)
- is experiencing, or at risk of, abuse or neglect as a result of those care and support needs.
- is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

Have you got a safeguarding concern about someone?

If you are concerned about someone's immediate welfare, please call 999 in an emergency

If you are concerned about an adult and want to make a safeguarding referral:
Please do so via Online referral here
Or call 0207 926 5555.

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WHAT IS THE LAMBETH SAFEGUARDING ADULTS BOARD?

The Lambeth Safeguarding Adults Board (Lambeth SAB) co-ordinates safeguarding adults work in Lambeth. Its main objectives are to ensure that the safeguarding arrangements across the partnership work effectively to prevent abuse and neglect, and to protect adults in Lambeth with care and support needs who are experiencing or at risk of abuse or neglect, and as a result of those care and support needs are unable to protect themselves from the risk or the experience of abuse or neglect.

The SAB's statutory functions include:

- Developing and publishing a strategic plan setting out how we will meet objectives and how the partnership will contribute to this.
- Publish an annual report detailing how effective their work has been.
- Commission and conduct Safeguarding Adults Reviews for any cases which meet the criteria. The Board has an Independent Chair and is a multi-agency partnership that includes a range of organisations. We want to ensure that all residents and people who work with adults at risk in Lambeth know about safeguarding adults and know how to respond should they come across a concern. We do this by promoting and maintaining cohesive partnership working to safeguard adults at risk from harm. The Board is not responsible for delivery of services, those who plan and make decisions about services locally have representation at the Board and give the Board regular assurance on how their services respond to and protect adults at risk of abuse or neglect.

Our Budget:

The Lambeth SAB does not have a working budget and it has been a priority to increase contributions from SAB Members in order to align with SAB budgets elsewhere in London and ensure that we are able to deliver on our stated aims. We are in conversation with our partners to ensure we have contributions that constitute a workable budget.

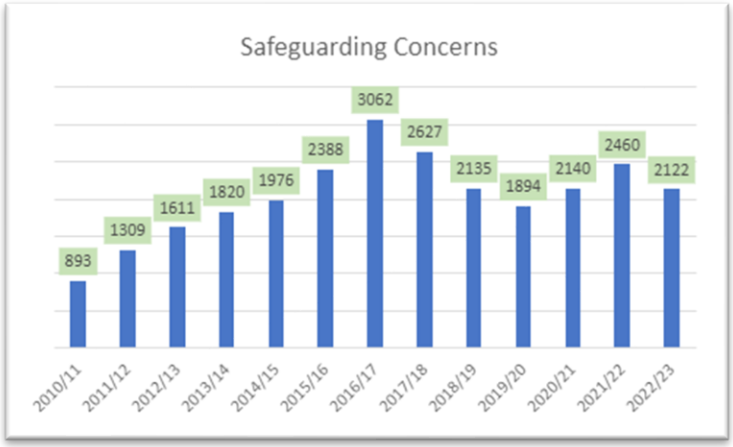
In the year 2022/23 we received partner contributions from:

- Mayor's Office for Policing and Crime (MOPAC): £5000
- South-East London ICB £30,000

This is the second year that we have received contribution from ICB colleagues, however we lost the London Fire Brigade funding in the next year due to their own financial pressures.

Our total yearly expenditure is approximately £200,000. This includes the salaries of those coordinating the work of the SAB, as well as funding for Safeguarding Adults Reviews (page 16) and the work of the Independent Chair. Lambeth Adult Social Care covers the remaining expenses as well as funding the roles of the Safeguarding Adults Board and Partnership Coordinator and Adult Safeguarding Lead who lead on the coordination the work of the Board and its subgroup.

The Local Picture



Safeguarding concerns

The period April 2022- March 2023 has seen a 14% reduction in the number of adult safeguarding concerns received, compared to the previous year. We are attributing the reduction to:

1. The level of referrals evening out after a period of increase following the end of lockdown which saw a spike in 2021/22 referrals compared to previous years.
2. The adult social care front door redesign which created the new Safeguarding Adults Hub.

The safeguarding hub ensures a singular process and highly skilled team who receive the majority of the safeguarding adult referrals in the borough. The team is set up to have an increased focus on early decision making and signposting to appropriate services. The team has demonstrated ownership in decision making around safeguarding matters which has prevented inappropriate referrals being captured incorrectly as safeguarding adult concern episodes, ensuring a focus on those matters which require a safeguarding response. Our process includes identifying those safeguarding referrals which need to be captured as safeguarding concerns, gathering information, and determining those cases which lead to a S42 (Care Act 2014) enquiry. There has been a 6% increase in the conversion rate from 29% to 35%. This data demonstrates the efficacy of the safeguarding hub where there is a focus on consistent decision making, it also shows that our partners have a good knowledge as to what constitutes a safeguarding concern and the local referral pathways.

Types of abuse

Neglect and acts of omission remain the most commonly reported type of abuse in Lambeth featuring in 39% of safeguarding adults' concerns. This has been the most prominent category of abuse reported since 2013/14 when this data was first published and is in line with national trends.

The second most common type of abuse is financial/ material abuse, and this was a similar level to 2021/22 at 16% of all safeguarding concerns. We will continue to focus on this as a SAB in light of the risk of increase to vulnerable adults of financial exploitation as we face a national cost of living crisis.

Self-neglect remains a large part of the care management and safeguarding work we do in Lambeth and represents 9% of all concerns we received in 2022/23. We continued to widely promote the self-neglect Multi agency guidance and

the animation which were developed by the LSAB and all partners have signed up to. We have further embedded the complex case framework which aims to provide a multi-agency risk management tool as an alternative to S.42 processes.

Location of abuse and source of risk

Abuse can happen anywhere including in a persons' home, day centres, in the community and in a hospital or care home setting. Similarly, to our 2021/22 data, the most prevalent location for safeguarding to take place is in the persons' own home. These concerns may relate to a variety of matters including, but not limited to, care provision, financial abuse, self-neglect, neglect, and domestic violence in the home.

Most alleged sources of risk are often known to the person such as friends or family at 44% of safeguarding enquiries or a service provider (49%). It is a priority for us to focus on increased standard of care in the services we commission. In the past year we continue to build close links with CQC and commissioning via our provider concerns panel and an updated provider concerns policy has been developed by the integrated commissioning service which was rolled out with all partners in 2023.

Risk management is a key part of the safeguarding process, and we want to promote service user safety as part of this. As part of the safeguarding work, we ask individuals and/or their representatives if they feel safer because of the help they received from people dealing with the safeguarding concern raised. In Lambeth we have a high level of risk reduction or removal following safeguarding interventions at 83%. In the remaining 17% of cases due to the nature of the concern and the impact on the person they have told us that their sense of safety remains unchanged.

Diversity and inclusion within adult safeguarding

An analysis of the equalities data within adult safeguarding work enables us to gain greater understanding of the people we are working with. Data from 22/23 shows there has been an increase in safeguarding for under 65's by 10%, with 45% of safeguarding enquiries being for those under 65 years old. This can be attributed partially to the changing demographics of the borough as we see an increase in younger adults moving into Lambeth. We have also done a lot of work around contextual or transitional safeguarding, and this has been helpful in supporting agencies in identifying those young adults at risk of harm and exploitation in the borough. This year we will be further defining the 18- 65 age group and breaking it into smaller categories to enable us to begin to draw even greater understanding of patterns in safeguarding.

Our 22/23 data shows that the majority of individuals who were subject to safeguarding concerns identified as White (41%) and Black African/ Caribbean at 37%. We aim to do more to further define these groups as well as compare the data with those recorded as having care and support needs in the borough, as this can be different to the local picture.

Where the primary service user group is known, the safeguarding enquiries primarily relates to those with physical support needs (32%), followed by social support needs (14%), mental health support (19%), and learning disability support (11%). We continue to work with staff and partners on ensuring accurate recording of demographics so that we can better understand the people we are supporting.

Reflecting on some of the work the SAB carried out in 22/23 we plan to incorporate demographic data collection and interpretation as part of our 23/24 work plan. We will build on our collection of data and particularly on recording sexuality. Lambeth has the largest LGBTQ+ in London and our ambition is to equip staff across the partnership with the skills to hold dialogue with individuals around their sexuality so that this can be routinely and accurately captured and recorded.

WHAT HAVE WE DONE IN THE LAST YEAR?

LSAB strategy and planning

The Care and Support Statutory Guidance gives more detail about how SABs should meet the requirements of the Care Act 2014. Lambeth SAB's Adult Safeguarding Policy says it will address these requirements:

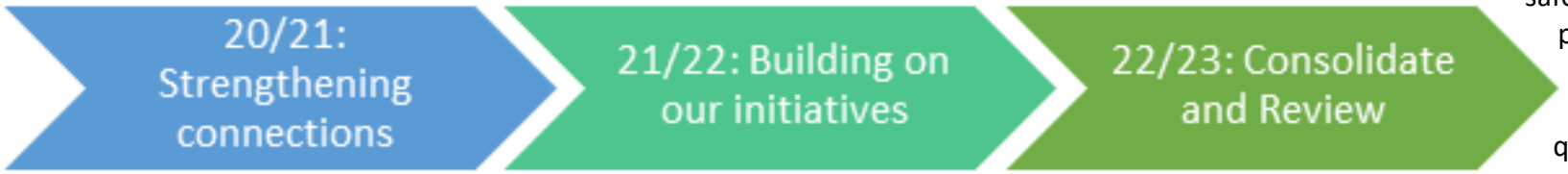
- **develop preventative strategies that aim to reduce instances of abuse and neglect in its area.**
- **develop strategies to deal with the impact of issues of race, ethnicity, religion, gender and gender orientation, sexual orientation, age, disadvantage and disability on abuse and neglect.**
- **Promote multi-agency training and consider any specialist training that may be required, to include exploring any scope to jointly commission some training with other partnerships, such as the Community Safety Partnership**

The Lambeth SAB has an overarching strategic plan for 2020-23. This year we were concluding our 3-year strategy and final work plan. In part, our focus for 2022-23 was to **consolidate and review** the actions taken previously. Within that we had chosen 3 areas of focus **Making Safeguarding personal, Prevention and early action** and **working together.** The work plan for 2022/23 can be found here.

Making safeguarding personal

Making Safeguarding Personal (MSP) emphasises a personalised, simplified approach to adult safeguarding, which prioritises the individual's wishes and empowers them, wherever possible, to feel they have choice and control.

The outcomes identified as part of the safeguarding process must be about improving quality of life,



well-being and safety for the individual themselves. The LSAB wants to ensure that all adults will feel listened to and have choice and control through the safeguarding journey.

As part of the **final work plan of 2020-2023** the aim of Making safeguarding personal is that Adults will feel listened to and have choice and control through the safeguarding journey.

Strengthen our commitment to inclusion and representation within adult safeguarding.

Work has been done as part of the work plan to increase representation and focus within the community engagement group. We have developed a summary of our refreshed community engagement group which seeks wide representation from the community. We have met with different organisations expressing interest in being part of this group and brought them on board. This has considerably increased the representation at meetings as well as the diversity of our community partners. On first forming the community engagement group we have looked at taking a community led approach, asking what members and the people they work with and represent, would like to be the focus of the safeguarding subgroup.

To consolidate prior work undertaken in relation to focus on lived experience.

Healthwatch Lambeth have continued to gather feedback via interview from people who have experienced an adult safeguarding enquiry process in Lambeth.

The LSAB considered this feedback and has committed to ensuring that this feedback is shared with frontline staff alongside promotion of tools and resources to support application of MSP.

Working together

Our aim under working together is for professionals, residents, and service users to feel more confident by being better informed and engaged about adult safeguarding.

We continue to work on new methods for gathering assurance on how SAR learning is shared and understood – for example in November 2022 a session was delivered which explored learning from SAR H, I and J and invited participants to feedback on challenges they see in practice and how we can overcome these. The outcomes and actions from SAR, H, I and J will be explored in greater detail later in the report.

Proposals to bridge gaps to address transitional safeguarding.

We have built links between LSAB and Lambeth Safeguarding Childrens Partnership (LSCP). A representative from Children services is a member of our MCA subgroup and we plan and work with them on the offer for 16-year-olds under MCA Act 2015, this included the work we did together in the consultation over LPS across 22/23. This helps to better support young adults moving from Children Services to Adult Services.

We have also co-ordinated alongside the new Contextual Safeguarding team and other partners in developing a draft transitional safeguarding strategy. This is still in development, but a task and finish

group has been formed to finish this and is closely linked to LSAB work in bridging the gap and ensuring the safety of young adults in the borough.

Collaboration and stronger communication with strategic partners on key pieces of work

We have broadened the ask of our partners in reporting to the board with a focus on assurance and sharing understanding of their work. We have had 4 different agencies provide quarterly reports to the board with a focus on what they are doing as an organisation in relation to safeguarding adults in 22/23 including Lambeth Housing, ICB, GSTT and Contextual safeguarding (CSC).

Prevention and early action

The focus of this area within the work plan was to ensure as a partnership that Adults in Lambeth will be supported to feel safe. Professionals and residents will be able to recognise risk and know how to respond. As part of the consolidation and review in this area we have taken a number of steps in our work plan areas which are described in more detail further on in this report.

To embed the complex case pathway review

The final version of the Complex Case Framework was agreed at our July 2021 SAB meeting following a trial period. The pathway aims to support a cohort of people who are often not compliant with traditional service delivery or interventions. Because of this, the professionals involved may need to devise potentially innovative and creative approaches to mitigate the risks evident. This was developed in collaboration with Bromley SAB (BSAB) and Southwark Council.

Over 2022/23 we have widely embedded this tool into frontline practice. LSAB members have broadened the reach to supported housing providers who are often supporting service users who may benefit from this risk management approach. We have delivered training and guidance to support its use.

In September 2022 we worked in partnership with housing to deliver a refresher session which reached over 100 professionals, the session focussed on how to use the tool as well as an opportunity to gather feedback from frontline professionals who have experience of using this tool. The feedback gathered is going to be used going forward to further strengthen and embed this multi-agency risk management framework.

KEY EVENTS IN 2022-2023

Alongside our key practice weeks in November 2022 and March 2023, the LSAB team have consistently continued to run sessions and discussions across the year to keep reflecting on safeguarding work, sharing learning and knowledge and developing greater understanding around safeguarding.

What to expect when raising a safeguarding concern

Following consultation with the previous community reference group (now community engagement group) we were advised that voluntary workers working in our local charities were not always clear on when and how to make a safeguarding referral, and they also had little knowledge on what happens once a referral has been made. Following this feedback the LSAB organised and facilitated a session specifically aimed at our voluntary sector cohort. This session took place on the 6th July 2022 and was well attended with representation from a variety of charity groups.

The session was co-produced with the community reference group members, ASC safeguarding champions and the ASC safeguarding lead. It was co- facilitated by 2 social workers from ASC who were safeguarding champions, this was a great opportunity for them to provide examples of the work they do and processes they follow when a safeguarding referral is received by Lambeth ASC. This was an excellent session with 50 volunteers in attendance. The aim of the session was to raise awareness of the process of safeguarding and what to expect when raising a concern as well as what to include within a good referral. The feedback from attendees was positive and the LSAB will be running more sessions like this in the future.

LSAB quarterly board meetings

During 22/23 we have looked to create a more reflective and collaborative space at the Quarterly safeguarding adult board meetings, this included presentations and break out sessions on topics such as Dual diagnosis, Contextual/ Transitional safeguarding, Pressure sores and our annual work plan.

This has allowed smaller groups to share and discuss these areas of practice and the efficacy of the work we do in safeguarding and where the gaps are. From small group discussions, a number of actions have been taken forward and are being implemented by performance and quality subgroup and will return to the board with updates e.g. Pressure sore action plan.

Board reporting and assurance

During 22/23 the partnership agreed that in order to allow for shared learning and understanding of each organisation it would be beneficial for the quarterly board meetings to have a slot for one of the partner organisations to do a presentation and showcase some of the safeguarding work they have been doing. This was following reflections that much of the safeguarding activity reporting was related to Adult social care within the board and at P&Q. We agreed at the start of the 2022/23 work planning to rotate a across all organisations in turn. They have reported on the following:

- Risks they are holding in 2022/23
- Any new processes around Safeguarding within their organisation
- Their responses to SARs in 2022/23
- General safeguarding/ MCA policy developments or updates

Our aim for 2023/24 is to standardise this with a reporting form to enable a set way for reporting into the board which links to the SAPAT.

Development and roll out of audit tools and use for assurance

Through work with the police the LSAB has developed both audit tools for looking at MERLINs and for looking at MCA's. These have been used regularly across the year to self-audit and to feedback within the board and in individual organisations.

NATIONAL SAFEGUARDING ADULTS' WEEK

National Safeguarding Adults Week took place in November 2022, and Lambeth SAB hosted several well received events which included sessions on different areas of safeguarding adults work that we come across. We worked with our colleagues across Southeast London to open up our programme to a variety of organisations providing staff with the opportunity to access learning and expertise from a variety of sources.

There were 287 delegates attending all the sessions across the week – these were found to be from 22 different organisations from health, social care and housing. There was an increase in social care and supported housing providers attending the sessions, this was very positive for improving understanding and promoting safeguarding practice across the partnership, and our aim is to further promote this in future practice weeks.

The themes covered within this successful week were County Lines and Exploitation, Self-Neglect, Safer Organisational Culture, Elder Abuse and Domestic Abuse in Tech.
The biggest session was **Executive functioning, MCA, and self-neglect** 120 people attended which received very good feedback and was supported by psychologists from Guys and St Thomas's and was repeated during MCA week in March 2023 and received 100 + views **Add Here**

As part of the national safeguarding adult week Adult social care took the opportunity to focus on safeguarding practice within the operational teams. 56 safeguarding case audits were undertaken. This was a positive piece of work looking at individual cases as part of the updated quality assurance framework. The data is currently being collated and themes will be further discussed at the April and October Boards 2023.

NSAW 2022 Training Sessions and Themes

County Lines and Exploitation

- Transitional safeguarding - Safeguarding: Learning from Adults & Children Reviews.
- Multi-agency violence and exploitation panel and contextual safeguarding session.

Self-Neglect

- A Safeguarding Adults Week event exploring abuse, neglect, and self-neglect in adults with mental health issues.
- Learning from thematic SAR H, I and J led by independent reviewer Steve Chamberlain.

Safer Organisational Culture

- Creating Safer Organisational Cultures by Dr Kenny Gibson, National head of safeguarding, NHS England.
- Meet the Lambeth Safeguarding adults board (LSAB) Independent chair
- Complex case pathway: refresher session and discussion around self-neglect.

Elder Abuse

- Learning from SARs- Autism, Suicide and safeguarding by Patrick Hopkinson.
- Self-directed reflective session- Professional Curiosity.

Domestic Abuse in Tech

- Self-neglect: applying s42 & risk assessment by Michael Preston Shoot
- London Fire Brigade- fire safety and new risk assessment tool
- Executive functioning, MCA, and Self neglect

Mental Capacity Act Subgroup – *Chair: Mala Karasu (Head of Adult Safeguarding, GSTT)*

The Mental Capacity Act Subgroup are tasked with overseeing the awareness, promotion and application of the Mental Capacity Act (MCA) 2005 within health and social care and throughout the wider community
in Lambeth. The group also seeks to provide assurance to the Lambeth SAB that partners are assuring and promoting MCA awareness, and appropriate application in practice. In 2022/23 the MCA Subgroup successfully carried out the first audit of mental capacity assessments across a range of key partners and launched a well attended Mental Capacity Act practice week in Lambeth.

Lambeth MCA Audit

The MCA Subgroup developed a new audit tool which is simple and easily applied at all levels across professions and can be used to look at both 'simple' decisions and more complex decisions. The audit aims to gather assurance that professionals understand the MCA and that recording is proportionate to the decision being made, with a person-centred approach using the principles of the MCA.

During August 2022, the tool was used by colleagues from Lambeth Adult Social Care, Guys and St Thomas's NHS Foundation Trust, South London and Maudsley NHS Foundation Trust and General Practice representatives. The MCA Subgroup now intend to use the analysis from this initial audit to identify shared themes and areas for improvements, as well as highlight good practice. This will inform the work of the group for the next year.

Focus on learning: MCA Week

As part of the groups aims to raise awareness, a dedicated week of learning sessions was developed and took place between 27th February and March 3rd, 2023. During this week the MCA Subgroup were successful in reaching to a large number of professionals working across Lambeth, with the aim of supporting professionals in the application of the MCA. In total eight sessions were held, each with a different focus:

- Introduction to Lambeth SAB Guidance
- MCA and the safeguarding process
- MCA Changes to Chapters 1-11
- MCA & Health Decisions
- Whose interest is best interest.
- MCA and the Letter of the Law
- LPS how ready are we?

This week was extremely well attended with over 800 people participating in the week from a range of difference services (this number does not include those who attended multiple sessions).

"I learnt so much about MCA".

"Can't wait to be sent the slides on MCA and Safeguarding".

The feedback we received from attendees was overwhelmingly positive, with 85% stating that they had learned something useful that they could use in their future practice. Recordings and Slides of the event can be viewed here

"Can't wait to be sent the slides on MCA and Safeguarding".

"Regular sessions like this are great for CPD"

"The sessions were informative and presented well".

Community Engagement Group

The Community Reference Group (CEG) was renamed the Community Engagement Group established to act as a link between the SAB (Safeguarding Adults Board) and the community.

The revised terms of reference for the group have been agreed by members to expand the membership of our core group to ensure that we have the right people present and the group is representative of Lambeth; this will also help us to reach different Lambeth communities when promoting our forums and make sure that we have accessible conversations.

Since May 2023, we are so proud that we have engaged with new members from Lambeth Links a charity that supports the LGBQT+ Community as Lambeth has one of the largest communities within the country. We are excited to also welcome the Carer Hub who support carers of vulnerable service users in Lambeth. These additional new members have increased our membership of the CEG to 11 members from the Lambeth community. The SAB introduced a new format and agenda to future engagement sessions where different members from the CEG chair the group supported by the Boards Business Manager.

Each agency presents to other agencies in attendance their role in community, how they support service users and how safeguarding impacts them. Black Thrive were first to present to the CEG in July 2023, this agency addresses the inequalities that negatively impact the mental health and wellbeing of Black people in Lambeth.

The LSAB shared with the CEG their targeted work plan for the year, the plan for 2023-24 focuses on

Communication Partnership and Equality Diversity and Inclusion.

Members of the CEG shared with the SAB that they would benefit from safeguarding sessions provided within their own organisations to have a better understanding of the safeguarding process. In response to this feedback the Safeguarding Lead Lizzy Lacey and SAB Business Manager, Jenny Johnson will begin a roadshow of events and webinars in Autumn 2023 focusing on safeguarding adults raising safeguarding concerns and other relevant themes.

Members and the SAB discussed a variety of safeguarding leaflets, questioning if they were accessible, if the language used was appropriate. It was agreed that the SAB & CEG would co-produce a safeguarding leaflet for service users which was fully accessible in an easy-to-read format, members also wanted clearer pathways to report safeguarding concerns improving the referral pathway for communities who find it difficult to engage with professionals.

Looking forward, the CEG were asked via survey what their areas of safeguarding focus will be for their organisations, what safeguarding themes they would like the SAB to focus on for 2023-24 and what their organisations would be focussing on. Members feedback was varied and positive, they would like to see raising awareness and the profile of carers and provide person centred support for carers.

Finally, CEG members will also be taking part in the NSAW (National Adults Safeguarding Week) November 20-24th 2023 working collaboratively with SAB to provide a week of events webinars and interactive sessions on current safeguarding themes to highlight safeguarding issues, facilitate conversations, and raise awareness of safeguarding best practices, so we can all be better together.

SAFEGUARDING ADULT'S REVIEWS

Under the Care Act 2014, the LSAB is responsible for the coordination of Safeguarding Adults Reviews (SARs). These are statutory independent reviews commissioned where there has been an incident of serious harm or death involving an adult at risk.

SARs are about learning and not apportioning blame. SARs also recognise the complexity of safeguarding work and will identify the areas of good practice too. Key recommendations are made at the end of a SAR and this will often include the learning needed to prevent future incidents of serious harm or death from happening again.

Previous SARs have identified themes such as:

- **Application of the Mental Capacity Act**
- **Direct work and professional curiosity**
- **Responses to self-neglect**
- **Case coordination: including escalation and communication in complex cases.**

Role of the SAR Subgroup

Chair: Claire Kelland (Until March 2023) DSI, Head of Public Protection, Metropolitan Police Service

We would like to extend our thanks to Clair Kelland, who acted as the chair for the SAR subgroup for 2 years prior to leaving in March 2023. Claire supported with leading on SAR oversight, chairing meetings and helping to disseminate outcomes

The SAR Subgroup plays a role in monitoring the actions plans that are developed following SARs, and we continue to reflect on previous learning. As part of this, we have refreshed our tracking tool to enable group learning from previous SARs.

Making a SAR referral

- Any agency, professional or individual can bring a case to the attention of the LSAB and request a SAR if they believe it to fit the criteria listed in SAR guidance (insert link)
- Requests for a SAR must be made in writing using the SAR request form.
- All of the details and policy can be found on the SAB website

A SAR can take place when:

- an adult dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.
- an adult has experienced serious abuse or neglect, but has not died.
- Some cases referred to the SAR sub-group may overlap with other statutory review processes such as a domestic homicide review, mental health homicide review, MAPPA review, Learning Disability Mortality Review (LeDeR) or a children services' serious case review.

At the end of Dec 2022, Lambeth SAB concluded one SAR: HI&J this SAR sought to identify learning from 3 ca

SAR H I & J

In 2022 a new SAR was commissioned. This thematic SAR was commissioned in 2022 to examine the experiences of three individuals in relation to their diabetes management and the interplay between the Mental Capacity Act and the Mental Health Act.

Thematic analysis is one of the most common forms of analysis within qualitative research. It emphasizes identifying, analysing and interpreting patterns of meaning within qualitative data.

This review was undertaken by Steve Chamberlain, independent reviewer and the report on the learning can be viewed **here.**

In summary:

- All three subjects of this thematic review are men. They were all Black British or of Black Caribbean heritage.
- All had mental ill health and vascular disease.
- Two suffered below-knee amputations.
- All had mental ill health and vascular disease.
- Decision by SAB to commission thematic review after identifying apparent common elements to the cases.
- Review identified common themes in two cases; one case significantly different.

6 key areas were identified:

1. Mental health and Diabetes care

Due to the prevalence of diabetes within the population of those people with chronic and severe mental ill health, the Trust establishes a professional who can 'champion' diabetic care and provide advice and assistance to colleagues, including escalation to a specialist if necessary.

2. Escalation pathway for MDT supporting chronic patients

Community professionals and providers of services to this group of individuals are reminded of the range of chronic and acute outcomes of poor compliance with diabetic care and advised on how to escalate concerns.

3. Understanding complex decisions and fluctuating capacity.

The Safeguarding Board considers how best to enhance understanding of the practical complexities of the MCA across all professionals, Including particular reference to professional differences of opinion, fluctuating capacity and legally robust but proportionate recording of capacity.

4. Ensuring S.117 care plans are completed.

All individuals subject to section 117 aftercare have a s117 care plan which specifies the range of care and support provided to them, and differentiates the support provided under s117 and that provided under other provisions (e.g., Care Act 2014)

5. Ensuring collaboration and communication on shared

Care plans, when they involve multi-agency involvement, include explicit provision for communication between agencies when circumstances change.

6. Annual health checks

Where individuals with chronic and severe mental illness refuse or do not cooperate with annual health checks, further consideration is given within the care planning process on how to ensure such health care support.

Individual Agency responses to SAR H, I and J

The review also made a series of recommendations for individual agencies. Their responses to these recommendations and learning from this SAR are outlined here.

South London and Maudsley NHS Foundation Trust (SLaM)

There were two specific recommendations for the Trust from SAR HI &J.

A focus on caring for the physical health of patients and ensuring ongoing support for health care support are part of the individuals plan of care.

The Trust (SLaM) has a physical health clinical policy. The Trust has a dedicated trust wide Physical Health Team, the physical health policy state that the physical health and wellbeing of service users is a Trust priority, the Trust promotes the 'Vital 5' model this model ensures there is a focus on key health measurements that include blood pressure, obesity, mental health, smoking status, and alcohol intake. There is guidance on how to provide meaningful physical healthcare for service users and to promote shared care with primary and secondary care local services e.g., GP (General Practitioner), outpatient services in the acute trust. Staff need to complete mandatory Level 1 physical health awareness training. All clinical staff are responsible for undertaking and recording physical healthcare assessments, examinations interventions, care plans and risk plans and recording information on the service user's clinical notes. If there are signs that are concerning these are escalated to medical staff. If service users do not want to participate in health screening on admission a screening may be offered at another time. Community Service users also can have their physical health care needs addressed. Physical healthcare needs for Community Service users are reviewed every 12 months throughout an episode of care. Service users are informed of all clinical findings by the person undertaking the assessment and an explanation of the significance given. Services also have a range of physical health and well-being promotion materials displayed; these include materials relating to alcohol and drug use, exercise/physical therapy, stop smoking services, cancer screening, and healthy eating Physical health assessment and interventions for services users is monitored by the Trust Quality Committee.

Section 117 of the Mental Health Act. Do staff understand what S.117 is and what is covered by S.117 care plan? A Section 117 (s117) provides aftercare services to service users who have been detained on a section of the Mental Health Act 1983. The specific type of aftercare services which are required for an individual will be determined by a thorough assessment of the individual's need for care and support and wishes, in accordance with the revised Code of Practice 2015. A care co-ordinator (an experienced mental health practitioner) is appointed to liaise with the service user and work with the service user on the detailed objectives of the s117 care plan.All SLaM staff must attend mandatory training on the Mental Health Act, and this includes a specific module on the provision of a Section 117.The Trust has a s117 (Mental Health Act 1983) After-care and procedures policy. The s117 will be monitored by the care co-ordinator and responsible consultant psychiatrist. The aim is to ensure after care plan objectives are followed. Audits of Care Programme Approach documentation is carried out on a regular basis. This includes whether s117 status is recorded appropriately and that the care plan clearly shows which services are provided under s 117 and which are not. This is built into the Trust's Clinical Audit regime. There are posters and leaflets giving information on Section 117 specifically produced for service users and these are available on the Trust intranet and publicised throughout Trust premises with (QR code).

SEL ICB/ICS

MCA – inconsistent use of MCA

Additional training has been provided on MCA and further dates scheduled for 2023-24

Multi-disciplinary working

Within new ICB structures, revised groups established in support of improved MDT working.

Mental health and diabetes care

We commission the Cambridge Diabetes Education Programme, PrescQIPP Diabetes e-Learning module to support clinicians' diabetes management and care education. The Lambeth Community Diabetes Service provides educational events during the year. The Lambeth Medicines and Prescribing Network holds monthly webinars for clinicians on a variety of topics including diabetes and overprescribing with support for our Consultant Pharmacists in diabetes.

We commission the EZ Analytics population health management tool which is linked to EMIS, which can be used by general practice to monitor the people on their diabetes registers. The tool can be used to identify particular cohorts of patients by ethnicity or those with a mental health condition, to undertake call and recall for these patients or tailor the approach to diabetes care.

Lambeth's Community Diabetes Service has worked with Look Ahead a housing association who support adults with mental health problems on a pilot to provide people with a dual diagnosis of type 2 diabetes and a mental health condition. A specialist support worker supported patients to improve attendance at clinic appointments, adherence to medicines, help with diet and lifestyle, with positive outcomes from the pilot in March 2023. Outputs are being considered.

Escalation pathway for MDT supporting chronic patients.

Lambeth's Designated Nurse is working jointly with colleagues to maintain correct points of contact for escalation.

Annual health checks

There has been a significant focus on increasing the uptake of annual health checks in Lambeth for both SMI and LDA populations. In 21-22, SMI uptake on annual checks was 38% and for 22-23 the target of 60% was achieved: for LDA, the target for 21-22 was 75% and in Lambeth we achieved 87% (with an increasing LDA population)

This significant improvement in performance was delivered through effective, co-ordinated joint working across partners and system promotion and we are now reviewing what the information from those health checks is telling us and where we need to target next support including on diabetes management and healthy lifestyles.

Lambeth Probation Service

The learning from SARs is disseminated on borough level and inform any wider learning across the Service. All staff have mandatory adult safeguarding training including understand the mental capacity act and when it applies. The Probation Service contributes to several multi-agency meetings within the borough and the community safety partnership to address contextual safeguarding concerns and work with specific groups. To support the transition from youth to adult services in the criminal justice system a PS Probation Officer is seconded to the Youth Justice Service. The co-location of units within both the Local Authority and PS continues to promote a positive working relationship and maintains the required integral partnership working.

Metropolitan Police

The MPS MCA policy is under review as part of the wider Right Person, Right Care project. AS Public Protection strand has created a dedicated Mental Health team, working with partners to ensure that those in crises receive the appropriate care. Through participation in the Safeguarding Adults Board and MCA Subgroup, we will continue to work with partners to reduce abuse and neglect, with a focus on the interaction of protected characteristics with these issues.
AS Public Protection has implemented a Public Protection Improvement Group and Review Learning Tracker to drive change and ensure that learning from this and other reviews is disseminated and embedded.

Guys and St Thomas's NHS Trust

Learning from SARS and incidents over the last year include sharing information – the importance of sharing information with other services and statutory bodies to allow informed decisions being made to protect individuals.

The importance of Professional Curiosity – that staff should always endeavour to get as much information as possible and to not be hesitant to sometimes ask difficult questions.

The importance of Multi-Professional and Multi-Agency working and the sharing of risks, responsibility, and management.

All lessons learnt are shared with staff widely using a 7-minute briefing approach via the Safeguarding Adults Operational Group meeting and clinical group specific meetings to engage frontline staff.

Kings College Hospital

There were no specific recommendations for King's College Hospital however the following reflect our efforts to incorporate the key findings in respect of this SAR, we have introduced mandatory training on safeguarding adults' level 3 across the entire organisation, we have a two-year plan/trajectory towards compliance.

We have commissioned legal experts to deliver training that relates to case law, advanced mental capacity practice and decision making and the interaction between mental health and mental capacity legislation.

We have revised our working arrangements to create a forum that allows all care groups who supports persons with long term chronic illness to have access to consultation spaces where persons at risk, persons not engaging with healthcare plans can be discussed with open consideration to the application of safeguarding processes.

The complex care plan is embedded within our core training and is regularly spoken about to clinical teams as a tool that can be helpful when considering the significance of non-engagement for persons who have capacity/fluctuating capacity.

Lambeth Adult Social Care

MCA - Inconsistent use of the MCA (understanding fluctuating capacity/ quality of MCA)

We have an audit and correlating themed practice week programme in place and held sessions at the last 2 years of MCA practice weeks and a session during National Safeguarding Adult's Week 2022 where we discussed and shared learning around the assessment of those who have fluctuating capacity. These sessions were widely attended by ASC staff, improved standard of practice in MCA work. As part of the work completed by the MCA subgroup 25 MCA audits in 2022 which drew out key areas and identified positive themes in recording and enabling decision making as well as creative communication. Through these audits we were able to determine areas of development and feed this into management oversight as well as training topics via the MCA week 2023.

MDT working - Review of Complex case pathway.

Adult social care has led the way in using the risk management framework, the complex case pathway which was introduced in July 2021. This was developed in partnership with Southwark and Bromley after 3 SARs linked to self-neglect. Following SAR H, I and J which also demonstrated elements of self-neglect and MDT risk we agreed this needed wider reach as well as a review of its efficacy. ASC has a strong ethos around risk management and this tool has helped to build on this. ASC have led the way in promotion and engagement of other agencies in using this process.

We have further promoted this in 2022/23, extending the training sessions to more providers, supporting with cases and sharing materials with different community groups. We have engaged with partners on their views and understanding of the pathway. We have also run two feedback sessions in Sept 2022 and Nov 2022 where we discussed areas of development. Since that time, we have developed a working group to take forward the outcomes from this review and ensure that this MDT process works well and achieves positive outcomes.

Mental health and complex physical health management.

We have worked in ASC to plan and form specific sessions run by Slam and ensure ASC teams are present at our practice weeks and in disseminating the outcomes and understanding in working with service users with MH needs. The recent MCA week was led by a Slam MH nurse practitioner Heidi Emery in March 2023 had particular focus on the need to involve service users with complex health needs and mental health needs to be involved decision making and risk management in light of this SAR.

The social work team in adult social care and Mental Health sit within the Living Well Network Alliance which has the aim in using an MDT approach to supporting local people to lead health lives while living with mental illness.

Black Thrive and CAPSA continue to work with senior managers in ASC in looking at how to better achieve outcomes for services users from black backgrounds to ensure they are achieving positive outcomes are supporting in signposting individuals to activities/ services that can improve their physical health, alleviate loneliness, help with finances.

Board Member achievements and reflections for 2022/23

SEL ICB ICS

Primary Care

The ICS has an established bi-monthly Safeguarding Executive Committee which receives exception reports from NHS providers and where the Trusts present assurance on how any identified gap on quality is bng addressed.

The three key NHS Trusts delivering in Lambeth are:

- South London and the Maudsley (SLaM).
- Kings College Hospital (KCH)
- Guys and St Thomas (GSTT)

A document entitled 'Southeast London ICB General Practice Guidance for Domestic Abuse' has been developed and approved by the quality and performance committee of SEL ICS. The document has been distributed to practices in Lambeth as a useful tool for when developing their own general practice procedures for domestic abuse.

The adult safeguarding lead GP produced chronologies for SAR CW, DHR AW and DHR CG last year. She also contributed to the respective panel meetings.

Training sessions have been organised and delivered for Lambeth in Prevent (07/06/2023) and the Mental Capacity Act (03/05/2023 and 20/09/2023). The adult safeguarding lead GP also delivered training to the GP registrars last year on 08/09/2022. The IRIS programme will be continuing in Lambeth for a further year providing the opportunity for ongoing training, education and consultancy for the general practice clinical team and administrative staff on domestic abuse and violence issues.

Advice and support was provided to Lambeth general practices on specific safeguarding issues relating to individual patients which were raised by the patients' GPs.

The Designated Nurse has been working in collaboration with LSAB in promoting the safety, protection, and welfare of adults in the Lambeth community, aligning with the 'Think Family' strengths-based approach and strengthen relationship across related safeguarding networks.

The Designated Nurse had been working with local practitioners and continues to develop relationships and work closely with colleagues across SEL ICB safeguarding system to ensure ways of working that are collaborative, encourage constructive challenge, and enable learning in a sustainable and co-ordinated way.

The Designated Nurse has been providing professional and strategic advice on safeguarding concerns and had been a vital source of safeguarding expertise for CHC, all related agencies and health and social care providers in Lambeth.

Lambeth LeDer

The Designated Nurse represents health commissioning at Lambeth LeDer steering group and Lambeth LeDer /Autism action group, which is a service improvement programme which aims to improve care, reduce health inequalities, and prevent premature mortality of people with a learning disability and autistic people by reviewing information about the health and social care support people received.

Everyone with a learning disability aged four and above who dies and every adult (aged 18 and over) with a diagnosis of autism is eligible for a LeDeR review. It aims to make improvements in the quality of health and social care for people with learning disabilities and autism, and to reduce premature deaths in this population. In conjunction with Lambeth Learning Disability team, the Designated Nurse has participated in the focussed LeDeR review of Lambeth patients by South East London ICB LeDer team.

Prevent

Lambeth Integrated Health and Care directorate continues to work in partnership with Community Safety Partnership assessing cases that could have potential terrorist activity.

Modern Slavery

The Designated Nurse has been working closely with Lambeth safer community partnership to

safeguard individuals who might be victims of and may not meet Section 42 criteria for a standard Adult Safeguarding enquiry.

South London and Maudsley NHS Foundation Trust (SLaM)

The South London and Maudsley NHS Trust (SLaM) has launched its first safeguarding strategy within a very challenging context, but also with a forward-looking lens, as we recover and respond to the changing needs of our population. Our Safeguarding Strategy supports our strategic aims to deliver outstanding mental health care and highlight the importance of prevention and protection against harm and abuse in everything we do. It is built on the principles of empowerment, prevention, proportionality, protection, partnership, and accountability.

The Safeguarding Strategy encompasses restructuring and centralising the Safeguarding Team is in progress. An Associate Director of Safeguarding has been appointed and they commenced post in August 2023. There are a series of workstreams in progress: Adult Safeguarding Governance – improving the governance process and interface with external partners. Safeguarding Clinical Policy – ensuring policies are updated and reviewed

Centralising the Safeguarding Team - for children and adults

Recruitment and Retention – recruit to new posts and ensure retention by providing opportunities for career progression. Safeguarding Training Strategy- Creating a Trust strategy to improve training content and compliance. Clinical Systems – Focus on improving data reporting to improve quality.

Building a Safeguarding Culture – developing routine audits of core processes.

Metropolitan Police – Central South BCU

Central South (AS) BCU Public Protection strand is committed to continuous improvement and learning, working with partners to identify development opportunities to enhance our activity to safeguard vulnerable adults and those at risk in Lambeth. An uplift from two to three DCIs within the strand allows a dedicated Partnership DCI to take the role of Safeguarding Adults Lead, with a DI deputy to drive quality assurance and identify areas of risk. Central South (AS) BCU has invested significant effort in VAWG initiatives in the previous year. AS BCU and partners are seeking to build on work from last year with a refreshed strategic plan that

encompasses learning and new ideas to make AS BCU safer for Londoners and work in partnership.

with Lambeth and Southwark local authorities towards MOPAC priorities of making women and girls safer. We are determined to address the recommendations contained in the Baroness Casey Report and to embedding the resulting learning, particularly that which relates to Public Protection in chapter 5. The MPS has recognized the need to strengthen Public Protection and will deliver an uplift in staff across the strand to ensure we deliver justice for our victims and safeguard the vulnerable. There are a significant number of young people leaving care upon entering adulthood and we acknowledge that transitioning from care is a pivotal moment in people's lives. Working across partners, we will be looking at how we can improve our support of those who require extra help upon entering adulthood to give them the best possible chance of success and leading happy, healthy lives.

Guys and St Thomas' NHS Foundation Trust (GSTT)

This annual report presents the highlights of all activities related to safeguarding adults, Prevent and MCA 2005 practice and how the Trust meets its safeguarding adults statutory duties. The report provides information on performance of services under safeguarding adults, dementia and delirium care, learning disability care, mental health support and end of life care.

The report is focused specifically under the areas of key developments, areas for development, lessons learnt and patient feedback.

Key Developments

GSTT has had a very busy year with 19% increase in safeguarding adults referrals compared to 2021-2022. The legacy of the pandemic continues with highest numbers of referrals being for self-neglect and for neglect by others with many of this cohort presenting with multiple and complex needs. The complex care pathway process has

been used successfully with many cases and clinical teams supported to achieve best outcomes for their patients. DoLS rose by 58% compared to the previous year as DoLS awareness improves with 25% of referrals received over the weekends. The increase in overall referrals and over weekend requirements has challenged the team with regards to capacity and a business case for additional resources has been submitted.

With the LPS being deferred indefinitely, the opportunity to embed the MCA requirements further was recognised. Discussions have been had with the Lambeth and Southwark safeguarding and DoLS teams to work together to provide. This included sharing DoLS hospital data with the respective local authority DoLS teams, notifying the LA DoLS teams when a patient on urgent DoLS has been discharged and working together on the interpretation of the Ferreira case law across all three hospitals so that DoLS is used consistently. This is work in progress.

Within the Trust we have set up an MCA implementation group looking at a programme of change to further embed the MCA requirements.

The programme started with an audit of practice using the LSAB audit tool. The results are being analysed currently and will go the LSAB for a Board response.

Following a Serious Incident involving the use of restrictive interventions, the Safeguarding adult's team has put together a restraint rapid read for staff especially temporary staff. An e-learning package has been developed and ward-based teaching continues. The patient voice is paramount when developing and providing services. Safeguarding adults feedback is recognised as being episodic as the safeguarding experience spans across the admission and also when the patient has returned into the community. Some preliminary work has been undertaken by adding a few questions to EPIC, the new patient system that will be live from October 2023. Additionally, a feedback questionnaire has been developed for patients who have been involved in the allegations process. The questionnaire is out to consultation and will be trialled in September.

Similarly, work is underway to develop a bespoke a patient experience tool to get the views of patients with a learning disability and their carers

Staff reprofiling for WRAP and Safeguarding Level training following RBHH merger, reduced Trust compliance for both. Significant efforts to improve the training compliance was undertaken; currently WRAP training is above target compliance and safeguarding adults Level 2 training is at 84.4%.

There continues to be good partnership working with the Trust engaged with 4 SABs. The head of safeguarding adults chairs the LSAB MCA sub-group with good attendance at other sub-group meetings. The safeguarding team meets weekly with the hospital social work team to discuss cases and follow up on section 42 enquiries. There is an agreed escalation flowchart with clarity on when and how to escalate when there are delay in submission of reports by the Trust and when the outcomes of the enquiries are not communicated to the Trust in a timely manner.

Areas for Development

Accurate application of the Mental Capacity Act (MCA)especially in relation to the assessment of capacity and use of best interest meetings is an area where improvement is required Trust wide. Guidance on the MCA use has been accessible to staff through safeguarding training, GTI web page and ad hoc specific training, however there has been evidence from documentation and contact with the safeguarding team that staff continue to require support to ensure they are applying all principles of the act appropriately. Additional training for ward-based staff continues to be provided by the safeguarding team, with the team also supporting with assessment of capacity and best interest decision making for complex cases as they arise. Other areas where support has been required has included lasting powers of attorney and advanced decisions.

Overall there has been a reduction in the number of section 42 inquiries by the local authorities with 21 cases in the last year compared to 45 the previous year. 57% of the section 42 enquiries have closed, with cases unsubstantiated, 5% (1) being substantiated, 10% were inconclusive, 2 remain under investigation and 19% are awaiting an outcome. The majority of inquiries were related to pressure damage to skin, 4 cases were due to alleged lapses in care. The last year has also an increase in allegations against staff compared to the previous year. Improvement of staff awareness of the allegations process may

attribute to the increase in reporting. 31% of reported cases investigated were unsubstantiated, 14%substantiated, 3% were inconclusive and were referred via the complaints process. The remainder of the referrals did not progress due to lack of patient engagement, staff having left the Trust without any forwarding contact and the cases not progressing as allegations. In June 2023, NHSE have contacted all Trusts and ICBs raising the need to look at sexual safety of NHS staff and patients due to reports of sexual assault, harassment, and abuse in the NHS. With over 1.3m people employed in the NHS, and with 2m contacts with patients every working day, the NHS has a responsibility to protect staff and patients and offer safe spaces and routes for support. The Trust has appointed the Chief Nurse as its Domestic Abuse and Violence Executive Lead with both the Directors of Nursing for safeguarding adults and children leading on policy development for sexual safety of NHS staff and patients as part of its Domestic abuse policy being supported by the heads of service for adult and children safeguarding. Work is also underway to improve data collection related to domestic abuse and allegations of sexual abuse from Trust services. Further discussions with the head of safeguarding at NHSE has provided an opportunity for the Trust to seek membership of the national collaborative on sexual safety with other NHS providers.

Learning from SARS/DHR/Serious Incidents

Learning from SARS and incidents over the last year include the following:

Sharing Information – the importance of sharing information with other services and statutory bodies to allow informed decisions to be made to protect individuals.

The importance of Professional Curiosity – that staff should always endeavor to get as much information as possible and to not be hesitant to sometimes ask difficult questions.

The importance of Multi-Professional and Multi-Agency working and the sharing of risks, responsibility, and management.

All lessons learnt are shared with staff widely using a 7-minute briefing approach via the Safeguarding Adults Operational Group meeting and clinical group specific meetings to engage frontline staff.

Lambeth Adult Social Care

Key developments and achievements

Our Safeguarding and Quality assurance team has grown with the appointment of Kate Buck as Head of Service expanding our capacity and leadership in this area, and Jenny Johnson as Safeguarding Adults Board business manager. Jenny has been integral in moving the agenda forward for the Lambeth Safeguarding Adults Board partnership, co-ordinating all Board business, including supporting the refreshed Community Engagement Group. A key focus of Adult Social Care (ASC) is to build our assurance of the quality of care and support we deliver and to be able to evidence this as part of the new inspection framework set out by the Care Quality Commission (CQC). The CQC will start their inspections of local authorities from the Autumn with a focus on 4 themes. Theme 3 – Ensuring Safety is particularly relevant to the work we are doing in adult social care around safeguarding, and is linked to the priorities set out by Lambeth SAB.

Practice and Development

ASC has a Quality Assurance Framework which sets out a regular programme of audits including for MCA and Safeguarding work. A Safeguarding audit was completed by ASC in December 2022 and overall, the audit identified good Safeguarding practice amongst the teams including consistent application of the Safeguarding criteria, good risk assessments, clear analysis of information gathered, consulting the right people including the adult at risk, resulting in outcomes being met and risks being reduced or removed. Going forward we will look to strengthen engagement with all key individuals that form part of the adult's network of support, and that it is important to set clear timescales for flow of information and any actions assigned to partner agencies. In addition to the audit work being done, there are correlating themed practice weeks which are an opportunity to share learning and increase knowledge and practice in key areas that are relevant to the core business of ASC. The Safeguarding and MCA Lead Lizzy Lacey and SAB Business Manager, Jenny Johnson, played a key role in organising successful Safeguarding and Mental Capacity Act practice weeks alongside the LSAB partnership. There has been a commitment

from ASC staff to attend and participate in these events and this is driving good practice.

Adult social care continues to develop and monitor the way we manage incoming safeguarding work. In 2022/23 we have seen a reduction in referrals by around 10%, this has been attributed to a drop following the peak of referral after lockdown was relaxed. We also believe it is due to the focussed work at the front door with the dedicated safeguarding hub where they ensure only appropriate notification go onto S.42 concerns. This change was part of the front door redesign, we reviewed our safeguarding and MASH pathways with a dedicated Safeguarding hub which launched in October 2022. This hub is made up of 4 social workers and a practitioner manager and sit under the management of the initial contact and assessment service. The aim of the hub is to ensure we have a more efficient and singular approach to managing safeguarding concerns with principles of Making Safeguarding Personal at the core of the work being done. This has also ensured we are working in a preventative way as we signpost to community services in the hub, build relationships with referrers and feedback to ensure they are using appropriate pathways.

The initial feedback at the end of 2022/23 has been very positive and we can see development in practice and relationships with partners. ASC has identified Safeguarding Champions who sit across the operational teams and who meet regularly to share good practice examples, learning and are kept updated and included in SAB priorities. ASC has monthly performance meetings which includes examining our Safeguarding rate of referral, conversion to S42 Enquiry, and the outcomes of the Safeguarding work. These arrangements further support ensuring that Safeguarding work is completed in a timely way.

ASC developed and embedded regular Safeguarding Surgeries in all teams, this has been positively received by practitioners and provides the opportunity to discuss and share learning from some of the more complex Safeguarding situations. ASC has played an integral role in looking at an increased understanding of EDI data and in looking at representation as part of the SAB. This continues to be a priority for ASC and there is proactive work being done around capturing key information about the people we come into contact within our daily work.

As part of this commitment and our work with the Board, we have made steps to improve our relationships with the voluntary and community sector in Lambeth and this is reflected in our LSAB Community Engagement Group which now has increased representation from a wider range of groups more reflective of the community we support. As we move into 2023/24 our priorities include: increasing service user feedback as part of the Quality Assurance processes; Equity and justice is a key objective for Lambeth Council as part of our Borough plan and this supports our focus on demographics and data as part of our Safeguarding; and a review of our Safeguarding hub, pathways and Making Safeguarding Personal.

The London Probation Service

The Probation Service (PS) Lambeth is a statutory criminal justice service that supervises all eligible offenders both in custody and in the community. We are responsible for sentence management in both England and Wales, along with Accredited Programmes, Unpaid Work, and Structured Interventions. The unification of services during June 2021 means the Probation Service (PS) is now responsible for all sentence management for community supervision orders and prison licences in both England and Wales. We have also unified the delivery, increasing effective service user desistance and rehabilitation. The Probation Service manages and delivers Accredited Programmes, Structured Interventions, Unpaid Work and Senior Attendance Centres across London whilst continuing to deliver sentence management in custody and the community. In Sentence Management our focus is on strengthening the probation practitioner's relationship with people on probation, using the right key skills, activities, and behaviours to achieve the most effective outcomes and enable offenders to make positive changes to their lives. Specialist intervention meetings have increased due to the increasing complexity of the cases within the Probation Service (PS). These extra meetings incorporate multi-agency working to support risk management in each area and give scope to react to local criminogenic needs and joint working with both statutory and non-

statutory agencies along with increased information sharing.

This includes making sure that all PS staff are clear about their roles and responsibilities in relation to safeguarding concerns including escalation routes for where they feel a manager, or another agency has not responded appropriately to a safeguarding concern.

Lambeth Age UK

Age UK Lambeth have had a busy year with many of our clients struggling with the cost of living and not managing well. What we gathered from this was that many voluntary clubs and group leaders for older people do not have an awareness of Safeguarding. What we have done and are continuing to do is offer Safeguarding training to these groups. Many of these groups don't only run activities in larger numbers but visit others in their homes.

KCH Hospital Trust

This report provides evidence on key safeguarding activity for 2022/2023 and highlights the challenges, risks and priorities for 2023/2024.

The safeguarding teams are now fully recruited, including substantive recruitment into the two leadership roles for each safeguarding service. This has had a positive impact on capacity across the services and feedback both internally and externally has been excellent.

There remains high demand across all safeguarding services. The Adult service has supported 1798 safeguarding concerns, 1060 Deprivation of Liberty Safeguards (DoLS)

applications and 585 adult learning disability notifications. Referral themes in adults relate to neglect and people experiencing challenge attributed to poor social conditions, but also increased acuity in respect to domestic abuse. There remains challenge across the system re. neglect and the local community experience a very pressured social care system which has led to some investigations re. Poor discharge planning for adults. The trust launched its safeguarding adult level 3 training during this reporting period, there has been mixed feedback as to the resource implication of such training and subsequently a new TNA and briefing paper is being drafted for the executive team. The teams are also engaging with the national teams around implementation of the Oliver McGowan Training and a KE briefing paper has been drafted. Allegations against staff have continued to be managed in line with NHSE guidance and in compliance of our statutory requirements to include the LADO. The leads for both services regularly review all LADO cases with all key agencies and each of the LADOs involved. Enhancing the overall safety of the workplace remains a significant priority for both departments, it is hoped that all patients and staff can feel safe whilst in our care or in our employment. Future priorities will continue to focus on training, specifically Level 3 Adults training, improving consistency with regard to the management of allegations against staff, partnership working and engagement across the trust, alongside the recommendations from Government re. MCA prioritisation due to the delay in implementation of the Liberty Protection Safeguards. We have successfully commissioned some independent legal training that has supported practice improvements Affiliated with the safeguarding teams is the Independent Domestic Abuse Advocates who are employed by Victim Support. The safeguarding teams have close affiliation with other internal departments who support the delivery of safeguarding activity, this includes the trust employed social workers, the trust homeless team, drug & alcohol services, psychiatric liaison, and the hospital discharge team. An aim in the next reporting period is to to consider how these services can be showcased under one network of vulnerability services led by the Director of Nursing for Vulnerable Patients. Our service works across all of KCH sites. The Adult and Child Safeguarding quarterly committee advises the Quality, People and Performance Committee and the Trust Board on how its statutory obligations are met throughout the year, all committees have been completed and external stakeholders have maintained engagement throughout the year. The provision of a safeguarding advice on call service at the weekends and bank holidays was implemented in this year and remains in place as a result of the demand noted since implementation. This has improved operational oversight of adult safeguarding across out of hours.

Service objectives for 2023-2024

Enhancing the identity of vulnerabilities care group through common leadership and networking opportunities

Promotion of best practice regarding MCA to ensure we are ready with any new launch of LPS Steering Group.

Continued development and targeted training for Adults Level 3 training to improve compliance to trust standard.

To enhance the care of those with a Learning disability who attend the Trust, through a review of the service, implementation of mandated Learning Disability and Autism training and creation of a Learning Disability Strategy.

To continue to improve on our collaboration with our maternity, tissue viability, domestic abuse and other specialist colleagues in a 'think family' approach.

To complete audit and review of Learning Disability deaths and enhance the LeDeR process through internal quality assurance exercises

Lambeth Housing

Lambeth Housing had 4 priorities in 22/23 relating to safeguarding work.

Safeguarding Policy Review

Over the past year Lambeth Housing have reviewed their Safeguarding policy The policy document also sets out how Housing works with other services and agencies to promote the welfare of children and vulnerable adults. The policy is complimentary to the existing policies of the Lambeth Safeguarding Board.

Domestic Abuse Housing Alliance (DAHA)

One of our primary goals in Housing is to obtain the Domestic Abuse Housing Alliance Accreditation and work is ongoing.

Electronic recoding of Vulnerability

The Housing Management service has recently implemented a new vulnerable module on Northgate, the database that is used to manage Lambeth's Council properties. The purpose of the new module is to assist Housing to identify our

vulnerable residents to ensure that they are provided with additional support.

Partnerships.

Housing recognise that they are well placed to identify individuals with care and support needs, that are at risk of abuse. We are a vital component of multi-agency working groups that seek to not only safeguard vulnerable residents but seek to improve their health and well-being. Our work includes but is not limited to the following:

Board Member of Lambeth Safeguarding Adult Board.

Attendance at Vulnerable Victims Panel along with various Sub-groups including Multiagency Violence and Exploitation Panel.

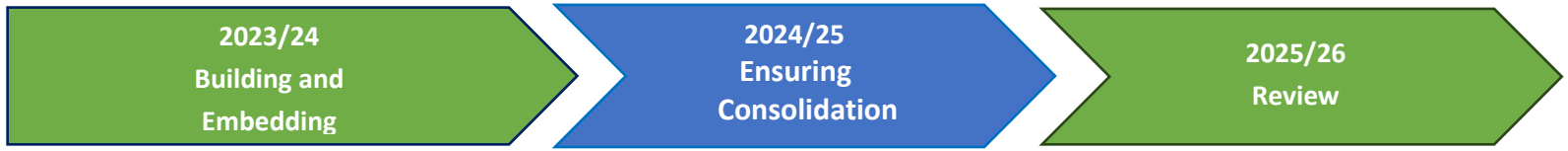
Supporting and promoting Safeguarding in Lambeth including support LSAB in running workshops/training.

Referring and attending Multi Agency Risk Assessment Conference.

Board Member of Lambeth Made Safer.

What we are planning to do next year?

The Lambeth SAB has an overarching strategic plan for 2023-26 **add here** this strategy was developed by all Safeguarding Adults Board Partners in consultation with members of the Board's subgroups. In particular, the strategy has captured the feedback from service users and residents of Lambeth so that this is embedded in all the priorities for future work of the board.



Our key priorities are Communication, Partnership and Equality Diversity and Inclusion. The strategy sets out how we intend to achieve each of the three key priorities and will be the Board's blueprint for the next three years.

Some specific focuses for the next year around:

Communication

- Improving the complex pathways escalation routes between partner agencies
- Ensuring, we are fully accessible to all Lambeth communities.

Partnership

- Adopting an agile approach to implementing learning from regional and national SARS.
- To consider the ways how all partners are proactive to our preventative approach.

Equality Diversity and Inclusion

- To build engagement with the LGBTQ+ community and focussed sessions on the lived experience of LGBTQ+ service users.
- To develop a co-produced 1-page information leaflet on what is Adult Safeguarding.

The Lambeth SAB will begin adult safeguarding roadshows during the Autumn of 2023 the adults safeguarding lead for Lambeth and the SAB business manager will be attending local community events and meetings to enhance communication about safeguarding with the residents we serve in Lambeth, promoting in person discussion and support between service users and the Board around safeguarding, and raising awareness of the SAB web page for community resources.

LSAB members continue to focus on finding ways to hear the voice of service users this includes obtaining feedback directly or indirectly. The Community Engagement Group will continue to work to improving links with community groups and ensure that the Board and its subgroups are representative of Lambeth. The CEG are currently leading on a co-produced safeguarding leaflet with the SAB.

National Safeguarding Adults Week (NSAW) will take place nationally between Monday November 20th – Friday 24th 2023 and it is a great opportunity for organisations to come together to raise awareness of important safeguarding issues. The aim is to highlight key safeguarding key issues, start conversations and raise awareness of safeguarding best practice. This year the week will consist of the following themes safeguarding:

- Taking the Lead on Safeguarding in Your Organisation
- What's My Role in Safeguarding Adults?
- Who Cares for The Carers? Secondary and Vicarious Trauma
- Adopting a Trauma Informed approach to Safeguarding Adults
- Listen, Learn, Lead – Co-Production with Experts by Experience

The subgroups of the Board are pivotal in supporting the LSAB to achieve its objectives and continue to deliver on campaigns and develop tools to support professionals and residents in understanding and responding to adult safeguarding concerns. Each subgroup will have specific targets that complement the overarching priorities of the Board.