Lambeth Safeguarding Adults Board

ANNUAL REPORT 2021/22

Safeguarding Adults in Lambeth

www.lambethsab.org.uk

Contents

INTRODUCTION FROM OUR CHAIR

I want to open this report by paying tribute to the amazing people who have helped us to support and protect the most vulnerable in our diverse communities. Firstly, a huge thanks to Siân Walker (previous Independent Chair) and Janna Kay (previous Adult Safeguarding Lead for Adult Social Care) who, although no longer with the Lambeth Safeguarding Adults Board (LSAB), continue to ensure high quality and person-centred practice through the legacy of their years of inspirational leadership of our partnership. I also wanted to recognise the dedication and resilience of our wonderful practitioners from right across the partnership. I use the word resilience hesitantly, as I recognise that our staff should not have had to work under such pressure, and at the cost of our workforce's wellbeing. The pandemic continues to take its toll on our communities and our staff, and I know that we stand together to remember those in our communities, our families, and our colleagues who have suffered over the last few years.

Despite the pressures facing our staff, the partnership that is the LSAB continued to support brilliant and person-centred practice through some really innovative online training and support. We have benefited enormously from the creativity of Ceri Gordon (Adult Safeguarding Board and Partnerships Coordinator) who has taken our learning and development into a new league. Our duty continues to be demonstrating how our partners ensure that people with care and support needs are protected from abuse and neglect. We have had to be more and more creative around helping our partners both improve practice and demonstrate this, especially around better understanding and supporting diverse groups.

We ask each of our partners to provide information about their approaches to safeguarding, and we also challenge each other to better make safeguarding personal. In particular the Chairs of our sub-groups contribute enormous energy and leadership to ensuring the LSAB continues to drive excellence for those that need protection. I would like to thank Detective Superintendent Clare Kelland for her leadership of our Safeguarding Adults Group; Mala Karasu (Head of Adult Safeguarding at Guys and St Thomas' NHS Foundation Trust) for her prior leadership of the Performance and Quality Subgroup, and now the Mental Capacity Act Subgroup; David Rowley (Designated Adult Safeguarding Nurse for Lambeth) who has now left this role but who played such an important role in establishing the Mental Capacity Act Subgroup; Heather Payne (Head of Adult Safeguarding at Kings College Hospital NHS Foundation Trust) who is sadly moving on from her current role but who has been such an important part of the work we do and who has led the Performance and Quality Subgroup for the past six months; and Catherine Pearson (Chief Executive, Healthwatch Lambeth) who is also leaving the partnership, after having Chaired the Community Reference Group and played a key part in shaping this group. Finally, I would also like to thank Lizzy Lacey (Interim Adult Safeguarding Lead, Adult Social Care) who has stepped into this role and ensured that we maintain the close working relationships that ensure we do not lost pace in the work we are undertaking.

SAFEGUARDING ADULTS IN LAMBETH

Safeguarding adults is about protecting someone's right to live in safety, free from abuse and neglect. It is also about preventing the abuse of adults who might be unable to protect themselves because of their disabilities or care needs. **We all have a role to play.** We want to ensure that all Lambeth residents, health and social care staff and other professionals working in the borough have access to information about Safeguarding Adults that helps them understand what this looks and what steps we can take support adults who may be at risk of or experiencing abuse or neglect. The Care Act 2014 states that safeguarding duties apply to an adult who:

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

We have lots of information on the Lambeth Safeguarding Adults Board website which explains what abuse and neglect might look like.

How to raise an adult safeguarding concern:

If you are concerned about a person who is over the age of 18 years of age, they have care and support needs, and you feel they are being abused or at risk of abuse from another person, you should seek help for them.

Report concerns using the online form - this is the quickest and most secure way to report concerns. The person telling us about the possible abuse or neglect can remain anonymous.

In an emergency dial 999. If the person is not in danger now dial 101.

If you're not sure what to do, or need some advice, there are people who can help. You can talk to your GP or nurse, a social worker, a police officer or your key worker. They will help you to respond to the concerns.

WHAT IS THE LAMBETH SAFEGUARDING ADULTS BOARD?

The Lambeth Safeguarding Adults Board (Lambeth SAB) is a statutory board that co-ordinates safeguarding adults work in Lambeth. It's main objective is to help and protect adults in Lambeth who:

- have care and support needs[1];
- are experiencing, or at risk of, abuse or neglect; and
- As a result of those care and support needs, are unable to protect themselves from either the risk of or the experience of abuse or neglect

The Board has an Independent Chair and is a multi-agency partnership that includes a range of organisations.

We want to ensure that all residents and people who work with adults at risk in Lambeth know about safeguarding adults and know how to respond should they come across a concern. We do this by promoting and maintaining cohesive partnership working to safeguard adults at risk from harm.

The Board is not responsible for delivery of services, though those who plan and make decisions about services locally have representation at the Board and give the Board regular assurance on how their services respond to and protect adults at risk of abuse or neglect.

Our Budget:

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

In the year 2021/22 we received partner contributions from:

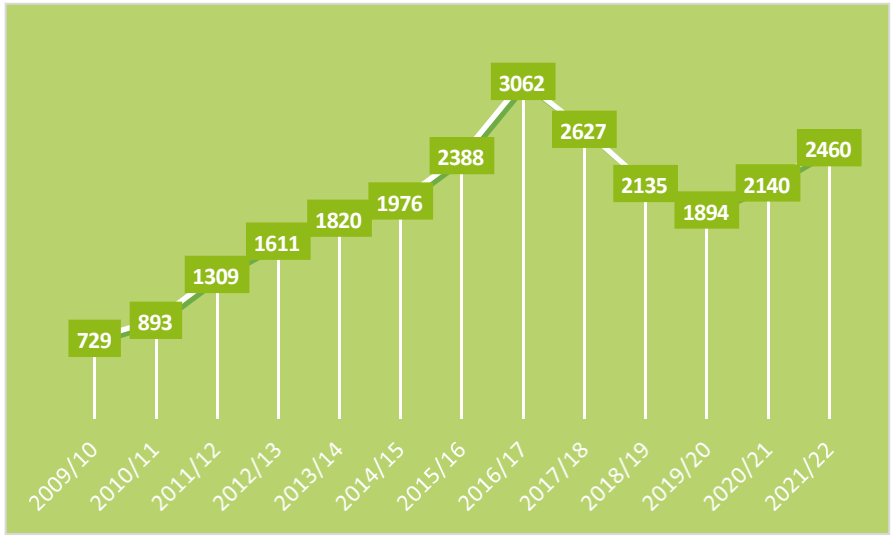
- London Fire Brigade: £500
- Mayor's Office for Policing and Crime (MOPAC): £5000
- South-East London CCG: £30000

This is the first year that we have received contribution from CCG colleagues, however we are likely to lose London Fire Brigade funding in the next year due to their own financial pressures.

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

[1] The Lambeth Safeguarding Adults Board's (LSAB) policy defines 'care and support needs' in the context of adult safeguarding issues as: *"needs that arise from or are related to a physical or mental impairment or illness."*

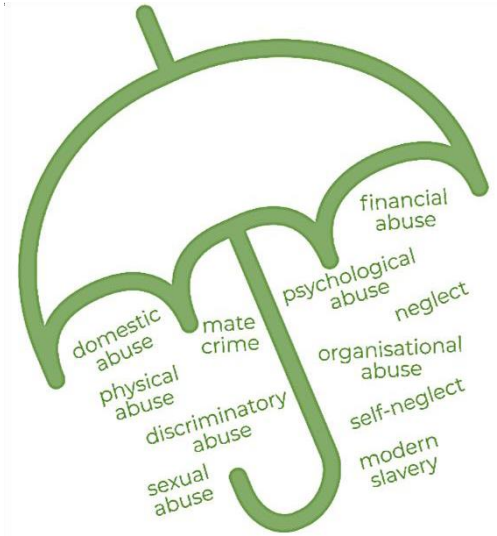
The Local Picture



2021-22 saw a 15% increase on the number of adult safeguarding concerns raised in the previous year. This follows from previous increase in 2020-21 which saw after several years of continuing decreases, which were a result of changes in practice in the borough. For instance, directing referrals to more appropriate pathways, such as an assessment of needs, before it is logged as a safeguarding concern. The more recent increases have coincided with the Covid-19 pandemic and may in part be a reflection of increased anxiety during this period.

We are now starting to see number of safeguarding concerns recorded each month stabilise.

Types of abuse



Abuse is when someone treats an adult in a way that harms, hurts or exploits them. It can take many forms – ranging from shouting at someone or undermining their confidence and self-worth, to causing physical pain, suffering and even death. Abuse can happen just once or many times; it can be done on purpose or by someone who may not realise they are doing it.

Neglect and acts of omission remain the most commonly reported category of abuse in Lambeth, featuring in 37% of all adult safeguarding concerns in 2021-22. This has been the most prominent form of abuse since 2013-14 (the first time we reported as a Safeguarding Adults Board) at which point it accounted for 33% of adult safeguarding. We have seen some small changes in this area, with an increase in the number of adult safeguarding concerns relating to private and family life, overtaking service-based risk for the first time. There have also been increases in the total volume of adult safeguarding concerns relating to physical abuse, psychological abuse, and financial abuse, though this must be considered within the context of greater numbers of adult safeguarding concerns overall. Self-neglect also continues to be a more prominent type of concern when compared to previous years. We also know that referring organisations see greater prevalence in other areas, such as domestic abuse. We want

to do more to explore datasets from the wider partnership so that we can gain a better understanding of this.

Location of abuse and source of risk

Abuse and neglect can happen anywhere including at home, in care homes, in day care centres, or hospitals. 57% of adult safeguarding concerns raised in Lambeth in the last year (2021-22) relate to abuse or neglect that took place in person's own home. home. This is in keeping with previous years and national trends, and these concerns may relate to domestic abuse as well as concerns about domiciliary care providers.

Most alleged sources of risk are known to the person, being friends or family (38%) or a service provider (34%).

Diversity and inclusion within adult safeguarding work

Our previous reporting on equalities data within adult safeguarding work showed that data relating to ethnicity was generally reflective of the Lambeth population. This considered broad categories of ethnicity, and so in 2021-22 we undertook a more detailed analysis in order to better understand the data. This has shown us that the majority of adult safeguarding concerns for people within the Black/Black British grouping are from a Caribbean background. According to the Lambeth State of the Borough report from 2016, Lambeth's largest non-white ethnic group is black African (11.5%), followed by black Caribbean (9.8%) This may suggest that we need to do more to reach Lambeth's Black African community, and this will be a continued focus as we move into the next financial year.

Based on this finding we also want to do more in the next year to look at other protected characteristics. What we know so far is that:

- Where primary service user group is known, this primarily relates to those with physical support needs (31%), followed by social support needs (17%), mental health support (12%), and learning disability support (7%). There are a large number (20%) where service user group is unknown; this may be a result of new people coming to notice over the course of the Covid-19 pandemic and where this data has not yet been recorded, or where they did not have care and support needs.
- 54% of safeguarding concerns relate to those identifying as female, and 44% relate to male. This is in keeping with previous data.
- 51% of adult safeguarding concerns relate to working age people between 18 and 65 year olds, with 48% relating to those age 65 and over.

There is also information that we are conscious is missing from our dataset. For instance, in 98% of the safeguarding concerns raised in the last year we have no data on sexuality. This is something we will be considering as part of our continued work to strengthen diversity and inclusion within adult safeguarding work.

WHAT HAVE WE DONE IN THE LAST YEAR?

Each year, the Lambeth SAB must publish its strategic plan outlining how it will meet its main objectives.

In February 2020, the Lambeth SAB agreed a new three-year strategic plan which identified our priorities and objectives for the next three years. 2021/22 marked the second year of enacting this plan, with a **building on our initiatives** in 2021/22. The Performance and Quality Subgroup plays a pivotal role in overseeing the workplan and the assurance that is presented to the Board. The below sets out our action plan for the year and the progress we have made.

Working Together

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

Targeted actions for 2021/22:

For the LSAB to build on work with Integrate Lambeth, to improve engagement with, and understanding of voluntary sector resources and how this can support the adult safeguarding agenda:

Over the course of the last year we have hosted four events aimed at this sector. This has included those sessions hosted as part of National Safeguarding Adults Week as well as session on what to expect when raising an adult safeguarding concern. Integrate Lambeth have supported this work by promoting events, increasing our ability to reach a wide range of organisations and community groups. Integrate Lambeth also supported up by promoting a survey to gather feedback on volunteer experiences in the last year, which was used to shape National Safeguarding Adults Week programme.

LSAB to pilot the Complex Case Framework to i) gather feedback on what works/needs to be changed ii) embed this way of working in practice

This piece of work was generated from learning from previous Safeguarding Adults Reviews in Lambeth (SAR Martin and SAR E). The final version of the Complex Case Framework was agreed at our July 2021 SAB meeting following a trial period. This was developed in collaboration with Bromley SAB (BSAB). Embedding this tool into frontline practice is an ongoing process, and since the tool was agreed we have focused on raising awareness amongst operational teams. To do this we have promoted the tool via digital communications and during in National Safeguarding Adults Week (with session hosted by BSAB). Board partners are continuing to discuss within team meetings, and we can already see evidence of the tool being utilised in practice. Our next steps will be to continue efforts to embed in practice and to review the effectiveness of the tool.

LSAB to seek assurance on how partners are improving responses to those that Self-Neglect or Hoard

In July 2021 the LSAB received a report which outlined current prevalence rates of self-neglect and our responses. This included feedback from partners on how they raise staff awareness and competence in this area, and how they promote learning from Safeguarding Adults Reviews (SAR Martin/SAR E). In addition, the LSAB considered how partners have adjusted

organisational systems and policies to embed more effective responses.
This report highlighted areas requiring further action, including that of dual diagnosis and commissioning arrangements. This will be an area of focus in the next year.

LSAB to receive a report outlining the types of crime relating to adults at risk, and how criminal processes aligned with adult safeguarding enquiry processes

The LSAB received a report in October 2021 from our partners within the Metropolitan Police Service (Central South Borough Command Unit). This considered the prevalence of cuckooing, hate crimes and domestic abuse amongst adults at risk and outlined police responses. As a result of this report, a programme of auditing has been established with Adult Social Care and the Metropolitan Police Service, to review at Adult Coming to Notice report (ACNs) sent to the local authority to determine their appropriateness and identify areas for learning.

LSAB to reach out to organisations in the borough who are not LSAB members, but who work with adults at risk, to raise awareness of adult safeguarding

In 2021/22 our focus has been on strengthening our connections with higher education colleges in Lambeth, particularly those who are commissioned to provide service to adults with learning disability or autism. As the first stage of this engagement, we have asked safeguarding leads to complete the Safeguarding Adults at Risk Audit Tool in order to identify areas requiring support. This will help inform our ongoing engagement in 2022/23 as we also look to establish relationships with other types of organisations.

LSAB to identify what and when LSAB work can be connected to other relevant partnerships including Lambeth Together, Lambeth Children's Safeguarding Children's Partnership, Safer Lambeth Partnership, VAWG Strategic Partnership, Housing Partnership, and other relevant boards.

There have been a number of areas where we have worked with other partnerships such as working with Safer Lambeth colleagues around Adult Family Violence (aligning learning from Safeguarding Adults Reviews and Domestic Homicide Reviews) and liaising with Safer Lambeth and the LSCP around transitional safeguarding. Nonetheless, this is still an area of work that could be strengthened and where we can be more proactive in highlighting the work of the SAB to these partnerships identifying areas of joint work for the next year.

Prevention and early action

We want to ensure that adults will be supported to feel safe, and that professionals and residents will be able to recognise risk and know how to respond.

LSAB to continue to hold a risk register which keeps track of identified current and potential risks for the partnership and what if any gaps require attention to prevent and reduce adult safeguarding issues

Our risk register has been renewed to consider risks that have emerged over the course of the Covid-19 pandemic and to reassess historic risks. This will be subject to continued monitoring.

LSAB members to raise awareness of available advance planning mechanisms in preparation for incapacity

In October 2021 the LSAB invited a presentative from the Office of the Public Guardian (OPG) to outlining planned changes to their service and the important role of future planning.
Following this discussion, the LSAB has promoted LPAs and other mechanisms of advance planning via our Board Bulletins.

The OPG also supported the SAB during our targeted week of events focusing on Mental Capacity (March 2022).

LSAB will deliver communication campaigns which are driven by need and shared across all agencies

The LSAB has launched new themed bulletins to complement our quarterly news update. These seek to raise awareness of key issues and draw attention to good practice and have covered topics including Adult Family Violence, homelessness, Making Safeguarding Personal and responding to complex cases. As we continue to build on this new strand of our communications, we are also looking to build in structure to measure the reach and impact of these bulletins (focus for 2022/23).

LSAB to receive training report which provides evidence of how organisations are embedding learning from Safeguarding Adults Reviews and integrating lessons in training compliance, and details of training compliance within partner organisations.

The LSAB received training assurance report in addition to submissions from Board partners via the regional Safeguarding Adults Partnership Audit Tool. This was considered by the SAR Subgroup and at Board level. The SAR Subgroup plays a role in monitoring the actions plans that are developed following SARs, and we continue to reflect on previous learning. As part of this, we have redeveloped our tracking tool to group learning from previous SARs together according to the main themes from the National SAR Analysis, which was completed at the end of 2020. This has allowed us to more clearly identify patterns and repeating issues that may require further attention as a partnership.

We continue to work on new methods for gathering assurance on how SAR learning is understood – for example in January 2022 a session was delivered which explored learning from SAR George and invited participants to feedback on challenges they see in practice. This will remain an ongoing piece of work.

Multi-agency MCA Audit to be completed, with targeted campaign to address understanding of Mental Capacity Assessments to be informed by analysis.

The LSAB received submissions from Board partners via the regional Safeguarding Adults Partnership Audit Tool. The MCA subgroup has also trialled a new local audit tool designed to look at quality of mental capacity assessments. The first formal audit using this tool took place in March 2022 and the planned analysis of these findings will allow us to better understand areas of practice which require further development.

The Board to receive a briefing on responses to rough sleepers

The LSAB received a report in July 2021 which provided a summary of the picture on rough sleepers locally and how this compares across London. This report highlighted the positive work Lambeth has done to date whilst also capturing the challenges faced by professionals working with rough sleepers and some of the key themes around entrenched rough sleepers (e.g. working with dual diagnosis which will be a consideration for the SAB in 2022/23).

For the LSAB to arrange/commission some targeted training which considers specific areas of safeguarding not covered in current training provision

Colleagues from the Metropolitan Police Service delivered two briefing sessions on providing witness statements for Adult Social Care and Health partners. These were recorded with the intention to make these available to wider partners.

Making Safeguarding Personal

Making Safeguarding Personal (MSP) emphasises a personalised, simplified approach to adult safeguarding, which prioritises the individual's wishes and empowers them, wherever possible, to feel they have choice and control. The outcomes must be about improving quality of life, wellbeing and safety for the individual themselves. The LSAB wants to ensure that all adults will feel listened to and have choice and control through the safeguarding journey

Targeted actions for 2021/22:

SAB Members to provide assurance around application of MSP in their own service areas.

The Safeguarding Adults Partnership Tool including focused section on Making Safeguarding Personal. The LSAB considered responses to this section of the tool in April 2021 and identified areas of focus as a partnership. This included a focus on strengthening supervision arrangements in order to provide discussion of MSP and cases of high risk. *[Resources: Supervision framework]*

Healthwatch to continue to obtain feedback from people who have been through the adult safeguarding process.

Throughout the year, Healthwatch Lambeth have continued to gather feedback from people who have experienced that adult safeguarding enquiry process in Lambeth. The LSAB considered this feedback and has committed to ensuring that this feedback is shared with frontline staff alongside promotion of tools and resources to support application of MSP. We also want to do more to incorporate feedback from staff involved in these enquiries going forward, so that we can also understand their perspective. It is also recognised that we need to do more to embed service user engagement throughout all partner processes.

SAB members to commit to equalities work within an adult safeguarding context including (i) consideration of how we improve representation and meaningful engagement with black, Asian and minority ethnic groups at the Board and its subgroups and (ii) SAB to receive regular reports from Local Authority safeguarding data which analyse equalities data in relation to safeguarding processes which can then inform which areas may require particular attention

Via regular reporting provided by Lambeth Adult Social Care the SAB has received new insight into how different ethnic groups are represented within safeguarding data in Lambeth and this has led to more meaningful interaction with the data. We are now looking at how we shape our response to what we have learnt so far. The SAB has also strengthened its relationship with Associate Director for Community Health and Engagement, which has now been made a permanent post within Lambeth Adult Social Care.

Nonetheless, there is recognition that there is still more to do in terms of representation within the SAB and its subgroup and we will continue to work on this area moving forward.

SAB to produce localised materials to promote and support understanding of MSP in practice.

The LSAB has established a new resource on the LSAB website which gives access to new animation, a quiz and a report produced by the Community Engagement Group (previously Community Reference Group), as well as easy access to external resources such as ADASS. This can be found at www.lambethsab.org.uk/MSP.

NATIONAL SAFEGUARDING ADULTS WEEK

National Safeguarding Adults Week took place in November 2021, and Lambeth hosted a number of well received events (see Community Reference Group update). We were also able to work with our colleagues across South East London to open up our programme and give Lambeth staff the opportunity to access learning and expertise from elsewhere. This included a session on the Complex Case Pathway hosted by Bromley SAB and led by Heather Payne (KCH Head of Adult Safeguarding) and which showcased what can be achieved when we work collaboratively.

Making Safeguarding Personal

Hosted in conjunction with Lambeth Council's staff conference week, this session saw good attendance from a range of organisations and services. Using the feedback gathered by the Community Reference Group this session sought to give participants an understanding of what Making Safeguarding Personal means in practice. We had good feedback from the session, and the polls used as have also given as a snapshot of professional understanding of MSP.

"It was an informative and involving session with practical examples"

"All of it, was excellent and reflective... really enjoyed hearing the voice of the adults, was very moving"

"The surveys were interesting, as well as the case examples"

"Presentation was really clear and really good use of examples, video and case studies"

Introductory session for volunteers

The CRG led a short session on Safeguarding Adults for volunteers and neighbourhood champions in Lambeth. This was developed in response to feedback gathered via an online survey. Prior to conducting this survey, the CRG proposed delivering a session to those supporting volunteers. However, the survey results indicated that the volunteers themselves needed further training and support. An introductory session was developed covering the types of abuse, definition of an adult at risk, signs and indicators of abuse or neglect and exploring the role of volunteers through case examples.

This session was held in the evening in an attempt to make more accessible for volunteers and neighbourhood champions who would not be able to attend during working hours and prompted discussion from participants about situations they have come across or have previously struggled with. As such, this session provided a good model for future open forums, along with themed events, so that people have opportunity to feedback on safeguarding issues that are important to them.

"A useful session for volunteer groups"

"Please host this session more regularly and in-conjunction with other councils"

Feedback from the session also reminded us that our reliance on online platforms can exclude some from the conversation, and we will incorporate this feedback into our plans as we seek to return to face-to-face events:

> *"I could not find how to manage the [interactive platform]… this is to do with not being IT literate. I was reluctant to use chat for same reason!""*

We also asked attendees how they would feel about raising an adult safeguarding concern, and this has shown us that there are still some uncertainties about what this entails. This will be considered as we plan future events for the coming year.

Cuckooing and adults at risk

> *"It was helpful to understand the different types of cuckooing and how [people] are targeted. I thought the session was great!"*

The CRG also approached Police colleagues for support in running a short session for voluntary and community groups looking at cuckooing. This session was led by PC Daniel McGlynn (Lambeth & Southwark Coordinator for ASB EIS and Vulnerable People & Places) with support from PC Laurence Lomasney (Camden Anti-Social Behaviour Team).

This session sought to help participants develop an understanding of cuckooing and its impact on individuals and communities and know how to respond to concerns of cuckooing. The session has attendees from a wide range of organisations working in Lambeth.

Radicalisation and adults at risk

Lambeth Council's Prevent Lead, Rupert Sutton, delivered an engaging multi-agency session which sought to give participants a better understanding of the radicalisation of adults at risk, including a closer look at the emerging risks in Lambeth and what to do if you have concerns about someone you work with.

Working with the Disclosure and Barring Service

Led by Kiran Rehal, the DBS's Regional Outreach Adviser for Greater London, this session outlined the benefits of working with the DBS and the different referral routes. This was an informative session for staff who need to engage with the DBS as part of safeguarding enquiries with practical tips for practice.

FOCUS ON MENTAL CAPACITY

Role of the Mental Capacity Act Subgroup

Chair(s): David Rowley (Designated Adult Safeguarding Nurse, CCG - Lambeth) and Mala Karasu (Head of Adult Safeguarding, Guys and St Thomas' NHS Foundation Trust)

The Mental Capacity Act Subgroup are tasked with overseeing the awareness, promotion and application of the Mental Capacity Act (MCA) 2005 within health and social care and throughout the wider community in Lambeth. The group also seeks to provide assurance to the Lambeth SAB that partners are ensuring and promoting MCA awareness, and appropriate application in practice. In 2021/22 the MCA Subgroup successfully carried out the first audit of mental capacity assessments across a range of key partners and launched the first Mental Capacity Week in Lambeth.

New Lambeth SAB audit tool

The MCA Subgroup have developed a new audit tool based on the Lambeth SAB MCA Guidance. As with the guidance, the intention is that this tool is simple and easy to use, and can be used to look at both 'simple' decisions and more complex decisions. The audit aims to gather assurance that professionals understand the MCA and that recording is proportionate to the decision being made, with a person-centred approach using the principles of the MCA.

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

Focus on learning: MCA Week

As part of the groups aims to raise awareness, a dedicated week of learning sessions was developed and took place between 14th and 18th March 2022. During this week the MCA Subgroup were successful in speaking to a large number of professionals working across Lambeth, with the aim of supporting professionals in the application of the MCA. In total eight sessions were held, each with a different focus:

- Introduction to Lambeth SAB Guidance
- Making Safeguarding Personal and MCA
- Learning from Safeguarding Adults Review: Executive Functioning
- Planning for the Future: Lasting Powers of Attorney
- Culture and capacity
- Advance Care Planning
- MCA learning from LeDeR (Learning from lives and deaths – People with a learning disability and autistic people)
- Deprivation of Liberty Safeguards (DoLS) and transition to Liberty Protection Safeguards (DoLS)

This week was extremely successful in terms of its reach, with attendance reports indicating that over 177 people participated in the week from a range of difference services (this number does not include those who attended multiple sessions).

The feedback we received from attendees was overwhelmingly positive, with 88% saying that they felt the session they attended would help them respond differently in the future, and an average of scoring of 4.35 to the question **"Do you feel more confident in your understanding of Mental Capacity having attended this session?"** (with 5 being definitely).

"Good pace, everyone felt validated and had an opportunity to talk, no question was left unanswered"

"I found it helpful to consider the importance of person-centred approach in Best Interests Decision making"

"The session broadened my understanding of the cultural issues and challenges with the MCA AND some practical ways to manage them"

"I appreciate each session probably builds on from the other, however as clinicians we can't attend all. A quick refresher about the mental capacity key principles at the beginning would have been useful to support the conversation/application of MCA to higher executive function"

"I'd like for this training to be more available to all staff"

"To be make clear which people/services/numbers we approach when we have concerns or issues. This training supported my idea that this is a really tricky area to work and how capacity can fluctuate so much which only adds to the complexity."

In addition to this feedback, we also received feedback which shines a light on the need to improve understanding of the basic principles of the MCA across the partnership, as some participants felt they were missing this. Feedback also highlighted the appetite amongst staff to access more training relating to the application of the MCA. The MCA Subgroup will now consider the feedback from this week and use this to plan future sessions as part of our continued aims to promote the proper application of the MCA.

Changes to the Community Reference Group

Chair(s): Catherine Pearson (Chief Executive, Healthwatch Lambeth) and Jill Gregson (Adult Safeguarding Lead, Faither Together in Lambeth)

The Community Reference Group (CRG) was established to act as a link between the SAB and the community. Over the course of 2021/22, members of the CRG took time to reflect on its role, noting the real success in in hosting a range of webinars and learning opportunities for the voluntary and community sector, and our residents (such as those exemplified above). These sessions talk to the preventative space of adult safeguarding, though the challenges in terms of capacity to host these session on a regular basis were recognised, as was the ability to reach those organisations who are not part of the core group.

Furthermore, the CRG reflected that there was a need for stronger links with statutory services and two-way communication with SAB partners, in order to give clear purpose to joining the CRG.

With these reflections in mind, the CRG have developed a new Terms of Reference. The principal changes include:

Changing our name to **Community Engagement Group** in to be more explicit about what our aims are. This change will come into place during 2022/23.

Establishing two strands to the groups work – this will include a core group membership which will focus on planning and meeting the objectives of the Lambeth SAB strategy. This core group will also help to facilitate Community Engagement Forums. These forums will aim to provide an open discussion space. The forums will remain open to all residents, service users, volunteers and frontline staff within Lambeth, and will be supported by the CE Working Group and the Lambeth SAB. The CRG will use its experience of hosting learning sessions and webinars to build these forums, seeking support from SAB Partners as required.

The CRG also hoped to expand the membership of our core group to ensure that we have the right people present and the group is representative of Lambeth; this will also help us to reach different Lambeth communities when promoting our forums and make sure that we have accessible conversations.

Current membership of the Community Reference Group includes:

- Healthwatch Lambeth
- Faiths Together in Lambeth
- Disability Advice Service Lambeth
- South London Cares
- Hourglass UK
- Age UK Lambeth
- Carers Hub
- Froglife Dementia Project
- Alzheimer's UK

Would you be interested in joining our Community Engagement Group and support the work we do to raise awareness of adult safeguarding in Lambeth? Get in touch!

SAFEGUARDING ADULTS REVIEWS

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

SARs are about learning and not apportioning blame. They set out to establish what may have gone wrong and to identify where agencies or individuals could have acted differently or worked better together. SARs also recognise the complexity of safeguarding work and will identify the areas of good practice too.

Key recommendations are made at the end of a SAR and this will often include the learning needed to prevent future incidents of serious harm or death from happening again. This learning is shared across all partners and is published on our website.

In 2021/22 we concluded one SAR. This SAR sought to identify learning from what happened to George and is outlined in more detail below.

Role of the SAR Subgroup

Chair: Clair Kelland, Detective Superintendent, Head of Public Protection, Central South BCU, Metropolitan Police Service

The SAR Subgroup plays a role in monitoring the actions plans that are developed following SARs, and we continue to reflect on previous learning. As part of this, we have redeveloped our tracking tool to group learning from previous SARs together according to the main themes from the National SAR Analysis, which was completed at the end of 2020. This has allowed us to more clearly see patterns and repeating issues, and identify areas that require our attention as a partnership.

Some of the key themes we have identified locally include:

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

As we move forward with this work we also aim to do more to incorporate regional and national learning into our local work plan.

The SAR Subgroup also reviews referrals for Safeguarding Adults Reviews, and in 2021/22 a new SAR was commissioned. This is a thematic SAR looking at the experiences of three individuals in relation to their diabetes management and the interplay between the Mental Capacity Act and the Mental Health Act. This review is being undertaken by Steve Chamberlain, and independent reviewer, and we hope to be able to report on the learning from this SAR later in 2022.

GEORGE

George is a 52-year-old man from an Irish background who lived with his younger brother Andrew. George has learning difficulties (and possible undiagnosed learning disability) and agoraphobia, and relied heavily on his older brother Michael for support until Michael's death in 2019, at which point Andrew became his main carer.

Andrew had a substantial history of domestic incidents reported to the Police and was violent towards his brothers. There were often disputes about money and who had control of their mother's pension when she was alive. In 2013, Andrew was sentenced to 5 years in prison following an attack on Michael. At this point, police call outs to the family home ceased.

Upon his release from prison Andrew was subject to conditions of residence at a hostel. Andrew was however found to be living in the family home at the time of Michael's death. Agencies going into the home at this time did not pick up on this.

Adult Social Care were contacted by George's neighbour Sheila, in March 2019. A safeguarding concern was raised about the condition of the property and the state of self-neglect of George. Work was undertaken to try and support the two brothers (George & Andrew) who were both struggling each in their own way.

In late 2019, Andrew set fire to the family home (a local authority property) whilst George was in the property.

George was supported by Sheila to evacuate the property.

Due to the extent of the fire damage George was unable to return to his home, where he had lived since 1979 with his mother and brothers.

A number of organisations were involved or aware of George and his brother. Working with the family was sometimes challenging and they frequently seemed to accept services only to change their minds at a later date.

What were the key multi-agency learning points?

Responding to Adult Family Violence: Professionals need to be able to identify and respond to cases involving financial abuse, violence and coercive control within families. Responses and interventions need to be tailored and appropriate.

Information Sharing:
The review highlighted the importance of robust information sharing agreements and ensuring that staff in all agencies understand how and when information should be shared.

Recognising Hidden vulnerabilities:
Agency systems assume literacy, IT access, and ability to attend unfamiliar venues. This played a role in George's disengagement.

Professional Curiosity:
Agencies did not display sufficient professional curiosity in understanding what was happening in this family, and this meant that they did not receive suitable support.

What has the Lambeth SAB done in response to this?

Responding to Adult Family Violence: This year we launched a suite of new animations to complement our masterclass series from 2020. This included a new animation focusing on Adult Family Violence which outlines some of the key learning points and directs people to watch the full training. All Board Members were tasked with promoting these resources, and this included embedding the resources within existing training, sharing in teams meetings, managers meetings or operational groups and embedding on intranet sites and in directorate emails.

All Board Members were also asked to provide assurance that they have reviewed internal domestic abuse policies and to ensure that these reflect findings and recommendations from this SAR G and Lambeth Domestic Homicide Review (Elaine) in regard to recognition of AFV. If they had not done this (due to internal structures for policy reviews), they were asked to give date by when this will done; this will be review by the SAB.

Information Sharing: The SAB led a multi-agency webinar which sought to better understand the barriers to information sharing. This gave participants an outline of the key learning from this SAR and asked them to reflect on what challenges they face in practice. Feedback included comments on difficulty in getting hold of partners, understanding each other's roles and the impact of high caseloads, competing demands and increased complexity. Only 31% of attendants knew where to find the Lambeth Data Sharing agreement. This feedback will be used to inform our awareness raising plans for the next year, where we will also seek to promote the new information sharing briefing developed in response to this learning.

Recognising Hidden vulnerabilities: The SAB asked Board Members to identify what is currently in place within their own organisation to pick up on hidden vulnerabilities. Responses varied depending on the service being provided but there were lots of clear examples of frameworks and mechanisms used within organisations to prompt reflection on hidden vulnerabilities or identify transparent and hidden vulnerabilities. The SAR Subgroup will play a role in ensuring proper scrutiny is given to these responses and to identify if additional action is needed.

Professional Curiosity: In January 2022 the SAB received presentations from partners within the MPS, ASC and Lambeth Children's Social Care which sought to explore what a culture of professional curiosity might look like in Lambeth, reflecting on the learning from this SAR. These presentations demonstrated some clear principles which should guide this approach (such as recognising unconscious bias and lived experience) whilst also prompting reflection on how this looks in practice: How do we empower staff to have and open and honest conversations, and enable reflective practice This will continue to be a focus over the course of the next year.

RESOURCES

- **Full report**
- **7-minute briefing**
- **Data sharing agreement**
- **Information sharing briefing**
- **Adult Family Violence animation**
- **Adult Family Violence masterclass**
- **Lambeth advocacy hub**

Individual Agency responses

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

Guys and St Thomas' NHS Foundation Trust

SAR George brought to the forefront the issues of Adult Family abuse which is becoming more evident at GSTT also from referrals received. The safeguarding adults' team will speak with all patients who disclose domestic abuse to ascertain the source of the abuse and if there were other adults in the household also at risk.
The case was presented to a variety of representatives from Trust services at a bi-monthly Safeguarding Operational Group and a good discussion held. The 7-minute brief was utilised, outlining the lessons learned and improvements shared.

The Trust utilises the sunflower lanyard for staff, patients and visitors to communicate hidden disabilities. These are available in every department and steer staff to enquire from the wearer what support they would require when accessing our premises/ services. Professional curiosity is explained and discussed at our safeguarding adults training and included in case presentations as a professional duty to be curious and not accept what is said if the professional has any concerns.

Using the complex case pathway is an excellent example of sharing information to promote patient wellbeing and prevent harm. The Trust also has a live register that identifies people with Learning Disability and or Autism (LD) who are admitted or are attending the hospitals daily. This allows for the LD specialist service to offer additional support to the patients and pick up any concerns early.

Clinical Commissioning Group – Lambeth

The learning from this SAR has been disseminated to the practice clinical staff including trainee GP registrars and Foundation Year 2 doctors. This has been supported with bespoke training.
During the training, Doctors are encouraged to ask patients about their household members and to link household members to Patient's Electronic Records.

On registration, patients are asked to identify their next of kin and family member's contact details of whom are entered on Patient's Electronic Records. The practice has a clinical meeting every Tuesday at which practice staff may raise concerns about vulnerable patients. There is also a fortnightly multidisciplinary 'huddle' for vulnerable patients over the age of 50, including those with a learning disability Easy read letters and leaflets will be used when appropriate.

Patients who live in Lambeth and reside just over the border between Lambeth and Croydon are included in the fortnightly huddle. If a referral to social care is required, a practice clinician will make the referral. The huddle district nurse for Croydon can hand over patients to their colleagues in Lambeth. The huddle personal independence coordinator who advises on benefits can visit patients who reside at the border of Lambeth and Croydon. A huddle community pharmacist can assist patients who require medication advice and was able to cross the border to Lambeth to visit patients.
The learning has been shared with colleagues in SEL CCG.

Furthermore, there is a domestic abuse template for general practice which is in draft.

South London and Maudsley NHS Foundation Trust (SLaM)

We have reviewed patient assessment tools to ensure they are able to identify hidden or underlying vulnerabilities and this review has been provided to the Safeguarding Adult Board.

The mental health trust provides mandatory training in relation to Information sharing within the context of safeguarding adults as part of mandatory training.

National Probation Service – Lambeth

Since unification of the National Probation Service and the Community Rehabilitation Company (CRC) in June 2021 there has been a London wide review of the information sharing agreements with partnership and 3rd sector agencies. In November 2021 there has been an updated agreement with the police regarding the information sharing agreements relating the multi-agency platforms. There has been a change in the management of those in custody to increase the information sharing between Prison and Probation including the medical staff working in the respective establishment.

When looking at the groupings for London this consists of a unique model sub divided by the 33 London Boroughs, each of which participate in a MAPPA level 2 and level 3 meeting which is comparable with other MAPPA areas. London has adopted an approach where they have an executive office where MAPPA business is coordinated for all of the London MAPPA area.

There has been a month on month increase in the volume of level 2 cases heard by the panel in Lambeth with an extra day per month for the panel convene. This is monitored both regionally and nationally with a comparison against the number of eligible cases in the borough / London.

Specialist intervention meetings have increased due to the increasing complexity of the cases within the Probation Service (PS). These extra meetings incorporate multi-agency working to support risk management in each area and give scope to react to local criminogenic needs and joint working with both statutory and non-statutory agencies along with increased information sharing.

Department of Work and Pensions (DWP)

DWP does have systems in place to support vulnerable adults and it is not reliant on Adult Social Services. The brothers' vulnerability was flagged on DWP systems and the support that the Job Centre staff provided was also recorded. The SAR report notes that in June 2019 it was a DWP Disability Employment Advisor who raised the question with Adult Social Care of TC's suitability to be MC's benefit claim appointee.

DWP's ambition is to be a flexible, inclusive and continuously learning organisation, able to identify the right solutions for our customers and their communities. As such it takes feedback from a wide range of sources to help improve its services for the most vulnerable claimants at critical points in their journey.

Some of the issues touched upon in this report have been discussed by DWP's Serious Case Panel (SCP), which was set up in late 2019.The SCP meets quarterly to consider systemic themes and issues that have arisen across DWP service lines, in order to agree changes and improvements.
It does not investigate individual cases but considers risks arising from a range of sources, including Internal Process Reviews, frontline feedback and Independent Case Examiner reports.

The Panel is made up of the Department's most senior directors, including the Permanent Secretary. External partners are also invited on occasion to provide additional expertise.

The Panel agrees recommendations for organisational learning and, where needed, will assign Director General or committee accountability for delivering these recommendations within the department. The Service Excellence Director General is responsible for updating Ministers on the Panel's outcomes.
Issues explored via the Panel so far include:

- how the Department supports vulnerable customers at higher-risk moments in their journey with us
- how we respond to customers who may be put at risk of harm because of an issue which is within our gift to resolve, and needs a rapid resolution
- how the Department engages with customers whose mental health issues pose an accessibility challenge

Lambeth Adult Social Care

Unallocated assessments are now dealt with at the front door rather than across different teams. This has increased ownership and focus on unallocated assessments so we can ensure we are completing assessments in a timely way.

We have also ensured that staff are engaging with Violence Against Women and Girls (VAWG) training and mandatory DV training as well as working more closely with VAWG around the review of the Multi-Agency Risk Assessment Conference (MARAC), increasing awareness within Adult Social Care of issues relating to adult family violence.

Metropolitan Police – Central South BCU

Central South BCU received two recommendations from SAR George, which have been completed and involved learning and debriefing for specific officers.

Firstly, around the importance of investigating and reporting the full circumstances around adults potentially at risk and living in challenging conditions and to ensure quality information sharing between safeguarding agencies. Focus on high standard of Merlin reports, sound decision making and effective information sharing.

The second recommendation concerned financial abuse between older siblings and the use of DASH questions to capture the relevant information. In Autumn 2021 all frontline staff received 'DA matters' training, which covered the controlling and coercive elements of domestic abuse and also different forms of abuse including Adult Family Abuse as part of a wider approach to tacking and reducing incidents of domestic abuse.

Work is ongoing on the BCU to give staff the confidence to be professionally curious in their approach to safeguarding adults. This supports the learning from SAR George and our hope is that the legacy of this SAR is that staff are committed to making safeguarding personal and a culture of 'professional curiosity' in all encounters with vulnerable people is evident.

Board Member achievements and reflections for 2021/22

Guys and St Thomas' NHS Foundation Trust (GSTT)

Last year was a busy year for GSTT safeguarding services as the Trust continued to work through the pandemic and began its restoration and recovery program with the return of many face to face services for our most vulnerable patients. The safeguarding team experienced an increase in the number of complex cases referred with significant numbers where patients were self-neglecting. The three highest reasons for a referral were neglect by others, self-neglect and domestic abuse (DA). This is a significant change with DA being the fifth highest reason for referral in 2020-2021 to third in the last year. In recognition of this the Trust is reviewing its DA services and staff training. The safeguarding adults team has received DA training from the Lambeth VAWG team and the team has since reviewed the DA component of the safeguarding training.

The Lambeth Safeguarding Adults Board (LSAB) with Bromley SAB produced a 'complex care pathway' facilitating relevant partners to come together as a team to consider the person and ensured individualised approach. The pathway has been disseminated across GSTT services who have found it very helpful. This approach to care and support provided good a framework for information sharing, partnership working, identifying risks and achieving best outcome for patients.

Recognising that application of MCA requirements is not consistent across the partnership the LSAB with partners have produced an MCA audit tool which has been trialled and found to be a good tool to use. This has been fed back to the LSAB and the Trust will use the tool for its MCA annual audit going forward. The Trust was involved in a number of events during the MCA week (14th to 18th March), presenting webinars on a number of MCA related topics, sharing tools with colleagues, and a focus on educational tools.

With all of face-to-face safeguarding and related training being suspended over the pandemic, extra efforts in providing training using a blended approach was undertaken to ensure that our training compliance remained over 85%. Training has been offered as webinars online or as e-learning packages together. All safeguarding and Prevent training are over 85 % in compliance. Safeguarding level 3 has been developed and offered to staff as a full day's training. The training is now available on the learning management system.

Within the Trust we have strengthened the governance for safeguarding adults through improved reporting and managing safeguarding concerns. The safeguarding adults service is being restructured in accordance with the Trust operating model to support and ensure that safeguarding underpins all clinical group activity and aligns with their complaints, clinical incidence and serious incident investigations.

The Trust has formally merged with the Royal Brompton and Harefield hospitals. This has resulted in merging and aligning of the safeguarding adults services. A workforce review is being undertaken together with a human resources consultation. The Trust has revised its Safeguarding adults and MCA related policies and procedures. The Trust is now also a member of the North-West London SAB

Preparation for implementation of the Liberty Protection Safeguards (LPS) is in progress. Profiling of staff for assessor training is underway with LPS awareness training being offered to staff. The Trust is represented in the national and London region LPS clinical reference groups and brings local and nation information to the Trust to disseminate widely.

The Trust has met with Lambeth Adult Social Care to look at a process of communication with regards to Section 42 enquiries. The aim of this exercise is ensuring a supportive process for improving communications, engaging in collaborative debrief following an enquiry and

clear escalation pathways to help teams with maintaining timeframes for different parts of the enquiry.

Clinical Commissioning Group (CCG) – Lambeth

Lambeth CCG adult safeguarding leads have remained principal partners of the Lambeth Safeguarding Adults Board (LSAB) and associated subgroups, contributing to the LSAB work plan throughout the year as well as contributing £30k to the Board's budget in 2021-22.

During the year the Southeast London CCG (Lambeth) has maintained its contribution towards safeguarding adults at risk of abuse or neglect through the development of robust governance processes and structures. These include the development and implementation of a Complex Case pathway, a local Mental Capacity Act policy and significantly on preparation for implementation of the new Liberty Protection Safeguard arrangements.

The Lambeth Adult Safeguarding Designate participated in the SEL CCG Safeguarding Executive Committee, specifically contributing to the development of a statutory review tracker, enabling identification of key strategic safeguarding learning themes for health services across South-East London.

The CCG has had a significant focus and role during the pandemic, supporting our local services and population on a range of measures such as Covid-19 testing and the vaccination programme within the borough including on developing approaches for people without capacity.

The CCG has continued to promote the development of adult safeguarding practice in primary care. This includes offering advice and support to GP Practices on a range of matters and promoting the development of adult safeguarding practice in primary care, in order to manage complex safeguarding concerns.

The role of the Designated Nurse for Adult Safeguarding and Named GP for safeguarding, continues to contribute to the successful safeguarding of adults within the London Borough of Lambeth, this is achieved by supporting primary care services and GP practices in implementing safeguarding strategies and processes, whilst also participating at safeguarding sub-groups within the borough, including the Violence Against Women and Girls performance and quality subgroup, modern slavery sub group , and Learning Disability Mortality Review programs .

We will soon be launching LeDer steering group in Lambeth, to ensure recommendations and learning is taken forward to improve practise. Finally, Lambeth CCG and Board said farewell to David Rowley in 2021 who had worked in the borough as Designated Adults Safeguarding Nurse for 5 years. David contributed to a number of work streams and will be missed although he has moved to a new post in safeguarding in the SEL team so will continue to have contact with Lambeth colleagues. In January 2022, we welcomed Romoke Abolade (preferred title Bola) as our new Adults Safeguarding Nurse from her previous job working on safeguarding at King's College Hospital – we're delighted to have her as a member of our team.

South London and Maudsley NHS Foundation Trust (SLaM)

This last year has been a real challenge for patients and staff. South London and Maudsley NHS Foundation Trust (SLaM) have been working hard to maintain the safety of all those who work in or use our service. During the year we have endeavoured to provide a responsive service to the people of Lambeth at the same time as experiencing an increase in referrals to our single point of access mental health triage service.

The challenges have brought opportunities to work differently. We have made full use of virtual meetings enabling SLaM to actively engage with the safeguarding partnership. The Safeguarding Adult Board has provided the opportunity to explore good practice and learn lessons as part of the safeguarding adult review process. We have also promoted the work of the board by sharing the learning resources produced by the board with our staff.

This year we Launched a revised SLAM safeguarding adult referral form improving quality of information sharing and capturing the personal perspective of the person at risk, ensuring their voice is heard within the process. We have Improved quality assurance and put in place

systems to improve our ability to provide reliable data relating to adult safeguarding.

The Lambeth Safeguarding Lead has been working in partnership with colleagues in the local authority to improve communication within the referral process. Our focus has been on delivering the message that the safeguarding process should be meaningful and personal to those who using our service. We have produced an organisational safeguarding strategy. As part of the strategy the Lambeth Safeguarding Lead will be promoting safeguarding best practice and will be rolling out an enhanced safeguarding supervision and training framework to our inpatient and community staff.

At a time when the extent of male violence against women and girls has been widely publicised SLaM has taken a zero -tolerance stance. As an organization we have recently acquired White Ribbon Campaign Accreditation aligning ourselves with the campaign promise to never commit, excuse or remain silent about violence against women and girls. Identifying and supporting those at risk of or experiencing domestic abuse and violence remains an area of our work that we as a mental health trust are committed to improving.

We recognise that the pandemic has exposed many residents to a variety of risk's and we have been working with a number of organisations to address the impact of Covid-19 within our communities. We have been working alongside The South London Listens Programme to meet these challenges head on – developing an urgent mental ill-health prevention response to ensure south London communities can recover from the impact of the pandemic. Despite the barriers to engagement posed by COVID-19, we managed to engage with many south Londoners including Lambeth residents to co-design a two-year mental ill health prevention plan. One of the major priorities is to address loneliness, isolation and digital exclusion. These are areas we know may increase the risk of abuse and self - neglect. During the next two years it is hoped the programme will recruit and train mental health champions and create over 50 mental health hubs across south London.

National Probation Service - Lambeth

The Probation Service (PS) Lambeth is a statutory criminal justice service that supervises all eligible offenders both in custody and in the community. We are responsible for sentence management in both England and Wales, along with Accredited Programmes, Unpaid Work, and Structured Interventions. The unification of services during June 2021 means the Probation Service (PS) is now responsible for all sentence management for community supervision orders and prison licences in both England and Wales.

We have also unified the delivery, increasing effective service user desistance and rehabilitation. The unified Probation Service has managed and delivered Accredited Programmes, Structured Interventions, Unpaid Work and Senior Attendance Centres across London whilst continuing to deliver sentence management in custody and the community.

In Sentence Management our focus is on strengthening the probation practitioner's relationship with people on probation, using the right key skills, activities and behaviours to achieve the most effective outcomes and enable offenders to make positive changes to their lives. This includes making sure that all PS staff are clear about their roles and responsibilities in relation to safeguarding concerns including escalation routes for where they feel a manager, or another agency has not responded appropriately to a safeguarding concern. The learning from SARs are disseminated on borough level and inform any wider learning across the Service. The Probation Service contributes to a number of multi-agency meetings within the borough and the community safety partnership to address contextual safeguarding concerns and work with specific groups.

To support the transition from youth to adult services in the criminal justice system a PS Probation Officer is seconded to the Youth Justice Service. The co-location of units within both the Local Authority and PS continues to promote a positive working relationship and maintains the required integral partnership working.

Department of Work and Pensions (DWP)

DWP has a framework in place for managing customers with an identified vulnerability. DWP has in recent years made further improvements to its service to vulnerable customers at critical

points in their benefit claim journey. For example:

- in August 2018 DWP began rolling out a training module on supporting vulnerable customers to all new entrants joining any of its service delivery teams. This provides a foundation level understanding to colleagues of the kinds of issues people may face; what constitutes good practice when working with those claimants; and where claimants can be directed to find sources of expert help and support. Mental health training is now mandatory for all new Personal Independent Payment and Employment Support Allowance telephony staff before they handle calls from claimants on their own.
- All Work Coaches and Child Maintenance staff have received mandatory training to raise their awareness of domestic abuse, which was developed in collaboration with domestic abuse charities. Every Jobcentre has a Domestic Abuse Point of Contact to raise awareness of this issue, and support staff to deal with it appropriately.
- DWP has appointed more than 30 Advanced Customer Support Senior Leaders (ACSSLs) across Great Britain. Their role is to reach across local communities to work with other organisations to support our customers who may need additional support because of vulnerabilities. ACSSLs are also seeking greater participation for the Department in forums such as local Multi-Agency Safeguarding Hubs.
- We look to maximise our opportunities to signpost vulnerable claimants towards support. We want to ensure that we provide support to customers to access benefits and to provide chances to flag concerns to agencies with statutory safeguarding responsibilities.
- Every Jobcentre has access to a Complex Needs Toolkit providing links to local organisations who can help and provide support to those who require it, including those organisations with statutory safeguarding responsibilities. The toolkit was developed by a range of experienced officials across the department, to support, signpost and raise awareness of claimants with various complex needs. Designated contacts from each Jobcentre attended training sessions where they were coached on how to use the toolkit. The toolkit is now covered within UC training for all new starters and refresher training is regularly undertaken. A Senior Leader acts as a sponsor for the Complex Needs toolkit – regular forums are conducted with key partner organisations to gain insight and expertise on supporting customers with complex needs.

Lambeth Adult Social Care

Lambeth Adult Social Care (ASC) has continued to adapt through 2021-22 as we have all emerged from a difficult year. We have seen an end to government restrictions in the pandemic and needed to develop new ways of working under the “new normal”. ASC has taken forward the learning and benefits of hybrid models of assessment and response to service users incorporating both online and face to face processes.

ASC has restructured its front door response to separate out new and existing workflows with new cases being managed via the Information Contact and Assessment Service (ICAS). Existing cases receiving services are managed via a new borough wide community duty service (CDT). This has enabled an improved response to managing risk. In addition, four colleagues from Age UK Lambeth are now embedded into the front door team, providing a preventative offer for those requiring low level support and signposting.

As part of the front door redesign, we have reviewed our safeguarding and MASH pathways with a dedicated Safeguarding MASH hub due to launch in September 2022. With the aim to ensure we have a more efficient and singular approach to managing safeguarding concerns.

2021-22 saw another year-on-year increase in safeguarding referrals. Following the lifting of lockdown this appeared to be significantly higher

than the average increase. This has been attributed to the reopening of services, following a period where many service users may have been shielding. This was a trend also seen more widely in referrals to ASC after lockdown restrictions were ended, leading to initial increases in requests for assessment or review face to face which has created increased demand on teams.

Work has also been done with individual teams to support safeguarding performance with embedded safeguarding champions within teams and regular safeguarding surgeries. We have identified reasons for fluctuating conversions of safeguarding concerns across teams and ensured this has now stabilised nearer to the average London level as well as improving the timeliness of safeguarding enquiries.

We continue to do regular audits of safeguarding across the department using our current quality assurance framework (QAF). In the coming year ASC will be reviewing quality in safeguarding further as part of the new safeguarding hub and reviewing the QAF, which will cover all areas of practice.

We have completed an audit on our training compliance to ensure our workforce is up to date on training for conducting safeguarding adults enquiries training and application of the Mental Capacity Act (MCA). This review was also extended to ensure they are completing mandatory training around GDPR, Modern slavery, Equality Diversity and Inclusion (EDI), and domestic violence. ASC led on delivering the multi-agency MCA week and National Safeguarding Adults Week within Lambeth. We supported the planning, design and running of many sessions looking at improving practice which were attended by hundreds of practitioners across the LSAB partnership and beyond.

ASC has led the way in looking at increased understanding of EDI data and in looking at representation for the board. More needs to be done to understand differences in safeguarding data and to engage with communities on why this is the case. We have made steps to improve our relationships with the voluntary and community sector in Lambeth and opened up the LSAB Community Engagement Group to increase representation from a wider range of groups more reflective of the community we support.

Metropolitan Police – Central South BCU

Central South BCU continues to develop its response to safeguarding and protecting vulnerable adults from those who seek to harm them.

The nominated Safeguarding Adults Lead (Detective Inspector) within the BCU seeks to professionalise and develop our response locally to adults at risk in Lambeth. This DI manages the Police MASH team, is sighted on issues of Merlin/report quality and information sharing and seeks to upskill and develop frontline staff to effectively identify adults at risk.

Early in 2022, the BCU developed a short package of training around 'professional curiosity' which was delivered to all frontline constables and sergeants. This awareness session, designed by staff from the newly embedded Organisational learning Hub and Continuous Improvement Team, links to real life scenarios (both child and adult to maximise context) and learning from statutory reviews: it encourages and challenges staff to 'think the unthinkable', to really understand what is going on for a vulnerable adult - to step into their shoes and make safeguarding personal - so they can appropriately raise concerns and take action as necessary.

DSU Kelland continues to co-chair the Lambeth Safeguarding Adults Board SAR sub group and is committed to implementing feedback and learning from both local and National SARs to learn from our mistakes and improve the response of local officers.

The Board is made up of senior members from a range of organisations. Though not all partners have been able to submit a reflection on the past year, they have still contributed to the SAB agenda and worked hard to protect adults at risk.

To find out more about our membership, visit our website.

What we are planning to do next year

The Lambeth SAB has an overarching strategic plan for 2020-23. This targeted work-plan has been developed to outline the specific actions we intend to take toward achieving our objectives over the course of the next year. These specific actions have been identified following reflection on issues that have arisen over the course of our work in 2021/22, and discussions held at our Development Day (01 March 2022). In part, our focus for 2022-23 will be to consolidate and review the actions taken previously.

Some specific focuses for the next year include:

- Gathering structured assurance from within the partnership
- Ensuring all key partners are actively shaping discussion at subgroup level
- Embedding the Complex Case Pathway within practice
- Building on work to identify effective methods to share key learning and measure impact on practice
- Targeted messaging and learning opportunities with specific focus on issues of domestic abuse, self-neglect, information sharing and executive functioning
- Identifying key areas for practice improvements following multi-agency audit of Mental Capacity Assessments
- Developing an action plan in response to analysis of data and audits focusing on Black Asian and Minority Ethnic Groups
- Strengthening processes for feedback from service users throughout the partnership
- Promoting importance of advocacy services and engagement within all communities about the Mental Capacity Act

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

Once agreed, further details of our targeted work-plan for the next year, will be published here.