ROYAL GREENWICH
SAFEGUARDING
ADULTS BOARD

2022 -23

ANNUAL REPORT

www.greenwichsafeguardingadults.org.uk

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Chairs Foreword

It is a privilege once again to introduce this Royal Greenwich Safeguarding Adults Board annual report, publication of which is a statutory duty. This annual report will be presented to the chief executives of the local authority and of South East London ICB, to the Chief Superintendent of the South East London Police Basic Command Unit, and to the Chief Executive of Healthwatch Greenwich. The annual report will be taken through the local authority's governance procedures to ensure scrutiny by elected members. Member engagement and partner support for the Board has been impressive, each of us supporting the work of the Board as critical friends and demonstrating what can be achieved for adult safeguarding through reflective appreciation.

The Royal Greenwich Safeguarding Adults Board is required by law to publish a strategic plan and this annual report describes the work undertaken to seek assurance about the effectiveness of single agency and multi-agency adult safeguarding in Greenwich, and to take forward the priorities in the strategic plan for practice development and sector-led improvement. Board agendas have contained the presentation of assurance reports, as anticipated in the strategic plan, covering such topics as compliance with deprivation of liberty safeguards, transitional safeguarding practice with care experienced young people and young adults, the findings and outcomes of learning disability mortality reviews, hospital discharge, and support for carers.

As part of its mandate to seek assurance about the effectiveness of adult safeguarding, the Board has received performance reports at each meeting, the overall summary of which is contained in this annual report. Work has been completed to understand what performance data is revealing, in which respect a completed independent audit of adult safeguarding practice within the local authority's adult social care department has proved especially informative and useful. So too has been a background analysis commissioned as part of preparation for forthcoming assurance and inspection of local authority adult social care by the Care Quality Commission. Robust interrogation of performance data will continue to be a feature of this Board's work. Completing safeguarding adult reviews, when the criteria in section 44 Care Act 2014 are met for either mandatory or discretionary reviews, is a third statutory duty.

This annual report provides detail of one review that has been published, the implementation of the action plan for which is being monitored jointly by the Board and by NHS London. The Board has also completed and signed-off a second safeguarding adult review, publication of which is awaiting the conclusion of an inquest. The Board has been actively monitoring the implementation of the recommendations from this review.
The Board has benefited greatly from contributions from family members, including their moving and insightful presentation at the Board's annual conference The Board has also pursued its objective to learn from cases where agencies have worked well together to safeguarding an adult experiencing or at risk from abuse or neglect. This annual report provides detail of one review that has been published, the implementation of the action plan for which is being monitored jointly by the Board and by NHS London

Chairs Foreword

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Following the successful launch of the "think family – see the adult, see the child – protocol", work has focused on embedding this protocol in practice, to ensure that practitioners across children's and adult services work collaboratively. The Board has completed revision of its self-neglect policy and is now supporting an initiative led by the local authority's adult social care department to develop practice in this complex and challenging area of adult safeguarding practice.

The Board has sought assurance about how health and social care services are responding to the needs of people escaping conflicts in Europe and elsewhere, and seeking asylum in this country. Where necessary, concerns have been escalated to the Home Office. The Board has also sought assurance about how the local authority, with its partners, is endeavouring to support people experiencing the cost of living crisis and to prevent financial abuse. The Board is also engaging with the London Fire Brigade to raise awareness of home fire safety, and with public health colleagues to ensure partnership working with people experiencing dependence on alcohol and other drugs.
A very successful conference was held, with presentations and workshops, with major themes being best practice when working with people who self-neglect and learning from safeguarding adult reviews completed locally and nationally. In adult safeguarding week, a number of webinars and other events were run, with strong take-up from Greenwich partners and London-wide.

The Board also needs to be assured that safeguarding adults practice is accessible to all the communities living in Greenwich. Plans are being developed to promote the Board's work with communities, neighbourhoods and faith groups, to raise awareness of types of abuse and neglect, and of adult safeguarding. I expect that this work to gather pace.

Finally, I would like to appreciate the contributions of Helen Bonnewell and Joshua Wybourn-Whyte who manage the business and administrative tasks of the Board efficiently and effectively. I would also like to acknowledge the work of practitioners and managers who are committed to keeping people safe in Greenwich.

Professor Michael Preston-Shoot
Independent Chair

What is the Safeguarding Adults Board?

The Royal Greenwich Safeguarding Adults Board is a partnership of agencies working across the borough. Its vision is to enhance the quality of life, health, wellbeing, andsafety of adults at risk of abuse and neglect. It aims to enable peoplewho need help and support to maintain independence and wellbeing; and to live a life that is free from abuse and neglect. Its role is to make sure local safeguarding arrangements are effective.

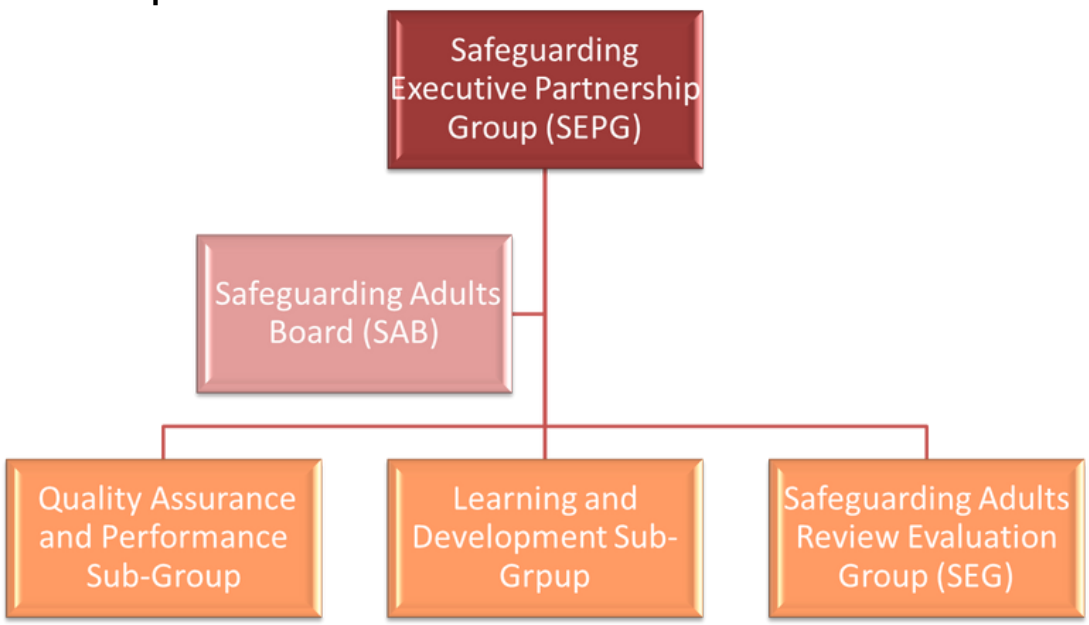
Under the Care Act 2014, the Safeguarding Adults Board has three core duties:

- **Publish a Strategic Plan for each year that sets out how it will meet its main objectives and what the members will do to achieve these objectives.**
- **Publish an Annual Report detailing what the Safeguarding Adults Board has done during the year to achieve its main objectives.**
- **Conduct any Safeguarding Adults Reviews**

The Chair reports directly to the local authority Chief Executive and meets regularly with the Adult Social Care Director, Health and Adults Services and other key partners. The Board Manager post sits within the Safeguarding Adults Team for the Royal Borough of Greenwich Council and is designed to ensure the Safeguarding Adults Board can confidently meet the requirements of the Care Act 2014 and deliver better outcomes for residents.

Safeguarding Adults Board Structure and Partners

The work of the Safeguarding Adults Board, including the work contained within the Strategic Plan is undertaken by sub-groups with oversight from the Safeguarding Adults Board. This year we have established the Safeguarding Executive Partnership Group, this group consists of chairs from the Safer Greenwich Partnership and Greenwich Safeguarding Children's partnership. the purpose of this group is to provide oversight to the three executive boards as well as aligning strategic objectives across the three partnership. See below Board structure and partners.



Lewisham and Greenwich NHS Trust

METROPOLITAN POLICE

HM Prison & Probation Service

serco

ROYAL GREENWICH SAFEGUARDING ADULTS BOARD

Oxleas NHS Foundation Trust

GAVS METRO GAVS

healthwatch Greenwich

Bromley, Lewisham & Greenwich mind

LFB LONDON FIRE BRIGADE

ROYAL borough of GREENWICH

WDP Life transformed.

South East London Integrated Care System

The Safeguarding Adults story in Greenwich

Overview	22/23	21/22	Change since last year	London Average	Comparison to London average
Concerns received	1347	1166	↑	1949	↓
Conversion rate	27%	19%	↑	32%	↓
Concerns for pressure ulcers	281	216	↑	Unknown	Unknown
Enquiries completed	363	221	↑	466	↓
Enquiries substantiated	45%	47%	↔	78%	↓

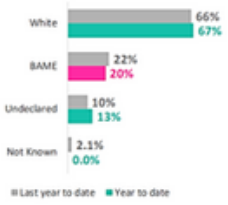
Our top 5 referral sources are:

- Hospitals
- Emergency services
- Mental Health
- Care providers
- Primary Health

49% of cases occurred in the persons **own home**. This has increased compared to last year but remains lower than the London average.

This year, we have seen an increase in the number of concerns referred by emergency services . This is due to an increase in cases referred from the Police and the Fire Brigade.
We have also seen a significant increase in the number of cases referred by primary health (both GP and community health).

20% of concerns were for people from a BAME background



People from **Asian**, **Black** and **Mixed** background are under-represented in the concerns received compared to the make up of the borough

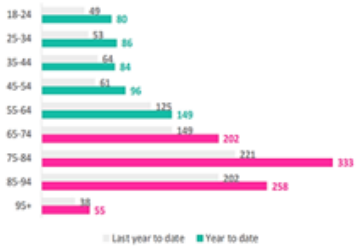
	This year to	Last year to	2011 census
Asian	5%	5%	12%
Black	13%	12%	19%
Mixed	1%	2%	5%
Other	1%	2%	2%
White	67%	68%	63%
Not known / Undeclared	12%	11%	0%

62% of concerns were for people with physical health needs followed by **Mental Health at 15%**

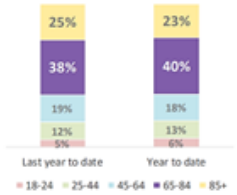
58% of enquiries related to cases of neglect. This has **increased** compared to last year but remains significantly higher than the London average (which is 30%)

The Safeguarding Adults story in Greenwich (cont.)

63% of concerns were for people aged 65 and over



There is a higher proportion of concerns for people aged 65 to 84 compared to last year



Making safeguarding personal: where people expressed a desired outcome, it was fully or partially achieved in 95% of cases in 2022/23 and 94% of cases in 2021/22. This is just above the London average.

92% of people who did not have capacity and were supported by an advocate were supported by a family member.

Deprivation of Liberty Safeguards (DoLS): Increased activity since October 2022

DoLS cases signed off

Latest month saw 124 cases signed off

↑ 61% compared with a monthly average of 77 over the last year.

DoLS applications in progress

Latest month saw 139 cases in progress at month end

↓ -73% compared with a monthly average of 506 over the last year.

Active Applications at month end

Latest month saw 389 active DoLs in place at month end up

↑107% compared with a monthly average of 188 over the last year

Since September 2022, there has been a huge effort focus to address the DOLS backlog. This had unfortunately built up significantly during the COVID pandemic and extra resources were agreed to address this issue. The DOLS Team recruited 2 extra administrators and thanks to their efforts and that of the DOLS coordinator we have manage to reduce the backlog to more manageable levels. There has also been improvements with the number of authorisations that are being completed internally with more managers having completed the relevant training. It is hoped by September 2023, the DOLS Team will be able to complete DOLS in the recommended time frame of 21 days.

Business Plan update

Safeguarding Principal	Action	When	Update	RAG
Proportionality	Develop a carers' strategy	Oct 2022	Carers strategy developed and launched in alongside a newly established Carers Partnership Board(including people with lived experience).The Partnership Board will have oversight of the Delivery Plan. To support the launch of the strategy, the offer to carers has been extended to include digital tools, engagement with employers and engagement with carers from BAME communities. Presented to the SAB March 2023.	
	Link with other boards across London to ensure priorities are aligned and shared	Nov 2022	Safeguarding Adults week agenda from across London shared with the partnership.	
Protection	Embed a "Think Family" approach by producing a practitioner's guide and launching across the partnership	March 2023	See the adult: see the child guidance developed and shared across both partnerships. 7 Lunchtime workshop sessions delivered virtually and in person. Merchandise produced and website domain created.	
	Assurance report on current Dols arrangements (included performance data)	Sep 2022	Assurance report presented in Sep 2022 and follow up in March 2023. Work continues on backlog and the position has significantly improved since the beginning of the year due to increased resources.	
Partnership	Assurance report around transitional safeguarding arrangements between children's and adults services.	Dec 2022	Assurance report presented to the board detailing the transition pilot and links with mental health services to support young people with care needs transition from children's services to adults services,	
Accountability	Safeguarding adults training to be offered to Elected members and cabinet lead members	May 2022	Elected member training delivered by the independent chair jointly with the Greenwich Safeguarding Children's Partnership	
	Create a cross cutting executive to agree strategic objectives and opportunities for shared working and learning	May 2022	Safeguarding Executive Partnership Group has been established including Safeguarding Adults Board, Greenwich Safeguarding Children's Partnership and Safer Greenwich Partnership. The group meets quarterly and is chaired by Chief Executive of the council.	

See the Adult, See the Child (StAStC)

In 2022-23, work was undertaken on revising the See the Adult see the Child Protocol in collaboration with the Safeguarding children's Partnership (GSCP). With steer from the Independent Chairs/Scrutineers and executive members from the GSCP and SAB, the Professional Advisers and SAB Manager reduced the 40+ page protocol document to a more memorable and user-friendly three-page guidance.

The guidance can be found here: www.stastcgreenwich.org.uk

The aim of the guidance is to improve joint working across all children and adults' services across the multi-agency partnerships and provide a clear process for when and how to refer to Children's or Adults' social care. The themes and learning highlighted in the guidance have come from local and national reviews in to Child and adult reviews (CSPR's & SARS's) and importantly include Information Sharing and Professional Curiosity.

This protocol was launched with a logo on a range of merchandise (pens, mugs, notepads etc) to promote the guidance alongside a series of **10 lunchtime workshops** delivered jointly by the Children's partnership and Safeguarding Adults Board across various locations (include health care, police and voluntary sector) in the borough, **207 employees** across the partnership attended the training sessions. Additionally a webcast will be produced which will be shared with professionals who were unable to attend the training and uploaded on respective websites.

"Simplifying the process and understanding the process better will ensure practitioners know what to look for and hopefully ensure better reporting".

Self Neglect Policy

In 2022 the Safeguarding Adults Board produced and launched its Multi-agency Self-neglect policy. This Policy, practice guidance and hoarding toolkit was created as a result of SAR Alexander recommendation no 2 and in response to professionals requesting more guidance on how to manage cases of self-neglect and hoarding especially in circumstances where the person does not wish to engage. The Policy was created in consultation with partners and signed off at the Safeguarding Adults Board in September 2022.

This policy, practice guidance and hoarding toolkit applies to all partners of the Royal Greenwich Safeguarding Adults Board and can be used as a good reference point for any organisation working with adults who self-neglect and/or hoard. The policy also supports the see the adult: see the child guidance by reiterating that everyone has a responsibility to take a 'Think Family' approach. This requires all agencies to consider the needs of the whole family, ensuring this work is coordinated and taking into account how individual problems affect the whole family. (See the "see the adult, see the child" protocol).

The policy aims to help prevent serious harm of 'adults at risk' who self-neglect and hoard and improve consistency of approach across the borough.

The policy was launched and then distributed and shared as part of the Safeguarding Adults conference on self-neglect, it was referenced by keynote speakers and workshop presenters.

You can access this policy via the Safeguarding Adults Board website www.greenwichsafeguardingadults.org.uk/legislation/updated-london-multi-agency-safeguarding-policy-and-procedure/

Alongside this Policy Royal Greenwich Health & Adult Services have now commissioned an innovative Self-Neglect & Hoarding Pilot with the aim of promoting an evidence-informed approach and better multiagency working in such cases. An experienced social worker with a particular interest in this specialist area of practice has been recruited to lead on this pilot. Two main initiatives will be the establishment of a local hoarding support group (to support people with hoarding behaviours) and the establishment of a new multiagency Self-Neglect and Hoarding Risk Panel (to support, advise and assist local authority officers and colleagues from the NHS and the voluntary sector who encounter such cases in the community).

Case Study- Claire

Claire is a 64yr old lady White British lady who lived alone at home. She was admitted to hospital following an overdose with suicidal intention. Claire was referred to hospital safeguarding team who requested psychiatric involvement and referred to the local authority. The hospital Safeguarding advisor also liaised with the Local Community mental health team as Claire had a care co-ordinator and a multiagency meeting was arranged to discuss ongoing concerns.

During the meeting the following concerns were shared:

- Claire had poor mobility due to previous pelvic fracture following a fall
- Reported increase in alcohol consumption and potential drug taking on the pre-existing chronic liver damage
- Potential risk of violence in the home
- Poor diet
- Not taking medication required for both physical and mental health conditions regularly
- Fire risk due to smoking.

Whilst in hospital referrals were made to the substance mis-use team and concerns about financial abuse were made to the Police. Claire was referred to a Independent Domestic Violence Advocate and the case was heard at the Multi Agency Risk Assessment Conference (MARAC), which is a multi-disciplinary meeting for people experience domestic abuse.

Claire was discharged home from hospital with support from the community mental health team and a safety plan put in place.

Case Study- Joshua

Joshua is a 57-year-old man from Greenwich. He was visited at home by a trainee clinical psychologist and an Occupational Therapist from the ICMP (intensive case management in psychosis) team. They discovered barely habitable conditions within the property, indicative of self-neglect and hoarding. There was a malodourous smell on approaching the flat, letters on the floor, a blocked sink in kitchen with flies, no running hot water, a dirty bathroom with dead flies around bath and cockroaches were observed in the living room and running on floor. There were many empty food packets on the floor and the bedroom was dirty with no bedding, a sheet over the window and the bed in a poor state of repair. Joshua appeared unkempt with matted hair a malodourous smell and dry flaky skin on his scalp and face.

Joshua agreed that he needed help and so a Safeguarding Adults Concern was raised, on the grounds of self-neglect and hoarding. Joshua and the trainee clinical psychologist formulated a safeguarding plan of applying for the commissioning of a deep clean for the flat, alongside an occupational therapy-based intervention to engage with Joshua on a one-to-one basis and to support him to improve his skills of maintaining his home environment. The case was discussed with the team's Safeguarding adults manager and a decision was made to progress to a s42 Enquiry under The Care Act 2014.

During the s42 enquiry, it was established that this was a long-standing issue which had required previous interventions. Therefore, a publicly funded blitz clean was not enough to address the issues and to enable Joshua to maintain his tenancy. The wider multi-Disciplinary team held a view that Joshua required intensive training to minimise the risk of further deterioration in his personal care and home environment.

The Occupational Therapist intervention ensured a graded exposure to ADL (activities of daily living) tasks in community including shopping and attendance of social opportunities. This was to ensure that skill building reduced the risk of further deterioration in home environment and supported Joshua to maintain his own tenancy. This met the principles of protection, prevention and empowerment under the Care Act 2014.

Due to the success of this intervention, Joshua was transferred to the care of CMHRES, the community mental health rehabilitation and enablement service.

Safeguarding Adults Reviews (SARs)

The Royal Greenwich Safeguarding Adults Board has a statutory responsibility to undertake Safeguarding Adults Reviews under the Care Act 2014.

The Safeguarding Adults Review Evaluation Sub-Group meets to consider all referrals for potential Safeguarding Adults Reviews. Once a decision is made to undertake a SAR an independent reviewer is appointed.

The Safeguarding Adults Board has published **1** Safeguarding Adults Reviews this year (see Mr G and Mr Q below) . There were **8** new case discussions for potential Safeguarding Adults Reviews considered by the Safeguarding Adults Evaluation Sub-Group during 2022-23. 1 case has been agreed to be a Joint adults and childrens review and is currently ongoing.

"Safeguarding Adults Boards must arrange a Safeguarding Adults Review when an adult in its area 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....Safeguarding Adults Boards must also arrange a Safeguarding Adults Review if an adult in its area has not died, but the Safeguarding Adults Board knows or suspects that the adult has experienced serious abuse or neglect"- Care and Support Statutory Guidance (updated Oct 2016

Safeguarding Adults Reviews (SARs)
Ms G and Mr Q

Background

In June 2018, it was reported that Ms G had died following a fatal incident where she was assaulted in the shared house where she lived. The alleged perpetrator, Mr Q, who also lived in the house, was charged with murder. Mr Q was convicted of murder and sentenced to life imprisonment in December 2018. Both the criteria for a Safeguarding Adults Review and an Independent Mental Health Homicide Review (IMHHI) were met and so the Safeguarding Adults Board jointly commissioned a review alongside NHS ENGLAND.

Both Ms G and Mr Q were known to local mental health services, they were both known to the same team and had the same care coordinator, the same GP and were both known to the same local Mental Health charity. Their living arrangements had change 8 months prior when 2 other residents had moved out leaving Ms G and Mr Q the only 2 residents.

You can access the full report and the action plan via https://www.greenwichsafeguardingadults.org.uk/contact/safeguarding-adult-review/

Learning

The report made 23 recommendations across multiple agencies. The report identifies that there was a failure by all the agencies involved to consistently recognise and respond to Ms G repeated allegations. They did not implement appropriate safeguarding processes or develop a multi-agency response. Substantial gaps were identified in safeguarding practices across all agencies, in terms of recognising and responding to allegations, quality assurance and monitoring. There were significant missed opportunities for safeguarding activity in relation to Ms G and to a lesser extent, Mr Q. In instances when safeguarding was used, there was limited adherence to the six principles of safeguarding.

Key Learning Points

- **Writing clear and concise care plans in line with policy including wider needs beyond day to day living.**
- **Ensuring monitoring of risk assessments and mental capacity assessments**
- **Ensure families are considered when planning care and reasons documented if family not consulted or do not wish to engage.**
- **Patients with long-term prescription of benzodiazepines should be reviewed and documented in line with NICE guidance**
- **Repeat safeguarding referrals and concerns should be monitored and reflected in policy.**

Learning and Development

The Learning and development Sub-group have been meeting every quarter during the past year, this group is currently chaired by the Principal Social Worker for Adult Social Care. The group consists of members from across mental health services, met Police, voluntary sector and SE London ICS. The group refreshed their terms of reference and membership list this year. Below details some of the work undertaken by this group during 2022-23.

Me learning

In response to a request for additional online training opportunities especially across the voluntary sector, in February 2022 the Safeguarding Adults Board and Health and Adult Services (Royal Borough of Greenwich) jointly commissioned and launched a new online e-learning platform. The resource is free to use for all Adult social care staff, Health Partners, Private, Voluntary and Independent sectors associated with The Royal Borough of Greenwich. Staff are able to access 21 courses related to Adult Social Care digitally including Safeguarding Adults level 1 and 2, children with disabilities, neglect and mental health awareness. We held two information sessions across the partnership in order to demonstrate how the platform works and answer any queries. The platform will be jointly managed and monitored and reports created to assess the uptake of this resource. To register on this platform send your registration request to **has-workforce@royalgreenwich.gov.uk a**nd we will register you onto the platform.

Voluntary sector Training

In addition to the above e-learning platform the Safeguarding adults board commissioned 3 virtual safeguarding adults awareness sessions. These half day sessions covered the responsibilities of front line staff and their managers to both identify and how to respond to Concerns about Abuse and Neglect. Information required to gather and share as part of referrals to the Local Authority and associated legal guidance and good practice principles. These sessions were very well attended with good feedback in relation to the content and the trainer.

Care home and home care training

The safeguarding adults board commissioned 3 face to face safeguarding adults care home manager trainings and 1 virtual home care managers training sessions. These full day sessions covered policy and procedures, knowledge of statutory duties and decision making, how to undertake a safeguarding enquiry and outcomes for the adult. The feedback received stated the course was extremely informative and the opportunity to discuss case scenarios hugely beneficial,

Safeguarding Adults Week
Monday 21st -Friday 25th November 2022

This year for Safeguarding Adults week we held local events as well as promoting London wide events which had been produced by the London Safeguarding Adults board. We also held a conference focusing on self-neglect. The Programme of events for the week covered domestic abuse, hate crime as well as See the adult: See the child workshop. We also held a professional networking event which included a workshop on the forthcoming mandatory Oliver McGowan training.

Sessions delivered were a mix of both virtual and face to face session. The virtual sessions were better attended than the face to face sessions, this was believed to be due to the effects of the corvid pandemic and caution in relation to mixing in larger groups. Partners supported this week by providing training sessions from community safety and trading standards.

Safeguarding Adults Conference
Tuesday 22nd November 2022

The theme for this years Safeguarding adults board conference was self-neglect and hoarding. We held this years conference at Charlton Athletic Football club on 22nd November 2022. The conference was attended by 100 delegates from across the partnership.

Keynote speakers were Professor Michael Preston--Shoot, Fiona Bateman, Dr Nicole Stelis and Dr Michela Tinelli . We were very honored to have the mother and sister of SAR Alexander attend and talk to the conference about who Alexander was and what their lived experience was. We like to thank them again for sharing their story with us.

Delegates had the opportunity of also attending two of the following workshops

- Heather Matuozzo & Sam Wainman from Clouds end- Responding to Sef-neglect and hoarding
- Dr Nicole Stelis and Dr Jennifer Owen from Kings college London - Self-neglect and/or hoarding behaviour: exploring their causes and your experiences and practice
- Alex Greenchester - Mental health services responding to issues of self-neglect

During the conference we asked delegates to consider what barriers they have faced in relation to self-neglect and hoarding, what good practice looks like and what policy changes would improve outcomes for people. The responses to these questions have been collated and will feed into further work the board will undertake in relation to self-neglect.

Quality Assurance

The Quality Assurance and Performance Sub-group have been meeting every quarter during the past year, this group is currently chaired by the Designated Nurse for Adult Safeguarding, NHS South East London ICS (Greenwich).
The group consists of members from across mental health services, met Police, voluntary sector, hospital and adult social care partners. The group refreshed their terms of reference and membership list this year. Below details some of the work undertaken by this group during 2022-23 as well as assurance reports received by the Safeguarding Adults Board.

Pressure Ulcer Pathways
Following concerns raised by the Safeguarding Adult Board on the proportion of safeguarding alerts that are related to pressure ulcers, the Performance and Quality Assurance sub-group established a task-and-finish group to explore this further. As a result, a regular meeting between relevant pressure ulcer leads from the ICS, RBG and both Oxleas and LGT has been established to discuss and challenge complex and/or delayed cases where indicated. Although the proportion remains high, this may in part be to delays in investigation between the safeguarding alert being raised and the appropriate pressure ulcer panel reviewing the case. In health services, the pressure ulcers assessed as category 3 and above have been reported under the Serious Incident Framework, and this is now being replaced nationally by the new Patient Safety Incident Response Framework (PSIRF). This will have an impact on the reporting and investigation of pressure ulcers and is likely to lead to an improved, more timely response to the local authority, patients and their carers. Both LGT and Oxleas are revising their pressure ulcer protocols to take the PSIRF into account.

Assurance reports presented to the board

- **Carers Strategy**
- **Self-neglect pilot**
- **Community engagement work of public health**
- **Drugs partnership**
- **Learning from fire deaths and home fire safety visits**
- **Financial abuse and cost of living crisis**
- **Quality assurance board and links with provider concerns**
- **Learning Disability Mortality Reviews**
- **Transitional Safeguarding**
- **RBG Audits on Safeguarding adults**
- **Deprivation of Liberty Safeguards**
- **Homes for Ukraine**
- **Kings College London Hoarding and Self-neglect among Older people study**

Priorities for 2023-24

The Safeguarding Adults Board strategic plan is a four year plan which comes to an end in 2024, below are some of the priorities for work which will be undertaken in 2023-24, this will be achieved through the work of the sub-groups and monitored by the Safeguarding Adults Board.

Getting Involved

If you live in the Royal Borough of Greenwich and would like to **become involved** in the work of the Royal Greenwich Safeguarding Adults Board, we would like to **hear from you**. Our Safeguarding Communication and Engagement Group provide an opportunity for residents and people who have used safeguarding services to share their stories and views. This helps other people stay safe from abuse and neglect and helps the Safeguarding Adults Board to improve safeguarding services.

If you would like to get involved, please contact us via
safeguarding-adults-board@royalgreenwich.gov.uk
Tel: 0208 921 2378
Royal Greenwich Safeguarding Adults Board
The Woolwich entre, 2nd Floor
35 Wellington Street London
SE18 6HQ

Concerned about an adult at risk of abuse?

If a person is in immediate danger **call 999** and alert the police.

If you suspect a person is at risk of abuse or is being **abused**, report it to Contact Assessment Team.
Tel: 020 89212304 (Out of hours): 020 8854 8888
•Email: aops.contact.officers@royalgreenwich.gov.uk

The switchboard is open 24-hours a day, seven days a week. Anyone who is concerned that abuse may be taking place or feels they are subject to abuse themselves should seek help
.

For more information visit our website:
https://www.greenwichsafeguardingadults.org.uk/

Or the council's website: https://www.royalgreenwich.gov.uk/