ROYAL GREENWICH
SAFEGUARDING
ADULTS BOARD

2023-2024 Annual Report

A Year of Accomplishments.

greenwichsafeguardingadults.org.uk |0208 921 2304 | safeguarding-adults-board@royalgreenwich.gov.uk

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Chair's 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 Southeast 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 continues to be impressive, demonstrating what can be achieved for adult safeguarding through strong partnerships.

The Royal Greenwich Safeguarding Adults Board is required by law to publish a strategic plan. This plan is reviewed and refreshed annually at a Board development event. This annual report describes the work undertaken to take forward jointly agreed priorities in the strategic plan for practice development and sector-led improvement. Board agendas have continued with presentation of assurance reports, covering such topics as provision of advocacy, compliance with deprivation of liberty safeguards, adult safeguarding decision-making, police introduction of "right care, right person", review of out of authority placements, meeting the health and social care needs of people in prison and/or approaching release, and partnership working to respond to substance misuse.

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 continues by the Quality Assurance and Performance Sub-group to understand what performance data is revealing. One particular focus this year has been on how services respond to meet the needs of people with neurodiversity. Another has been on service development to respond to increasing numbers of cases of people who self-neglect and hoard, this work is being led by Health and Adult Services. Additionally, there has been a focus on ensuring effective support for people living in the community with mental distress and mental ill-health, responding to the learning from the Board's completed safeguarding adult reviews.

Completing safeguarding adult reviews, when the criteria in section 44 Care Act 2014 are met for either mandatory or discretionary reviews, is also a statutory duty. This annual report provides details of decisions in response to the increasing number of referrals being received for consideration. SAR Alexander has been published and both the independent chair and the review author gave evidence at the inquest. The Board actively monitors implementation of the recommendations from reviews. The Board has been slightly more successful in collating learning from cases where agencies have worked well together to safeguarding an adult experiencing or at risk from abuse or neglect. This focus must continue. The Board is currently engaged in a joint review with the Greenwich Safeguarding Children Partnership, which will enable scrutiny of the implementation of the "see the adult, see the child – protocol."

The Board has developed policy and procedures for responding to allegations of abuse and/or neglect by people in positions of trust. The Board has continued its oversight of 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, and about how the local authority, with its partners, is endeavouring to support people experiencing the cost-of-living crisis. Alongside the local authority, the Board has also escalated concerns about growing evidence of modern slavery in international health and social care recruitment.

The Board has continued to offer a programme of learning and development webinars and in-person workshops, including during the November adult safeguarding week. The Board has picked up work on communication and engagement with communities in Greenwich, to raise awareness of types of abuse and neglect, and has had a presentation from London Voices that reinforced the importance of co-production of policies, training and outreach to communities. This work is now gathering pace.

Finally, I would like to appreciate the contributions of Helen Bonnewell who manages 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. In my conversations with them about challenging and complex cases, I have been impressed with the values and knowledge that have underpinned their work, the skills they have shown, and how services have worked together.

Professor Michael Preston-Shoot
Independent Chair

The Royal Greenwich 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,** and **safety** of adults at risk of abuse and neglect. It aims to enable people who 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 fiscal 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 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.

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. Last year we 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 partnerships. See below Board structure and partners.

The Safeguarding Adults Board is made up of the following partners who have all signed up to this strategic plan.

serco

healthwatch Greenwich

LFB LONDON FIRE BRIGADE

HM Prison & Probation Service

v-i-a

South East London Integrated Care System

South East London mind

METROPOLITAN POLICE

Lewisham and Greenwich NHS NHS Trust

ROYAL borough of GREENWICH

GAVS METRO GAVS

Oxleas NHS NHS Foundation Trust

"Safeguarding requires collaboration between partners in order to create a framework of inter-agency arrangements. Local authorities and their relevant partners must collaborate and work together…and in doing so, must, where appropriate, also consider the wishes and feelings of the adult on whose behalf they are working"- Care and support statutory guidance S14.137

Overview

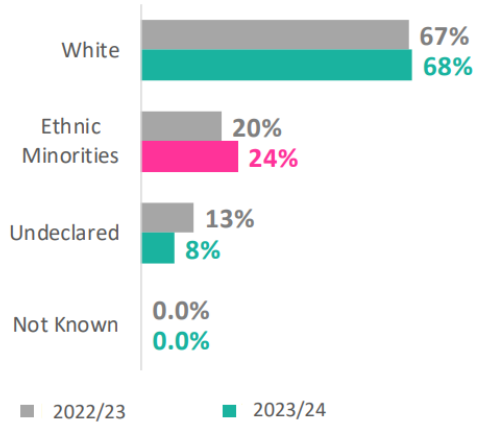
	23/24	22/23	Change since last year	London Average (22/23)
Concerns received	1579	1347	↑	1849
Conversion rate	30%	27%	↑	35%
Enquiries completed	521	349	↑	414
Enquiries substantiated	41%	45%	↓	76%
Risk removed	31%	31%	↔	29%

The **5 main referral sources** are:

- Emergency Services
- Hospitals
- Mental Health
- Care providers
- Primary Health.

There has been a big increase in concerns from all emergency services.

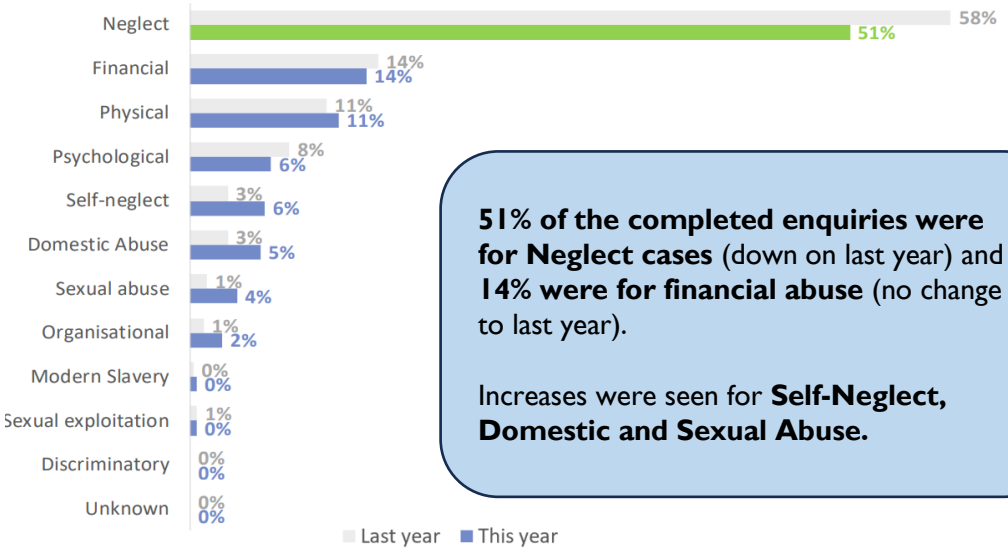
24% of concerns were for people from a Black and Global Majority background



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

	23/24	22/23	2021 census
Asian	6%	5%	13%
Black	15%	13%	21%
Mixed	2%	2%	6%
Other	2%	0%	4%
White	68%	67%	56%
Not known / Undeclared	8%	13%	0%

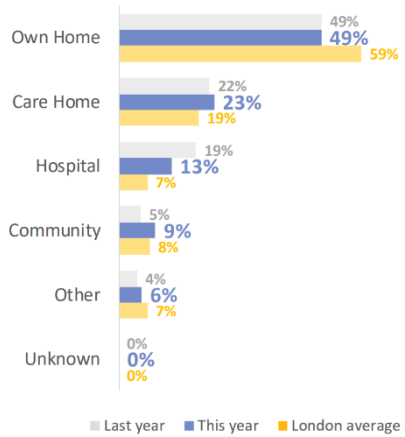
Abuse Types



51% of the completed enquiries were for Neglect cases (down on last year) and **14% were for financial abuse** (no change to last year).

Increases were seen for **Self-Neglect, Domestic and Sexual Abuse.**

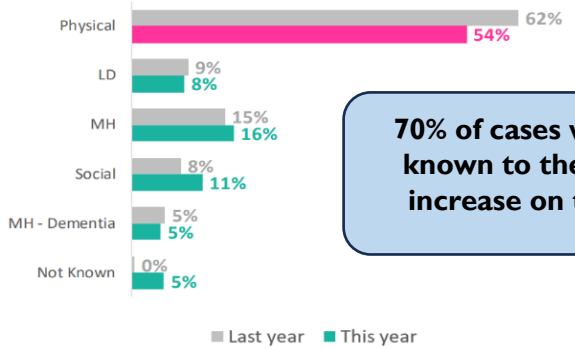
Location of Risk



49% of cases occurred in the person's **own home**. No Change compared to last year and remains **lower than** the London average.

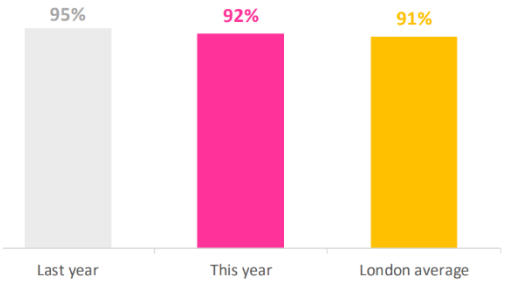
We have seen a **decrease** to cases happening both in **hospital** but still **Higher than** than the London average. **Care home** levels are similar to last year but **Higher than** to the London average.

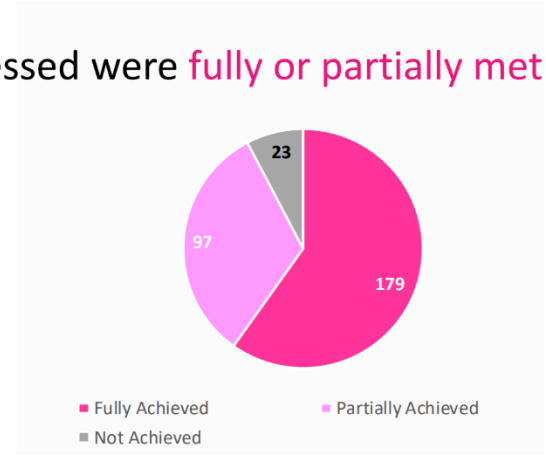
54% of concerns were for people with Physical support needs



70% of cases were from someone known to the individual, a slight increase on the last year's 67%.

92% of outcomes expressed were fully or partially met





Deprivation of Liberty Safeguards (DoIs)

RBG received more applications this year – **750 or a 16% increase on last year.** The team **completed 775 applications this year**. This is less than last year as the focused work to clear out the backlog is now complete. Which means an average of **65 cases were signed off each month**.

- More active authorisations were open at year end – 187 (+15% compared to last year) but slightly below the London average (198)
- Less applications were still in progress at year end – 113 compared with 136 last year. This is significantly lower than the London average (203)
- Applications were completed in a timelier manner. On average, it took **60 days to complete an application** – compared to 294 last year and 115 for the London average.
- Both the assessment and the sign off stages are taking less time. As a consequence, a higher proportion of applications were granted this year – **77% which is higher than the London average of 61%.**

Business plan update

The Royal Greenwich Safeguarding Adults Board strategic plan 2020-24 has now come to an end with updates provided at the board meetings and in each annual report. Below details the updated action during the year April 2023- March 2024.

Safeguarding Principal	Priority	Assurance or Board Activity?	Action	Who?	When?	Update March 2023	RAG
Empowerment	Expanding user engagement across the borough to ensure the voice of lived experience are heard	Board Activity	Create a community engagement group with clear term of reference for engaging with members of the local community	Community engagement sub-group	March 2024	The Board has established links with the Healthier Greenwich Partnership and the director of communications and engagement, to ensure Safeguarding Adults is on their agenda. The community engagement sub-group presented a communication strategy and action plan which was agreed by the board.	
Prevention	Undertaking Safeguarding Adults Reviews as agreed by the board and consider using or adapting the Rapid reviews methodology.	Board Activity	Safeguarding Adults Review Evaluation Group to consider referrals from partners in relation to deaths or serious injuries in the borough due to neglect where partner agencies could have worked better together. Look at adapting the Social Care Institute for Excellence (SCIE) rapid review mythology when undertaking SAR to ensure learning is gained quickly	Safeguarding Adults Review Evaluation Group (SEG)	When required	Four Safeguarding Adults Reviews (SAR's) underway including a thematic SAR and joint SAR. Referrals discussed at SEG which do not meet the criteria for a mandatory SAR are being considered for discretionary reviews where appropriate or passed to learning and development group to consider how to share learning,	

Proportionality	Linking with other boards across London to ensure priorities are aligned and shared.	Board activity	Joined up approach to Safeguarding Adults week in November sharing the workshops and activities across the partnership	Board Manager and Learning and Development Sub-group.	November 2023	Safeguarding Adults week agenda from across London shared with the partnership and a safeguarding adults hub held.	
Protection	Deprivation of Liberty Safeguards (DoLs)	Assurance	Assurance report to be presented to the board to assure the board of current Dols arrangements (included performance data) and any impact of this on new LPS implementation.	RBG- Health and adult services	December 2023	Assurance report presented in Sep 2022, March 2023 and December 2023. Work continues on backlog and the position has significantly improved since the beginning of last year.	
	Develop a Person in position of Trust (PipoT) Police	Board Activity	Develop a PipoT Policy and pathway as stipulated Under the Care and Support statutory guidance of the Care Act (2014)			Pipot policy presented to the board in March 2024 and uploaded onto the website.	
Partnership	Ensure there is a robust learning and development program which addresses the needs to the borough and addresses learning from SARs	Board Activity	Arrange engaging workshops/ training sessions and conference for safeguarding adults' week in November. Commission training, workshops, me-learning as well as video content and website content to support the actions from SARs.	Board Manager and Learning and Development Sub-group	Ongoing- November 2022	Supported national Safeguarding Adults week as well as holding a safeguarding hub for adults with learning disabilities. Me Learning online training recommissioned and launched for all SAB partners. A Programme of SAR learning events were held across the partnership.	
	Good practice case studies to be shared to encourage learning form good practice.	Board Activity	Case studies demonstrating good practice or areas for learning to be shared with the SEG and then decisions as which to be presented to board to be agreed.	Safeguarding Adults Review Evaluation Group (SEG)	Every Board meeting	Cases are being presented routinely by partners and are fed into the learning and development group to highlight good practice and share the learning.	

	Transition Safeguarding arrangements between Services	Assurance	Assurances to be made to the board around transitional safeguarding arrangements between children's and adults services, hospital and community settings (both Acute and MH)	Quality assurance and Performance Sub-Group	Dec 2022	Assurance report presented at the Board in December 2022.	

Case study- Sheila

Sheila moved away from the borough of Greenwich 17 years ago to seek help with addiction, she made the decision to live in another borough and became estranged from her children. Sheila was a victim of Domestic abuse in past relationships and made the decision to return to Greenwich to flee the abuse and to be with her daughter who was dying from cancer.

After her daughter passed away, she saw her estranged son at the funeral, and they remained in contact. Sheila has a visual impairment with limited vision, uses a walking stick due to reduced mobility and diagnosed with bipolar disorder, PTSD and anxiety. She is on medication for her mental health.

On the 8th of August 2023, Sheila called the Police to report that her son had attacked her in her own home. He reportedly punched her in the head 4 times and pulled her back into the flat when she has tried to escape via the front door. The son's girlfriend and newborn baby were present during the attack, the son became angry with his mother because she found the girlfriend sleeping on the sofa holding the newborn baby intoxicated. She told the girlfriend she could not do this because it was a danger to the baby.

It was reported that the son handed himself in to the Police and he was interviewed, he denied the allegations against him and claimed his mother had attacked him. The son confirmed in his statement that his girlfriend was his witness. Whilst the child's social worker (out of borough) questioned the girlfriend about the incident, and she denied even being at the property.

The Police dropped the charges. Multi Agency Risk Assessment Conference (MARAC) case presentation found this was not an appropriate outcome and Sheila was offered the right to review. Sheila wanted her son to be arrested and punished for what he did to her. She was very distressed by the Police outcome and disengaged and would not answer her phone to anyone. It was very difficult to engage Sheila who had isolated herself in her own home after the incident, she was extremely anxious, afraid, tearful and felt let down by the Police.

Adult social care and a Safeguarding Advisor undertook a joint home visit to Sheila initially; however, she did not want any men to enter her home, she was willing to speak to the Safeguarding Advisor through the intercom. But not the male Social Worker. A female social worker was reassigned and returned to engage Sheila. The Adult social wok team made a number of health and social care referrals to ensure Sheila's needs were met.

The professionalism, compassion, and dedication displayed by the Adult social work team were truly commendable. From the moment they received the referral they were very proactive with trying to engage Sheila.

The Safeguarding Advisor and Adult social team's Social Worker's ability to establish a sense of trust and safety played a crucial role in ensuring Sheila felt supported and heard. The commitment to providing immediate assistance while respecting the dignity and privacy reflects the highest standards of care.

Furthermore, the collaborative efforts among different agencies were seamless and well-coordinated.

To date Sheila has received support from an Independent Domestic violence Advocate, support to access medication from GP, support with the landlord to make necessary repairs to shower, a basic assessment, a Comprehensive assessment, Care and support plan and a Care and Support Plan review. Telecare installed and OT intervention, sensory assessment completed.

Self-neglect and hoarding pilot

This is a project that is being funded exclusively by Royal Greenwich Health & Adult Services with the support of the Safeguarding Adults Board. The aim of this work is to promote a better, evidence-informed and more effective multiagency approach to how such cases are dealt with in the borough. Self-neglect is defined in the Care Act 2014 as a lack of self-care to the extent that it threatens personal health and safety. It can include neglecting to care for one's person hygiene, physical or mental health or their physical environment. Hoarding is listed in the act as a specific example of self-neglect and is defined by a compulsion to acquire new possessions and/or a reluctance to discard possessions one already owns. The resulting clutter can amass to truly dangerous proportions, leading to significantly increased risks associated with fire, trips and falls and disease associated with unsanitary conditions. Hoarding Disorder is now recognised as a distinct psychiatric condition by the NHS and is diagnosed when hoarding behaviour results in psychological distress and functional impairment in the person who hoards (e.g. the kitchen can no longer be used to prepare meals, the bathroom cannot be used to bathe etc.).

The Self-Neglect & Hoarding Pilot was launched by Royal Greenwich because of a significant increase in the numbers of hoarding cases being encountered in the local community in recent years and research showing that self-neglect is a prominent theme in 45% of all Safeguarding Adult Reviews conducted nationwide, as defined in the National SARs Analysis (Preston-Shoot, 2021).
The aims of the pilot are:

- To improve the local offer made to people with hoarding behaviours and to those engaging in other forms of self-neglect.
- To promote evidence-informed approaches being adopted by professionals when working with this cohort of service-users.
- To provide opportunities for more "joined up" multidisciplinary working between the public and voluntary sectors and the NHS.
- To strive for better outcomes for people who engage in self-neglect.

There are 4 streams to this work which are detailed below.

The Buried in Treasures Workshops
One of the key initiatives of the Self-Neglect & Hoarding Pilot has been the launch of a dedicated **hoarding support group for residents of Royal Greenwich**. Prior to this, we were signposting people to support groups as far away as Tottenham and towards the few online support groups which exist. A key priority was therefore to establish a regular, in-person hoarding support group based within the borough.

The support group follows a highly structured, bespoke **cognitive behavioural therapy (CBT)** programme that has been designed specifically for people who struggle with clutter and hoarding behaviours. This CBT approach is recognised in the academic literature as the most widely researched treatment intervention for problematic hoarding and provides psychoeducation alongside strategies to challenge maladaptive thoughts and beliefs about one's personal possessions and practical tips for **enhancing motivation, reducing compulsive acquiring** and developing skills in sorting and discarding.

An important element of the Buried in Treasures Workshop is to help people who hoard understand that this is a **mental health issue** with a complex aetiology including psychological factors, possible genetic factors, learned behaviour from others, issues relating to executive dysfunction and unresolved trauma.

The first of these *Buried in Treasures Workshops* commenced in

September 2023 and runs on **alternate Thursday lunchtimes for 1.5 hours**. We are extremely grateful to the **Woolwich Service User Project (WSUP)** for providing a free venue for this support group, which attracts 8 regular participants. More recently, this has been supplemented by a new, weekly support group which is held on **Monday evenings in the Town Hall**. This is also well attended and was established to address the issue of people wanting to participate, but who were unavailable to attend the Thursday lunchtime group due to other commitments.

As the Buried in Treasures Workshop follows a structured programme, it is anticipated that future groups will be rolled out periodically for new cohorts of participants. Feedback obtained from the current cohort of participants has already identified anxiety about the cliff-edge withdrawal of support once the Buried in Treasures programme has been completed, and this has led us to consider the provision of a **regular "maintenance" support group**.

One of the very positive things to see has been how the Buried in Treasures Workshop has helped address deep-seated feelings of **shame, stigmatisation and isolation** that are often experienced by people who hoard. It has been heartwarming to see the development of informal support networks emerge as an offshoot to the Buried in Treasures Workshop (e.g. some participants opting to share their contact details with one another and keeping in touch with one another outside the group to prove **peer support**).

The support groups are supplemented by regular **text and video updates** sent to participants via a WhatsApp Broadcast List (which does not involve sharing participants' phone numbers). These provide encouragement to complete the designated "homework" tasks alongside links to hoarding-related information and relevant podcasts and other media that may be of interest. This has been well-received by participants.

One problematic issue is that there is currently only **one regular facilitator** for these groups; a social worker in the Complex Care Team who uses the Non-Clinician's Facilitator's Guide provided by the academics who developed the programme. Efforts to recruit more facilitators both from adult social care and Oxleas Mental Health are ongoing in order to ensure this initiative is sustainable and not overly reliant on one individual to ensure its continuity.

It is positive to note that we have recently been approached by colleagues based in neighbouring boroughs and NHS Foundation Trusts who have heard of our initiative and have expressed an interest in emulating the Buried in Treasures Workshops model in their own areas.

The Self-Neglect & Hoarding Risk Panel

Another key initiative launched as part of the pilot has been the Self-Neglect and Hoarding Risk Panel. This adopts a multi-agency approach to self-neglect and hoarding and enables any professional grappling with such a case to bring it to this new advisory panel with the aim of collaborative strategizing of solutions and new approaches to consider adopting. Self-neglect and hoarding cases can be amongst some of the most challenging faced by professionals, exacerbated further by the fact that evidence clearly shows the very significant risks involved in such cases and the disproportionate prevalence of self-neglect as a prominent theme in Safeguarding Adult Reviews. The rationale for developing this panel stems from the plethora of research which shows that the complex psycho-social phenomenon of self-neglect and hoarding behaviour is best addressed when a multiagency approach is adopted with professionals from different disciplines.

This operational panel commenced in September 2023 and currently sits every six weeks and is attended by a representative from core group stakeholders including Oxleas Mental Health, RBG Adult Safeguarding, RBG Complex Care Team, RBG Environmental Health, RBG Housing, Live Well Greenwich and the London Fire Brigade.

Thus far, analysis of referrals into the panel indicates referrals from multiple sources, especially Oxleas Mental Health, Adult Social Care and RBG Housing. Referrals from Children's Services and the Probation Service have also been made. Referrals are open to any professional in the public and voluntary sectors The lead social worker for the pilot presented to the Registered Providers Community & Management Forum meeting on 7 March 2024 and it is hoped that we will start receiving referrals from registered social landlords.

Another issue of note is that initial thematic analysis of the cases presented to the panel outline a recurrent issue

whereby professionals struggle to maintain the frequency of engagement that evidence suggests is necessary in such cases. Potential solutions to help address these challenges are currently being explored.

The Self-Neglect & Hoarding Strategic Group

The third element of the pilot has involved the creation of a strategic group that sits above the self-neglect and hoarding risk panel. This consists of senior managers (Assistant Director level and above) from Housing, Environmental Health, Health & Adult Services as well as from Oxleas Mental Health. The Borough Commander of the London Fire Brigade, the RBG Head of Adult Safeguarding and an Inspector from the Metropolitan Police Service also sit on this panel, which meets quarterly and is chaired by the Director of Health and Adult Services.

The remit of the Strategic Group is to review the progress of the Self-Neglect & Hoarding Pilot and to be informed by the data and trends that are being generated as the pilot progresses. Additionally, the Strategic Group is well-placed to foster and promote a more integrated, joined up approach to this challenging area of practice. This includes not only trying to promote a better "whole council" approach to self-neglect and hoarding, but also extending this to include our partners in Mental Health and the Emergency Services.

Embracing Innovation and Promoting Evidence-Informed Practice

Finally, the Self-Neglect and Hoarding Pilot has sought to promote evidence-informed practice by rolling out a series of training and awareness-raising sessions across both the Royal Borough of Greenwich and Oxleas NHS Foundation Trust, as well as to several voluntary sector partners including Mind and Bridge Mental Health. These sessions have included presenting to multiple individual teams within Oxleas Mental Health and RBG Health & Adult Services and RBG Children's Services as well as providing specific sessions for the benefit of local GPs. Training sessions have also been delivered as part of the adult social care in-house training programme and have also been incorporated into the Assessed and Supported Year in Employment (ASYE) programme for newly qualified social workers.

These sessions aim to provide practical information about the new initiatives mentioned above alongside psychoeducation regarding hoarding disorder and a summary of current trends emerging from academic research into problematic hoarding. Facilitating this is the fact that Royal Greenwich now actively participates in the UK Hoarding Partnership (UKHP). This is an initiative headed by Professor Nick Neave, a psychologist at the University of Northumbria. The UKHP is a group of professionals, academics, and people with lived experience from around the country interested in better understanding hoarding and related behaviours. It was developed in response to growing interest from professionals from around the UK who were keen to adopt best practice when working with individuals exhibiting self-neglect and hoarding behaviours.

One of our social workers now sits on the UK Hoarding Partnership's steering group which has resulted in excellent networking possibilities with professionals all over Britain who have a specialist interest in self-neglect and hoarding and who are embracing innovation and alternative approaches towards supporting people in this challenging area of practice. Professor Neave has been supportive of our local self-neglect and hoarding pilot here in Royal Greenwich and has previously presented at the Royal Greenwich Hoarding Strategic Group.

Is your home cluttered?

There's now a friendly support group for people in Royal Greenwich who have a lot of stuff.

- **Do you struggle getting rid of things or organising your possessions?**
- **Is it difficult to use rooms in your home because they're full of your belongings?**
- **Do you buy more things than you can use, or struggle to resist picking up freebies?**
- **Are you, or anyone else, concerned that you have difficulties with hoarding?**
- **Would you like to learn tips on how to de-clutter and how to stop over-acquiring?**

This group is free and is open to anyone. It offers a confidential, judgment-free environment with people who know what it's like.

For further details please call **020 8921 2446** or email **hoarding-support@royalgreenwich.gov.uk** for more information.

Supported by

WSUP Oxleas NHS LFB LONDON FIRE BRIGADE ROYAL borough of GREENWICH

Case Study- Olivia

Olivia is a 52-year-old single mother who lives with her 2 children in a 3-bedroomed council rented property in Royal Greenwich. Olivia experiences various challenges in relation to both her physical and mental health and has a long history of hoarding behaviour. Both her children are currently on the Child Protection Register, and a significant contributing reason for this is due to the property being cluttered to the extent that Children's Services were concerned that it presented a risk to the children's safety and welfare. Olivia's Tenancy Enforcement Officer was also aware of her long history of hoarding behaviour and was concerned at the risk this posed to Olivia, her children, and their neighbours.

Olivia's case was referred to the new Self-Neglect & Hoarding Risk Panel for advice on how best to approach this situation. At the same time, Olivia was persuaded by her children's social worker to start attending the new Buried in Treasures Hoarding Support Group which is provided by Health & Adult Services as part of their Self-Neglect & Hoarding Pilot Project. Olivia shared with her peers and the support group's facilitator that she had previously had a forced clearance undertaken by the local authority several years before and she had been highly traumatised, stigmatised and humiliated by this.

When Olivia disclosed to the support group that she was feeling overwhelmed and harbouring some thoughts of being "unalive" at the prospect of the proposed decluttering intervention, the facilitator later spoke to her about this privately. With her consent, it was agreed that these concerns would be passed on to her allocated worker at Oxleas Mental Health Hub. This person was then able to provide a targeted intervention to support Olivia with her fears and anxieties about the proposed supported clearance. Olivia also consented to the support group's facilitator liaising with her children's social worker about Olivia's anxieties about the decluttering intervention.

When Olivia's case was subsequently presented to the multiagency Self-Neglect & Hoarding Panel, all of this important information was therefore able to be collated and discussed by the panel members. It was identified that whatever action was taken by statutory services, it was imperative that there be no repeat of the intervention undertaken some years before, which resulted in Olivia feeling that she lacked any agency, choice or control over her own home and her own belongings.

Using the experience gained by the Complex Care Team in Health & Adult Services, the Self-Neglect & Hoarding Panel strongly recommended to RBG Housing and RBG Children's Services that a particular specialist service provider that works exclusively with people who hoard should be seriously considered in this instance. It was explained that this specialist provider would adopt a highly person-centred and empowering approach. Olivia had visits from three specialist companies who provided quotes. RBG Housing and RBG Children's Services agreed to equally co-fund the decluttering intervention with the service provider with whom Olivia felt she had developed the most trust and best rapport. At the same time, Olivia was able to be informed by the support group facilitator that she was entitled to a Care Act Assessment whereby her needs (as opposed to those of her children) could potentially be explored. Olivia has declined a Care Act Assessment at this time.

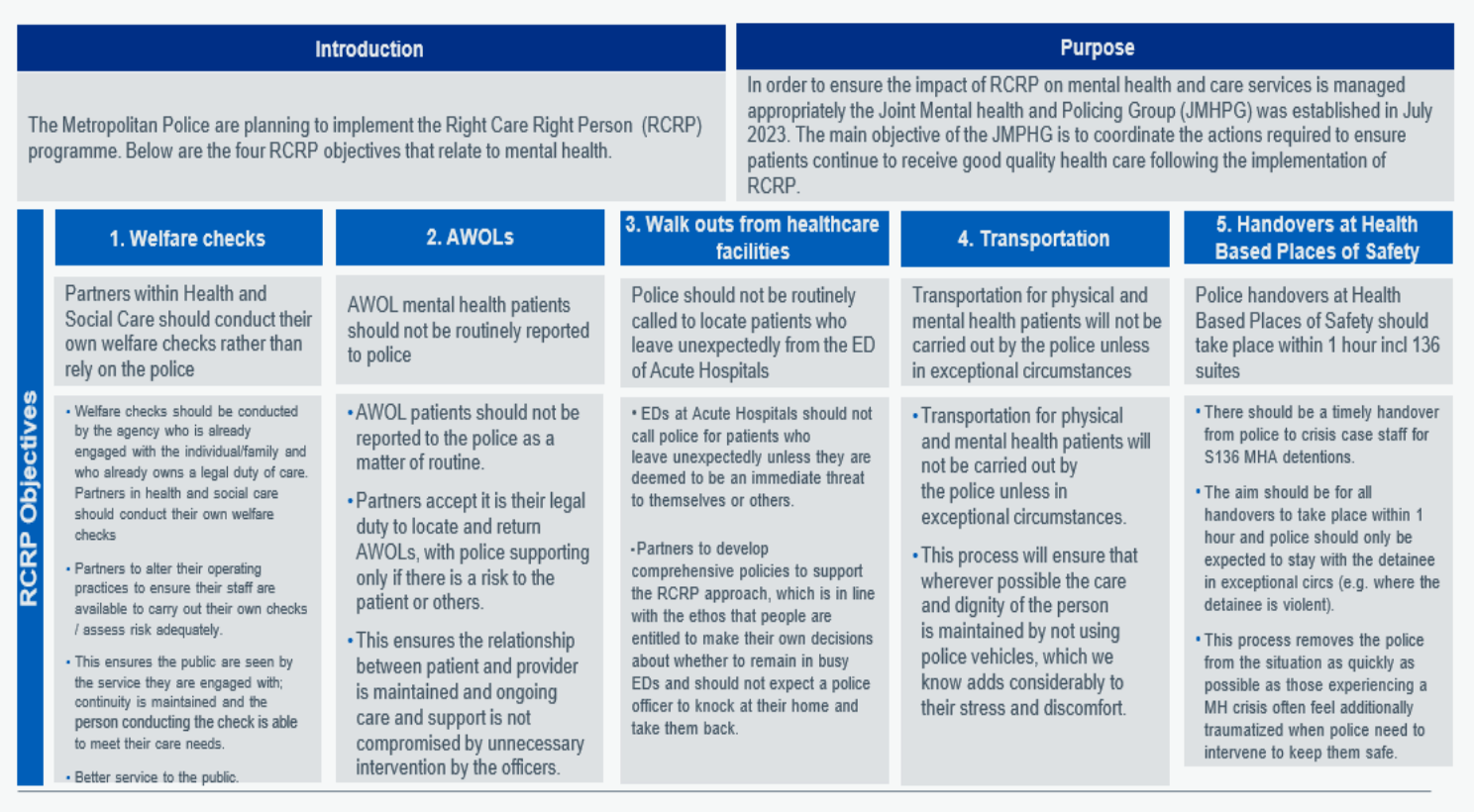
The decluttering intervention was undertaken over a series of several weeks. During this time, Olivia's wellbeing was able to be continually monitored by the facilitator of the support group and she also received support and encouragement from her peers attending the group. Olivia fed back to the support group that she considered the intervention to have been very successful and found, to her surprise, that it had been a positive experience in which she felt she was at the centre of the decisions being made.

Both the Tenancy Enforcement Officer and the children's social worker have both subsequently confirmed that there has been a marked reduction of clutter in the property and an associated reduction in risk to Olivia and her children. The children's social worker has subsequently stated that she may now even be prepared to consider recommending that Olivia's children be removed from the Child Protection Register and be re-categorised under s.17 of the Children Act 1989 as Children in Need. Support has also been put in place to help Olivia ensure that, going forward, the gains in useable living space in her home are able to be maintained and to support her to develop the appropriate parenting skills in this regard. Promisingly, Olivia continues to be a regular attender at the Hoarding Support Group as she is anxious not to become complacent as she now understands that her hoarding behaviour stems from complex and entrenched psychological mechanisms and past trauma.

Right Care: Right Person

- Right Care, Right Person is an operating model designed to ensure that when there are concerns for a person's welfare linked to mental health, medical or social care issues, the right person with the right skills, training and experience will respond to provide the best possible service.
- This operating model is being implemented in the context of the 'London All-Age Mental Health Crisis Care Agreement' which was published in July 2023. The agreement between health organisations and London Councils, the Metropolitan Police and the London Mayor's office, outlines an ongoing commitment to provide better access, experience and outcomes for anyone using mental health services in London.
- As part of that commitment, agencies and organisations from across London have set out a path to help keep people safe, free from harm and able to access the care they need in the right place at the right time. An important part of that pledge includes ongoing work to ensure that assessment and detention under the Mental Health Act should only occur when detention is the only option to support someone out of crisis and should always be a last resort.
- Support for people in crisis will be tailored to each person's needs and will ensure their voice, and the voices of their families and carers are central to decisions made about their care.
- Right Care, Right Person was fully implemented In November 2023

The four objectives of the RCRP model are detailed below.



In response to this new initiative and the concern that there may be risks for vulnerable adults the Safeguarding Adults Board held an exceptional SAB meeting on 2nd November 2023. In attendance were key partners from adult social care and health including the Detective Superintendent from South East BCU. Updates were provided from Met Police, Oxleas NHS Foundation Trust, Lewisham and Greenwich NHS Trust, Adult social care and NHS South East London integrated Care board. Assurances were provided including policy changes, escalation processes and training for staff. It was agreed that the board would keep Right Care,Right Person as a standard agenda item. The SAB received additional assurance reports during board meetings in December 2023 and March 2024, as well as the Safeguarding Executive partnership group receiving updates in February 2024.

Safeguarding Adults Reviews

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

Section 44 of the Care Act 2014 (and the Care and Support Statutory Guidance 2016) states that a SAR must be arranged in the following circumstances:

- When an adult in its area dies because of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.
- 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.

The Safeguarding Adults Review Evaluation Sub-Group (SEG) meets to consider all referrals for potential Safeguarding Adults Reviews as well as good practice case examples. Any partner organisation can refer to the SEG if they believe someone has been seriously injured or died as a result of neglect. Once a decision is made to undertake a SAR an independent reviewer is appointed, and a panel is convened to oversee the process.

The Royal Greenwich Safeguarding Adults Board hasn't published any SARs this year; however has considered **9** new SAR referrals. Out of these 9 referrals **3** were deemed to meet the criteria for a mandatory Safeguarding Adults Review plus an additional case which is being undertaken as a discretionary SAR as the SEG believes there is still learning to be gained.

All four new SAR referrals have a focus on self-neglect, substance misuse and mental health. The SARs will aim to answer some key questions specifically:

- The interface between mental health services and substance misuse services and how was this managed.
- Responses to protected characteristics and whether reasonable adjustments were made.
- How are problems of engagement managed and how were interfaces between agencies, including housing managed.
- Responses to, and leadership in, mental health crisis

The SAB has also commissioned a joint SAR and Child Safeguarding Practice review (CSPR) which is ongoing. This review involves both an adult and child from the same family and we hope that this will reinforce the See the Adult: See the Child message.

All the Safeguarding Adults Review referrals received had an element of mental health and most of the referrals were in relation to self-neglect.

All published reviews can be viewed via the Royal Greenwich Safeguarding Adults Board website www.greenwichsafeguardingadults.org.uk

In addition to the work of the SEG the Safeguarding Adults Board asked for assurances in relation to published SAR Alexander. Assurances were requested in relation to recommendations 6 and 7.

Recommendation 6: GSAB and partners should review how best to monitor locally the use of Community Treatment Orders and those who receive support under the CPA. The GSAB should seek assurance that both are utilised effectively to enable recovery. If national change is required, they may wish to raise this at a regional level, but in the interim GSAB should work with their partner agencies to better support Responsible Clinicians and care coordinators undertake the responsibilities of their role within a supportive, but accountable framework. In line with recommendation 1, particular consideration should be given to decision making for patients from BAME backgrounds.

Assurance

The purpose of a community treatment Order is to allow suitable patients to be safely treated in the community rather than under detention in hospital, and to provide a way to help prevent relapse and any harm – to the patient or to others – that this might cause (MHA Code of Practice para 29.5). Only patients who are subject to s3, 37 or 47 may be considered for a CTO. Oxleas NHS Foundation Trust has begun to implement actions aimed at supporting care coordinators and responsible clinicians. These involve:

- CTO workshops, funded by Health Education England, to improve the understanding and practices of staff in using CTOs. Staff have found the workshop comprehensive and informative.
- Edge Training have produced a guide for the use of CTOs, specifically tailored to reflect the trust's policies and procedures.
- QI Project. Carried out in another borough, but still proving useful. Once the project has been delivered from the mental health legislation team, it will be implemented across all community mental health teams in Oxleas.
- Adoption of PCREF (Patient and Carer Racial Equality Framework), providing a collaborative approach to combat racism.

Recommendation 7: GSAB may wish to highlight to partner agencies the expectations set out in the statutory Care and Support guidance, NHSE/I and ADASS practice guidance in respect of out of borough placements. GSAB may also wish to request London SAB review and, if necessary, revise regional pan London Safeguarding guidance on out of borough placements where individuals are at high risk of foreseeable harm or have complex care needs. This should also consider obligations to involve practitioners responsible for care management and review, as well as commissioning and safeguarding officers in placing authorities who have responsibilities for provider concerns or large-scale enquiries.

Assurance

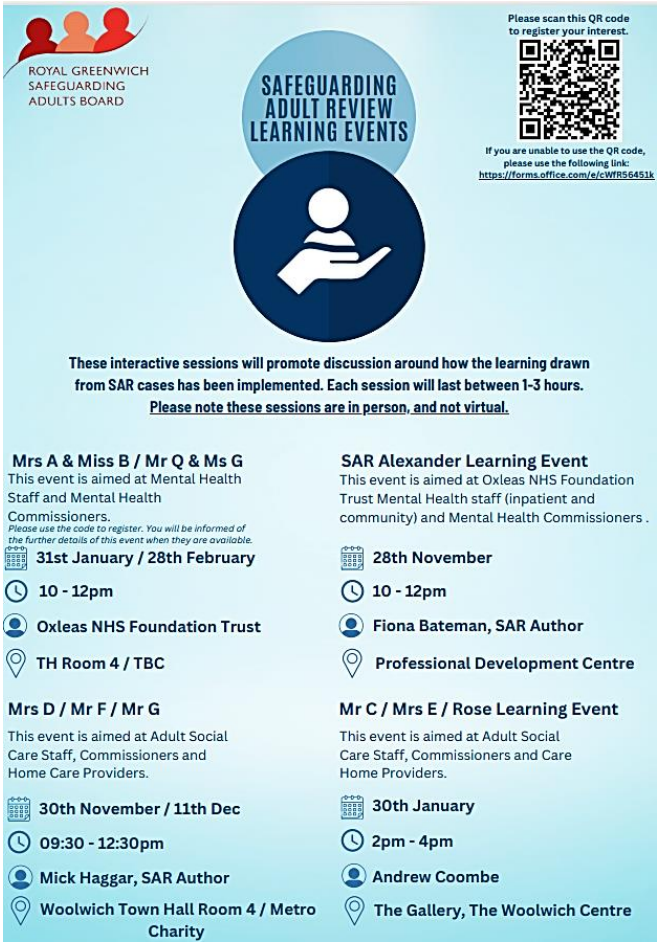
A legal briefing was produced and shared with the partnership which highlighted the expectations set out in the statutory Care and Support guidance, NHSE/I and ADASS practice guidance in respect of out of borough placements.

A new task and finish group (OOB Placements Assurance Meeting) was established which was chaired by the Head of Adult safeguarding, this group identified a list of out of borough placements and developed a Policy Statement - Quality Assurance in Out of Area Placements. This work was then passed over and monitored by the Adult Social Care Quality Board (ASCQB) which hold monthly meetings, membership includes Oxleas NHS foundation Trust Mental health colleagues, commissioning, safeguarding and Principal social worker.

An assurance report was shared with the Safeguarding Adults Board in June 2023.

Safeguarding Adults Review Learning events

The learning and development subgroup commissioned eight SAR learning sessions. The reviews were grouped by theme for example, self-neglect in own home, care home related deaths and mental health homicides. Three of the sessions were presented by the SAR authors, whilst the other 3 were presented by experts from Integrated Care Board (ICB) and Oxleas NHS Foundation Trust. Specific organisations were targeted to attend sessions which were deemed most relevant, however with the understanding that learning is always open to everyone.



The decision was taken to make all of these sessions 2 hour, in person sessions. On reflection we may have secured more attendance if we have implemented a mix of in person and virtual or a hybrid approach. The total number of delegates who attended was approximately 150 from a mix of organisations including care homes, mental health services and voluntary sector, however majority of staff who attended were Royal Borough of Greenwich staff.

Feedback was positive with all delegates agreeing that their knowledge has increased, that the sessions were thought provoking and subject matter relevant. All delegates agreed they would recommend these sessions to colleagues and that the sessions met their objectives.

Delegates stated some improvement could be more breakout rooms and opportunity for smaller group discussion Delegates stated they would be sharing the learning with their teams, through supervision and team meetings.

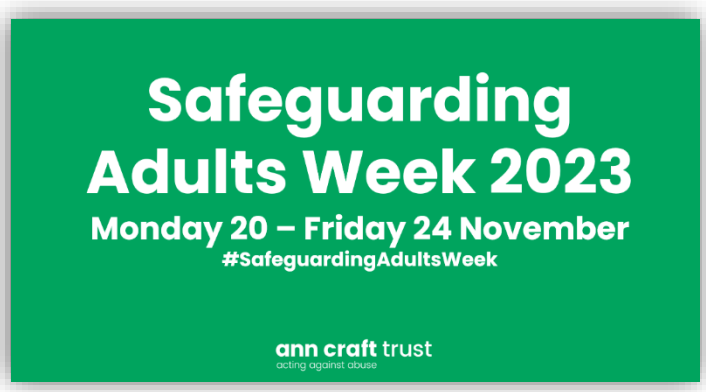
Discussions during the session were useful and highlighted areas of improvement that the board may wish to consider as a result of the SAR learning. Some areas of continued improvement were discussed.

- Not being afraid to share information especially around safeguarding matters.
- Using multi-agency meetings to bring all relevant agencies together to best support people, including third sector providers.
- Professional curiosity and not being scared to ask questions.
- Increased awareness of self-neglect and how to support those who do not want to engage.

"The session was very informative and a lot to learn from the session".

"It was good to see how learning has been implemented in day-to-day practice"

Safeguarding Adults Week 2023



This year the London Safeguarding Adults Board along with London Safeguarding voices group produced a programme of events accessible to all London boroughs. Royal Greenwich Safeguarding Adults Board took the decision to support the London wide programme rather than creating a further local programme for the week. Feedback from previous Safeguarding Adults Weeks have highlighted the difficulty for staff to attend all the different training opportunities when national, regional, and local programmes are offered. The Safeguarding Adults Board shared the London wide programme across the partnership and encouraged them to circulate amongst their organisations and teams.

The below table shows the number of attendees at each event during the week across London, unfortunately we do not have the information of the breakdown of each borough, and this has also been feedback to the London Safeguarding Adults Board.

	London Online Programme		
National Adult Safeguarding Awareness Week	20-Nov-23	421	
	21-Nov-23	323	
	22-Nov-23	461	Conference Day
	23-Nov-23	407	
	24-Nov-23	350	
		1962	

As part of the week an annual virtual conference was held on the Wednesday 22nd November 2023, as part of this event a request was made for local SABs to hold a service user hub who could engage with the conference and share their feedback. Royal Greenwich held a hub for service users with a learning disability based at Sherard Road Greenwich Day opportunities centre. The Safeguarding Adults Board manager attended along with a Safeguarding Adults Support officer, support staff and team members form the Community Learning Disability Teams, a free lunch was also provided.

The event was not as well attended as we would have hoped; however the people who did attend were engaged with the event and were able to ask questions via the chat function on Microsoft Teams. Feedback has been given to the London Safeguarding Voices group that perhaps it was difficult to cater for both professional and people with lived experience simultaneously.

In addition, the Safeguarding Adults Board held an awareness raising campaign in the library at The Woolwich Centre. In attendance was the safeguarding adult team, live well Greenwich, drug and alcohol services and London Fire Brigade; we also had material to promote the Hoarding support group and information on domestic abuse. The event went well, and many good conversations were had with people who felt they were experiencing abuse or needed extra support. We were able to offer people support directly through Live well Greenwich and took some information to follow up referrals for people.

Work of the Sub-Groups

Learning and Development Sub-group

- The learning and development sub-group has assisted in the delivery of the Safeguarding Adults Review learning events as well as the promotion of London SAB Safeguarding Adults week.
- The learning and development sub-group have also assisted with the LFB training of domiciliary care providers, which will now be rolled out to adult social care staff.
- The sub-group have also supported with engagement work and building better relationships with partners to ensure better multi-agency working.
- The group have future plans to develop more learning content including videos to share the learning form Safeguarding Adults reviews and hopes to hold a partnership wide networking event later in 2024.

Quality Assurance and Performance

- Work is still underway to develop a South-East London wide pressure ulcer policy to replace the national policy, which was withdrawn, there is currently a reduction in the number of pressure ulcer safeguarding, however it remains high.
- After reviewing SE-London wide policy on whether a S42 enquiry should finish once an individual has passed away that if there were any ongoing risks, a S42 enquiry should be pursued and completed.
- Data analyses shared with the board including the increase in complexity and numbers of safeguarding concerns as well as the increase in referrals from emergency services.
- The group has undertaken research in relation to unsafe discharges and shared the ICB quality alert system which any agency can use for health concerns.

Safeguarding Adults Review Evaluation Group

The Safeguarding Adults Evaluation Group has been meeting every other month and considering whether cases referred meet the criteria for a Safeguarding Adults Review.

The group have also been hearing good practice examples and sharing these amongst their agencies.

Community and Engagement

- This sub-group is newly established and is chaired by colleagues from public health along with representation from voluntary sector, safeguarding adults and community engagement colleagues from Royal Borough of Greenwich.
- The sub-group has undertaken extensive research to identify the disparity in the numbers of Safeguarding Adults concerns received and the demographics in the borough. It was identified that the number of referrals received were proportionally low amongst those from an Asian community.
- The sub-group developed a communication plan along with an action plan which was agreed by the Safeguarding Adults Board in March 2024.
- The community and engagement sub-group will now focus their efforts on outreach and engagement with community groups which will aim to break down the barriers of safeguarding amongst community groups and ensure that engagement is sustainable.

Case Study- Anthony

Anthony was a 30-year-old gentleman known to a Greenwich mental health team. The Anxiety, depression, personality disorder team (ADAPT) is part of Oxleas Foundation trust and this gentleman has been known across several mental health teams since his adolescence. Anthony has a diagnosis of autism spectrum disorder (ASD), psychotic disorder and depression and lived in supported accommodation.

Anthony was being financially abused, his mother reported that he had been talking to scammers on his mobile phone, who had taken a lot of money from him, and that he was laughing inappropriately about this when she had asked him about it. He said that he was talking to the singer Ariana Grande and that he had given £1500 to them. He indicated some understanding that this may represent a scam, but that he enjoyed talking to the people concerned and this singer had featured in his delusional ideas previously.

He had been encouraged to try talking to other people at his accommodation, but he had not engaged with this in part due to his constantly being distracted and looking at his mobile phone. This prompted the multi-disciplinary team to discuss and to raise a safeguarding adults concern.

The team Safeguarding Adult Manager concluded that Anthony had downloaded apps on his mobile phone to enable him to access these people who were scammers, and that he continued to remain at risk of further financial abuse.

During this period, he became more mentally unwell and was detained in hospital under the Mental Health Act 1983 (2007). A safeguarding planning meeting was held on the ward but unfortunately, he was unable to contribute much towards due to his mental state and lack of insight at that time, but staff involved him as much as he was able.

It was decided that the Approved Mental Health Practitioner (AMHP) Team would undertake a Mental Capacity assessment for his finances, whilst he was an inpatient. His care agency also attended the meeting so they could support him when discharged and he was helped to change phone numbers, passwords and to block unwanted contacts on his social media platforms.

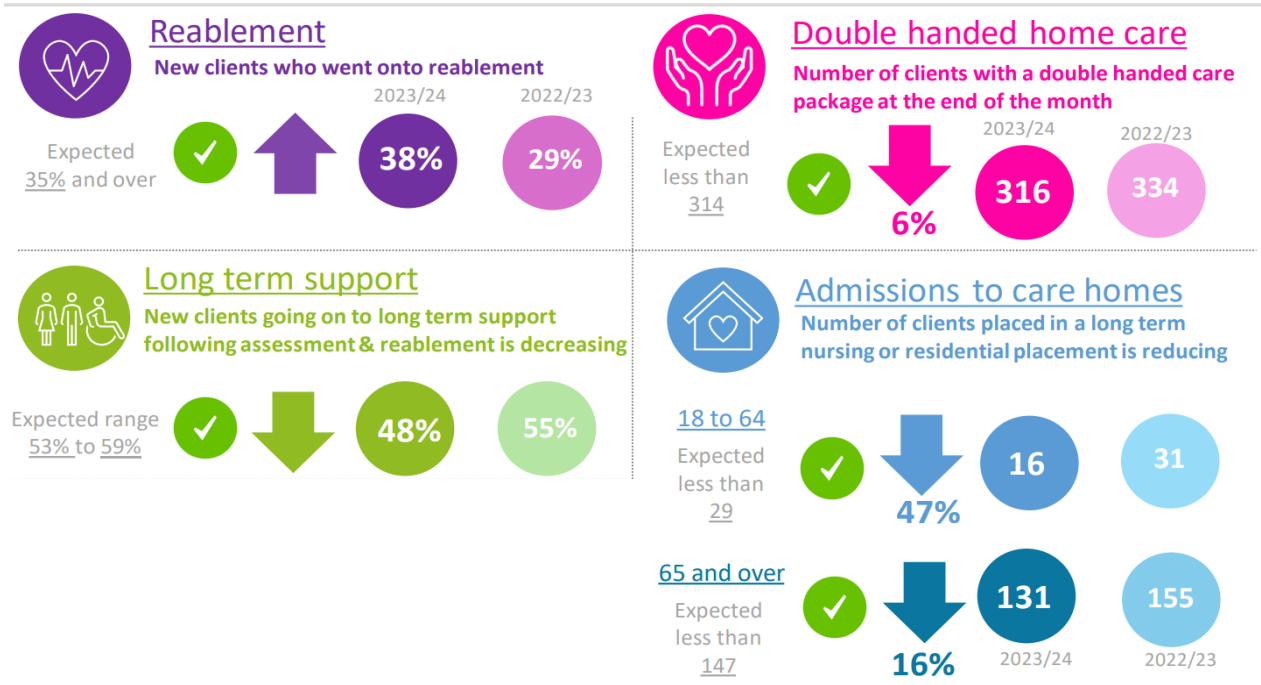
The bank was also alerted, and he was supported to remove those social media outlets where he was being targeted the most. He agreed to stop speaking to the person impersonating Ariana Grande and to allow his mother to manage his finances going forward; having made this decision during the MCA assessment where it was determined he had the mental capacity to make unwise decisions around sending money to scammers. It was agreed that if this did not work for both mum and son then an appointee could be considered so that they could maintain a good relationship as this was a concern from Mum.

It was established that his loneliness was a driving factor in how he came to be abused, and he was referred instead to a befriending service to promote human interaction and reduce his isolation.

Health and Adult Services- Royal Borough of Greenwich

Highlights

- Managing increased demand across adult social care with more contacts and requests for assessments
- Introducing a risk based policy for those waiting for assessment including a focus on those who have waited more than 90 days
- Improving outcomes to residents through
  - More clients going onto reablement
  - Fewer clients going into long term support
  - Increased independence with less complex care packages
  - Decreased double handed care packages
  - Fewer admissions to care homes
- Increasing referrals to reablement by teams particularly by HID
- Reablement managing throughput with increased number of clients completing reablement and more independent with smaller ongoing care packages
- Whilst there are increased request for DOLS, the team is managing this with fewer ongoing cases in progress
- OT since October has made really good progress in reducing the numbers of clients who are waiting for assessment
- Along with higher demand at the front door teams have made excellent progress in ensuring clients receive their annual review including those who are placed out of borough
- Progress in increasing the number of carers who have eithe a separate, joint or review and with more carers are being supported with a direct payment



Borough of sanctuary

The Royal Borough of Greenwich has officially been awarded Borough of Sanctuary status, in a unanimous panel decision by the City of Sanctuary Local Authority Network. This means that Royal Greenwich has been recognised as a place that welcomes and values the contribution of refugees, migrants and those seeking sanctuary. This year we launched the Borough of Sanctuary Policy 2023- 2026.
www.royalgreenwich.gov.uk/downloads/download/1367/borough_of_sanctuary_policy

This award is not only recognition for the substantial policy and practice changes we have made as a Council, but it is also confirmation of our commitment to making sure that Royal Greenwich continues to be inclusive and welcoming, that we are meeting people's specific needs, and that we will continue to listen to and amplify the voices of refugees, asylum seekers and migrants. At a time of increased pressure on those with uncertain immigration status, being awarded Borough of Sanctuary status is something for the Council and the local community to be hugely proud of.

Our goal is that refugees, asylum seekers and migrants are able to fulfil their potential and contribute to Royal Greenwich's community, culture, and economy, while living in safety and security.

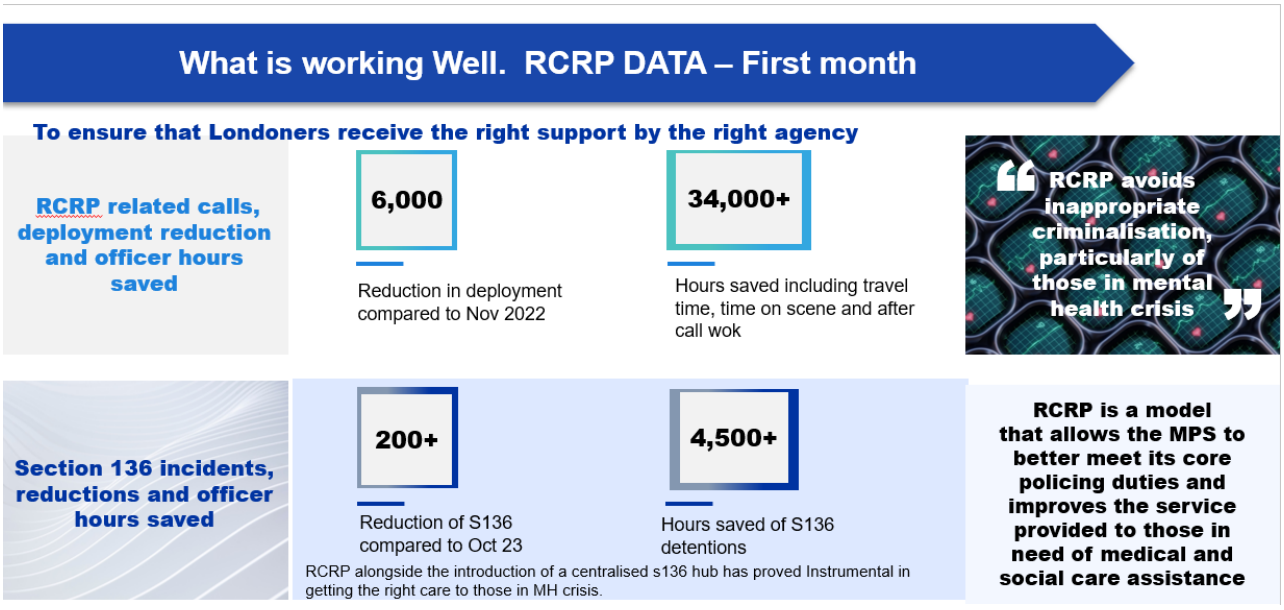
Metropolitan Police

The CONNECT programme has been launched and replaces the MERLIN system, this new system delivers an integrated core policing IT solution, which will enable the transformation of operational policing services within the Metropolitan Police Service (MPS). This will be achieved through the replacement of standalone legacy applications and building on the investment already made in mobile devices.
Links information and intelligence via POLE data:

- Person
- Object
- Location
- Event

The Central Vulnerability Hub (CVH) pilot to improve initial investigations into missing people being trialled at South and South East BCUs. With our A New Met for London delivery on improving our support to victims, we are overhauling our support to missing persons, those suffering mental health crises and young people at risk of exploitation. The proposed Central Vulnerability Hub (CVH) will be a centralised hub of subject matter experts who have been trained to become specialists in missing person cases. The Hub is made up of officers and staff who are trained and specialise in assessing and managing missing persons. The CVH can more precisely and consistently identify the highest risk cases – reducing unnecessary demand on our frontline. Officers participating in the pilot have received additional training from Frontline Policing Delivery Unit, MO2 and Police Search Adviser (PolSA), on a range of topics including assessing risk, conducting high quality investigations, and working with specialist units. As well as the training officers and staff receive throughout the pilot, they will also have access to colleagues from the central missing persons team for practical advice. Evaluation of the pilot will consider a range of metrics, including total demand, demand by grading, accuracy of risk assessment, duration and quality of investigations, and officer views via surveys' officers and staff will be trained to specialise in assessing and managing missing persons, managing the triaging and progression of all missing cases, before passing longer-term cases to BCU Missing Person Units (MPU).

Right Care: Right Person is now operational and has been working well.



NHS South East Integrated Commissioning Board (ICB)

NHS South East London Integrated Care Board (SEL ICB) was established on 1 July 2022, so 2023/24 saw its first full year of operation. In March 2023, NHS England announced efficiency requirements for all ICBs nationally to reduce running cost allowances by 30% by 2025/26, with a minimum of 20% cuts achieved by April 2024. Understandably this had a significant impact on SEL ICB, with a review of all ICB functions and costs and many staff being subject to consultations and job changes. The safeguarding function of the ICB was excluded from stage 1 of the Management Cost Reduction (MCR) process and as a result the impact was minimal in 2023/24, however there was a commitment to undertake an independent external review of safeguarding in the ICB and a report and recommendations are expected in early 2024/25.

One focus for adult safeguarding in 2023/24 has been to ensure that GPs and other primary care staff are competent and confident in responding to adult safeguarding and domestic abuse concerns. The primary care domestic abuse service, jointly funded by the ICB and RBG, has continued to have a positive impact with a further 74 primary care staff trained. The Her Centre have received 49 domestic abuse referrals from GP practices with 27 high risk cases referred to Multi Agency Risk Assessment Conferences (MARAC). It is anticipated that building links with Greenwich Health (GP training provider) in 2024/25 will further improve primary care engagement with domestic abuse and safeguarding training.

The ICB in Greenwich has continued to work closely with RBG and other partners in improving the Enhanced Health in Care Homes offer to ensure that safe healthcare is offered to this vulnerable group of residents, and this has included a recommissioning of the primary care service offered to care homes with a new GP provider selected."

Oxleas NHS Foundation Trust

Safeguarding achievements:

The Safeguarding adult team have been working with 2 staff in the generic safeguarding role of "Specialist safeguarding Nurse" who currently work between the children's and adult safeguarding team, working in Multi-agency Safeguarding Hub (MASH) and with our adult teams supporting our staff in their safeguarding work. This has been a further step for the trust's Think family agenda and supports safeguarding being everyone's business in the organisation.

Oxleas continue to build on our domestic abuse work stream which now includes, face to face and E-learning Domestic Abuse (DA) training for staff, a new stand-alone staff DA policy and a trust wide DA strategy led by the Domestic abuse lead who is a key part of the safeguarding team.

Our safeguarding adult hubs in each borough continue to support our staff with complex safeguarding cases, giving them access to senior staff in the trust to get advice and supervision, which has led to high quality safeguarding adult enquiries and continue to receive good feedback.

Priorities for 24/25:

- We continue to focus on the Think family approach within all our work, we already have a joint safeguarding adult and children's committee and will be taking this further with the development of one trust policy and annual report for safeguarding in 2024. We have also introduced "Think family" champions replacing our safeguarding children champions, and these staff get communications, networking, and training opportunities across all safeguarding.

- We aim to embed routine DA enquiry and safe effective pathways for responses to DA within the organisation, this will be informed by work with service users with lived experience of DA. We are also hoping to further develop partnership working with DA specialist services to include "in reach" opportunities and co production of resources.

- Following SAR's around self-neglect in all 3 boroughs we work with, we are updating our staff intranet page with resources to support staff, circulating information and actions from these SAR's and doing a local embedded learning event in 2024 to improve practice.

Metro GAVS

We're engaging with G-HIVE - Greenwich Hub for Influence Voice & Engagement, which through activities and

digital infrastructure, is supporting communities in Greenwich to have greater influence in the health & social care system, fostering collaboration across sectors, with the overall aim of creating better local services. greenwich-cvs.org.uk/services/voice-influence-representation-and-engagement/greenwich-hub-for-influence-voice-and-engagement

Metro GAVS have been key partners in influencing the set up and membership of the Community Engagement Subgroup

Metro GAVS continues to represent and build the capacity of the voluntary community and faith sector in Greenwich, our membership for voluntary organisations and community groups working with adults, is conditional upon having a safeguarding policy and that contact staff/volunteers know what to do if abuse is suspected. Each year the voice and infrastructure manager and the Safeguarding Adults Board manager meet to ensure the voluntary sector policy template is up to date.

Metro GAVS is working with the HER Centre regarding a lack of awareness of the different forms of abuse that constitute Safeguarding. Discussions are being held to determine how work can be undertaken with various communities to help understand how abuse is defined in different cultures.

London Fire Brigade

This year the London Fire Brigade ran four bespoke sessions and spoke with approximately 80 domiciliary care providers about fire safety in the home, what 'triggers' to be aware of/look out for when visiting client's homes and how to make a referral into LFB for a Home Fire Safety Visit. The sessions were very well received with very positive feedback, and we are now in discussions in regard to delivering the sessions to RBG's social worker cohort.

LFB have also continued to raise awareness of Home Fire Safety Visits with adult social care teams to ensure that referrals are made in a timely manner.

The LFB has also been involved with preventative work alongside the Safeguarding Adults team and have managed to gain entry and ensure fire safety measures are in place to adults at risk who would not engage with other statutory agencies. The London Fire Brigade borough commander continues to be an engaged member of the Safeguarding Adults Board and the London Fire brigade are fully engaged with the self-neglect and hoarding panel.

Safeguarding Adults

The safeguarding adult's team have been working on improving engagement and relationships with partner agencies, this work has been led by the Safeguarding Adults Advisor. Over the year the safeguarding adults team have meet with the following partners agencies:

- Oxleas NHS Foundation Trust District nursing services
- Lewisham and Greenwich NHS Trust, safeguarding adults' team
- Care homes and domiciliary care agencies
- Oxleas NHS Foundation Trust- community mental health teams
- Greenwich and Bexley Hospice

This work has delivered better relationships with partners to ensure better multi-agency working. Outcomes of this work have included establishing monthly meetings to discuss safeguarding adults' cases, improved representation at various panel meetings, dedicated email addressed being set up, improvements in timescales for S42 enquiries being met. The team have also ensured there are continued good relationships with internal managers within adult's social work teams.

The Safeguarding Adults Team have been working jointly with commissioning colleagues, community safety and Met Police to address concerns in relation to modern slavery with the care sector, specifically in relation to oversight of sponsorship arrangements, this will be closely monitored, and an assurance report will be presented to the board.

The Safeguarding Adults Team continue to attend 13 various panel meetings including Multi-agency Risk Assessment Conference (MARAC), problem premises panel, rough sleeping panel and self-neglect and hoarding panel.

The Safeguarding Adults forms which are used to record and manage Safeguarding S24 (1) and (2) have been changed to ensure compliance under The Care Act and to address concerns raised in recent audits in relation to the low conversion rates from concern to enquiry. These forms were launched in January 2024 in consultation with all Safeguarding Adults Managers (SAMs) and staff trained on how to use them. We hope that this work will lead to improved conversion rates in future performance reports which will be monitored at the board.

Lewisham and Greenwich NHS Trust

During 2023/24 arrangements were in place to safeguard adults in contact with Trust services, and the Trust is fulfilling its duties under the Care Act and the Mental Capacity Act.

Staff across the Trust have worked hard to realise the 6 principles of adult safeguarding.

- 423 Deprivation of Liberty Safeguarding Applications were made, a 48% fall in numbers since the peak of the pandemic.
- Trust staff raised 2665 adult safeguarding alerts, a 29% fall in numbers since the peak of the pandemic.
- Training figures remain very high, but training is almost exclusively completed online.
- The predominant safeguarding concern for adults in contact with the Trust remains neglect.
- Three safeguarding policies have been refreshed in line with new national guidance, the Mental Capacity Act Policy, the Domestic Abuse Policy and the Adult Safeguarding Policy.
- We continue to work closely with our local partners in adult services and the local safeguarding adult.

What Next?

- We need to prioritise face to face learning so we can be assured that staff are able to recognise and respond to safeguarding adult concerns.
- We need to recruit to the team to ensure we remain fully staffed.
- We need to prioritise that a Routine Enquiry question into domestic abuse is embedded in both EDs.
- We need to ensure all inpatient units recognise Deprivations of Liberty.
- We need to improve the adult safeguarding referral form and mental capacity assessment form on Icare to support effective practice.

Highlights

The Mental Capacity Act (MCA) protects and empowers people who may lack the mental capacity to make their own decisions about their care and treatment. The Trust Mental Capacity Act Policy has been completely revised, and now incorporates the Restraint and Deprivation of Liberty Policy. It is currently progressing through ratification. The policy was largely drawn from the Mental Capacity Toolkit developed by Bournemouth University and the National Centre for Cross Disciplinary Social Work.

The Safeguarding team deliver bespoke face to face sessions on request to wards and departments. New face to face training at Level 3 is now on offer. The e learning for adult safeguarding has been completely revised but the E learning on the MCA remains out of date with recent Court judgements. This is a priority to update in 2024/5.

Although training compliance is high, there is a concern that e learning whilst efficient is not as effective as face-to-face learning, and staff are deprived of the opportunities to learn from each other and discuss the complexities and challenges of safeguarding.

Statutory guidance on the Prevent duty has been revised this year, and the Trust remains in compliance with the new guidance. All staff undertake mandatory Prevent training. One member of the safeguarding team is awaiting an opportunity to complete Level 4 Prevent training.

Healthwatch Greenwich

The key role of Healthwatch Greenwich is to:

- Listen to people, especially those from the most deprived areas in Greenwich, to understand their experiences of local health and social care services.
- Share evidence-based insights with NHS leaders and decision-makers to help drive improvements across health and social care services.
- Provide trustworthy and reliable information and signposting to residents about health and social care services and the options available to them.
- Share areas of concern with Healthwatch England and CQC - who use this information when carrying out special reviews or investigations.
- Every month, we compile feedback from people using health and social care services in Greenwich into a summary report and send this to providers.

This year we published 35 following reports, including:
Young People's Contraceptive Use: Knowledge and Awareness of Long Acting Reversible Contraception (LARC). Our findings suggest low use of LARC methods amongst young people can be understood as a result of low awareness of availability, misinformation of side effects, and concerns that LARC methods reduce bodily autonomy. Moreover, attitudes are heavily influenced by personal and social networks.
Maternity care for asylum-seeking and migrant women in south east London. Using a peer research model to understand maternity care experiences of migrant and asylum-seeking women and birthing people living and using services in south east London. We found experiences marked by variations in care and barriers to access. This group of women and birthing people encounter challenges related to language and communication, limited understanding of the healthcare system and entitlements, inconsistent access to antenatal and postnatal care, and a lack of culturally sensitive services.

Carers Experience of Reablement Services. Benefits of the reablement service are evident in the improved health and well-being of service recipients. Carers spoke highly of the positive impact on their loved ones' mobility and confidence, and carers valued the brief respite these visits from reablement staff offered them.

Enter and view report: We carried out a series of visits to 5 learning disability care homes, supported living, and respite facilities in Greenwich to understand the quality of life, and views of those using the service and their families. All enter and view reports can be found on the Healthwatch Greenwich website

Usability Testing: Oxleas Children's Integrated Therapies Website. User testing found that the Children's Integrated Therapies website was largely inaccessible for parents despite their children being regular users of some or all the therapies. However, testing revealed that parents felt much of the information on the site could be useful to them if presented in a more accessible way, such as using plain English and avoiding clinical language.

Development Event

Under The Care Act a Safeguarding Adults Board must publish a strategic plan for each financial year that sets how it will meet its main objective and what the members will do to achieve this. The Greenwich Safeguarding Adults Board held a development event on the **22nd of February 2024** in order to develop the new strategic plan for 2024-2027. Partners were asked to consider the below questions and statutory and non-statutory partners were asked to prepare presentations, the group then discussed areas of similarities and challenges in order to form the basis of the new strategic plan.

In relation to safeguarding adults and underpinned by the 6 key principals of safeguarding, please answer the following questions.

1. ***Key issues/ abuse types****- what has been the main safeguarding abuse type/ area that your organisation has dealt with this year, is this consistent with previous years or an increase? Why might this be?*
2. ***What is working well?*** *- give examples of initiatives/ work that have been implemented or continues to work well, what evidence do you have this works well (include views of people with lived experience)*
3. ***What needs attention?*** *- what challenges or barriers has your organisation faced this year, what learning/ plans are in place to address this?*
4. ***Areas for Board consideration to be included in the strategic plan*** *– What areas would you highlight as key areas of concern for the board to address in the new strategic plan, what emerging trends/ themes are you aware of, what do you see as the main risks?*

Presentation was received from – Met Police, Adult social care, Community safety and housing, Lewisham and Greenwich NHS Trust, Oxleas Mental Health Foundation Trust, SE London Mind, NHS SE London ICB.

Reflections and discussion

Discussions focused on the commonalities around current and emerging themes for example transitional safeguarding and an all-age approach whether to health, housing or social care for care experienced young people or an all-age approach to exploitation. The board agreed to re-double its efforts to engage with the different communities in Greenwich more effectively and to focus on domestic abuse and financial abuse. The board agreed to look at training strategy and what we might be able to do for provision of multi-agency training especially Mental Capacity Act (MCA) and how we might support people to understand and implement the MCA. The board also discussed the Importance of Mental Health and impact of the pandemic of mental health and explore this further.

Safeguarding Adults Board theme for the next three years

The full new strategic plan 2024-27 can be viewed via the Safeguarding Adult Board website.

www.greenwichsafeguardingadults.org.uk

ABUSE

Stop it now!

Abuse is when someone treats you badly. This could happen anywhere; at home, at work, or even in a public place.

- Physical Abuse
- Neglect
- Financial Abuse
- Emotional Abuse
- Sexual Abuse
- Discriminatory Abuse
- Domestic Abuse
- Self-Neglect
- Organisational Abuse
- Modern Slavery

Staying safe in the Royal Borough of Greenwich.

If someone abuses you – tell someone!

Talk to someone: a member of your family, a friend, or someone else you trust. To report any abuse, or if you suspect someone is being abused, contact Health and Adults Services on 020 8921 2304 or 020 8854 8888

In an emergency phone 999

For more information visit greenwichsafeguardingadults.org.uk

ROYAL GREENWICH SAFEGUARDING ADULTS BOARD

ROYAL borough of GREENWICH