RICHMOND AND WANDSWORTH SAFEGUARDING ADULTS BOARD

Annual Report 2024-2025

Richmond and Wandsworth Safeguarding Adults Board

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

I am pleased to be able to introduce our Joint Richmond and Wandsworth SAB Annual report for 2024-2025 as this is my last report after 3 years and 8 months as Independent Chair. I am delighted to say a new Independent Chair has been appointed from June, Fiona Martin, who will introduce herself below.

Last year was a significant milestone for the Richmond and Wandsworth SAB as following extensive consultation with partners and community groups we agreed to a new 5-Year SAB strategy and have completed the first year's business plan.

Following the SAB Executive governance review, more focus was given on Richmond and on Wandsworth separately. This enabled more input from the respective Community Forums and in tern, focussed interventions especially working with local voluntary sector partners to understand better safeguarding training needs reflecting the different populations in Richmond and Wandsworth.

Some progress was made supporting and working with Wandsworth Prison, having met the new Governor in the autumn, with the sign off of the Wandsworth Framework of Safeguarding in the Criminal Justice Pathway in January 2025. This is still work in progress, with some delays due to senior personnel changes.

The SAB Executive oversees strategic assurance and alignment with partners' objectives. Achievements ranged from Modern Slavery and concerns over misuse of international workers in the Care Sector, involvement in the Suicide Prevention strategy update to ensure focus on the impact of Violence against Women and Girls and those with neurodiversity needs. In addition, the Executive signed up to the updated South West London ICB Multi-Agency Joint Protocols on Medication Errors, Falls and Pressure Ulcers, and the revised London Metropolitan Police Multi-Agency Safeguarding Hub (MASH) changes to improve safeguarding referral systems.

Our strategic objectives in the annual business plan highlight Prevention and Early Intervention, focusing on raising awareness about abuse types like neglect, self-neglect, and financial abuse. This was achieved through leaflets, website videos, and events with partners like health services, police, and community groups.

Regarding objective two, Making Safeguarding Personal, performance data shows high satisfaction rates. However, quantitative audits reveal additional learning opportunities – a quality audit of repeat concerns in self-neglect cases identified good practices and areas for improvement, such as considering broader impacts on individuals.

Richmond and Wandsworth Safeguarding Adults Board

Quality assurance and embedding learning particularly from Safeguarding Adults Reviews (SARs) was developed. Whilst lessons are embedded jointly across the SAB, there was particular learning in Wandsworth from a case which did not meet SAR criteria but resulted in an independent led learning event to focus on multi-agency risk management and quality of mental capacity assessments.

In Richmond, a SAR recently published had an early learning multi-agency event on Trauma Informed Practice linked to preventing self-neglect associated with alcohol misuse, physical health deterioration and end of life care needs. You will find details in the section on published SARs further in the annual report.

Promoting cross sector working with particular focus on transitional safeguarding resulted in improved pathways for multi-agency support both with the Richmond Children's partnership and with Wandsworth Children's partnership.

The SAB aims to ensure partners embed SAR learnings and make improvements. The SAR sub-group led on trialling a survey of all SAB partners, including Community Safety, on how far they had embedded learning from a previous SAR which resulted in new Multi-Agency Cuckooing Guidance and how partners assured Mental Capacity Assessments. This showed key partners had ensured their teams were aware of the Cuckooing Guidance and monitored it.

Turning our eyes to the future, the Business Plan priorities for 2025/26 are drawn up from the annual multi-agency individual borough challenge events and the joint SAB Annual General Meeting in March 2025. They include promoting safeguarding awareness and understanding within faith communities and the voluntary sector.

My involvement in the National and London SAB Chairs' Networks ensures bringing in wider learning from SARs, such as homelessness and rough sleeping prevention, as well as developing the criminal justice framework for prison and probation engagement.

Importantly the respective Scrutiny Committees and Health and Wellbeing Boards provide both support and ideas for development following the Annual Report presentations at their meetings. In Wandsworth, concerns about the lack of safeguarding training for GPs were addressed by the ICB. Working with Public Health to explore the location of abuse and areas of deprivation and health inequalities will continue. In Richmond the concerns for Carers were highlighted and assurance given on considering carer support needs as well and working more with the many voluntary groups to have appropriate training and information on safeguarding.

National changes following the change of government in July 2025 leading to the NHS review will have a fundamental impact on local systems and structures and the SAB Executive will want to work with its partners to minimise the impact. The changes in the Met Police capacity are still being followed through; and the Care Quality Commission's inspections of Adults Social Care in Richmond and Wandsworth will undoubtedly have an impact on systems.

As I hand over to the new Independent Chair, ongoing efforts will focus on working with partners to address national issues affecting safeguarding responsibilities.

I would like to pay tribute to all the multi-agency front line staff part of the SAB, who work tirelessly to safeguard people at risk from abuse. To all the dedicated voluntary sector partners who do their utmost to engage in protecting people from abuse and giving us feedback form people with lived experience as well as unpaid carers who provide the backbone of support. And crucially none of this development work could be achieved without the tireless support and

commitment of the SAB Business Manager, who brings together all the SAB sub-groups actions to provide a coherent business plan and drive the work of the SAB forward.

I would like to thank the SAB Executive Partners – Health, Police and the Local Authority – who provided me with the opportunity to get involved in the development of their strategies and focus on preventing abuse for the residents of Richmond and Wandsworth.

Christabel Shawcross
Independent Chair of Richmond and Wandsworth Safeguarding Adults Board until end of May 2025

I am excited to be appointed as the new Independent Chair of the Richmond and Wandsworth Safeguarding Adults Board. I would like to thank Christabel for all her help and guidance she has given me; as well as her commitment and determination in progressing the board's agenda and profile over the last few years.

Having lived and worked in South London all my life and completed 32 years in the police, focusing on safeguarding and public protection, I understand the issues and challenges we face together. I am passionate about listening to the Voice of the Communities of Richmond and Wandsworth, both together and separately, to better understand the needs of each area and encourage prevention strategies from all partners to reduce risk and bring the 5-year SAB strategy to fruition. I want to ensure the profile and learning from the board and its vibrant sub-groups, helps to inform and develop best practice across agencies with the aim of improving outcomes for the most vulnerable.

I am looking forward to working with you all to ensure that the residents of Richmond and Wandsworth can live in safety, free from abuse or neglect.

Fiona Martin
Independent Chair of Richmond and Wandsworth Safeguarding Adults Board from June 2025

1 INTRODUCTION

The Care Act 2014, Section 43, mandates Local Authorities to establish a Safeguarding Adults Board (SAB) with statutory partners like local police and the Integrated Care Board. The SAB's primary goal is to ensure effective safeguarding arrangements to prevent abuse and neglect of those at risk who have care and support needs.

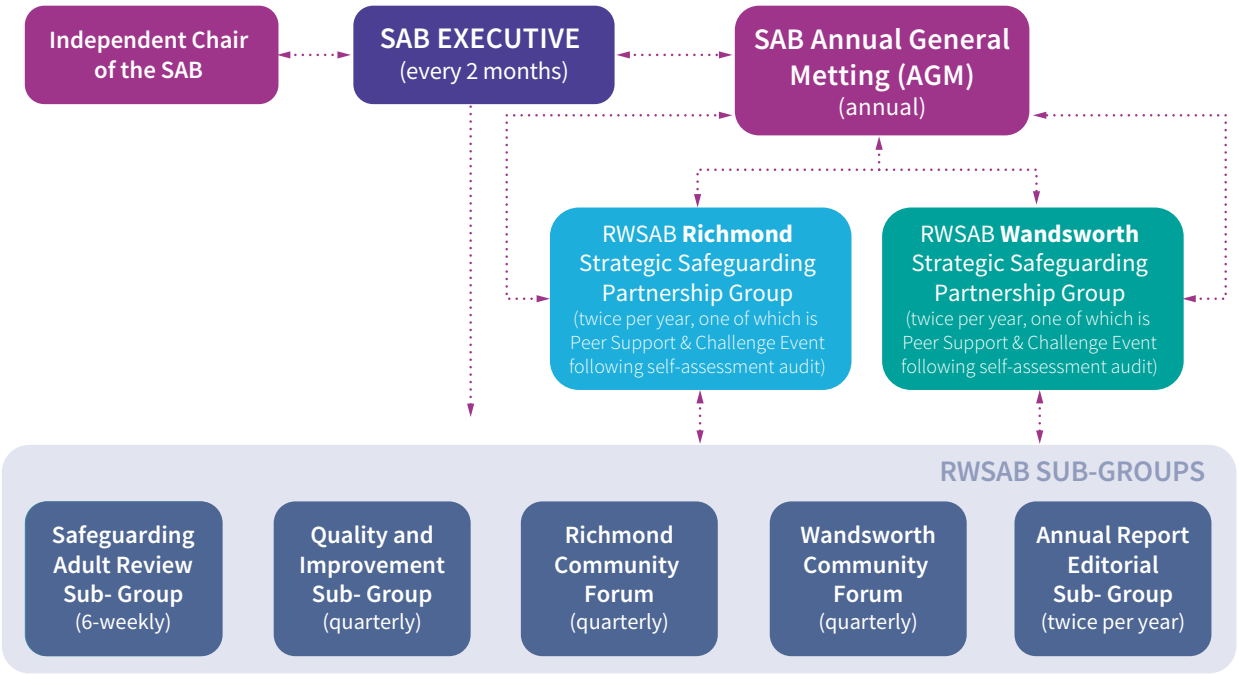
The Richmond and Wandsworth Safeguarding Adults Board (RWSAB) is a partnership of a wide variety of organisations and communities working collaboratively to ensure that individuals can live without abuse or neglect. It achieves this by:

- Collaborating to prevent abuse and neglect.
- Ensuring timely and proportionate responses to abuse or neglect.
- Ensuring that local safeguarding measures are implemented in accordance with the Care Act 2014 and statutory guidance.
- Ensuring safeguarding is focused on the individual and their desired outcomes.
- Seeking assurance of continuous improvement in safeguarding practices to enhance adults' quality of life in its area.

This report presents safeguarding data for Richmond and Wandsworth, details on the monitoring mechanisms for safeguarding, and insights into the collaborative efforts of the Board and its partners. Additionally, it highlights our achievements in relation to our strategic priorities over the past year.

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

Structure of the RWSAB



2 WORK OF THE SUB-GROUPS AND REVIEW OF THE BOARD'S BUSINESS PLAN 2024/25

SUB-GROUP ACTIVITIES 2024/25

The SAB Executive is responsible for overseeing the implementation of the Board's strategy, while the sub-groups handle much of the practical work. They are the engines behind the Board. This section outlines the work of each sub-group.

SAB Executive

The Executive consists of three core partners: the Local Authority, Police, and Integrated Care Board. This group supervises the strategic direction of the RWSAB and approves final policies, SAR reports, and strategic documents such as the Business Plan.

The group oversaw and updated the Risk Log, ensuring strategic oversight of the risks for the SAB, such as workforce capacity.

It signed up to the National SAB Guidance on the Interface between SARs and Coronial Processes and signed off the Simon SAR report.

As part of the assurance role of the SAB Executive, partners discussed developments around::

- Modern Slavery ICS work – discussed the support for international workers in the social care sector, focusing on ethical recruitment, support for displaced workers, and coordination with health services and local authorities
- Revised MASH process – discussed the changes, and progress update
- Asylum Seekers Team – update on the work, cohorts, and key Safeguarding issues.
- Update on Suicide Prevention Strategy - highlighting data trends, key priorities, ongoing programs, and the importance of understanding local needs, reducing stigma, improving crisis care pathways, and addressing issues such as gambling harm, violence against women and girls, and neurodiversity.
- Signed up to the updated SWL Multi-agency Joint Protocols on Medication Errors, Falls and Pressure Ulcers
- Strategic links with the Kingston and Richmond Safeguarding Children's Partnership, the Wandsworth Safeguarding Children's Partnership and South-West London SAB Chairs and Managers – outcome to have more agreement to shared strategic priorities.
- Work with colleagues in overseeing recommendation related to Safeguarding from the Drug and Alcohol Deaths Annual Report, particularly in promoting awareness of substance misuse and availability of palliative care for end-of-life cases related to drug or alcohol.

Richmond and Wandsworth Safeguarding Adults Board

Quality and Improvement Sub-group

The Quality and Improvement sub-group offers strategic oversight of safeguarding quality in Richmond and Wandsworth. The group meets quarterly with core partners providing representation and assurance.

Performance

- Monitored performance via the Performance Dashboard and compared location of abuse with data from MARAC cases – this did not show any worrying trends or areas of concern.
- Work is proceeding with mapping of location of abuse in relation to health inequalities and areas of deprivation.
- Noted significant increase of volume of Safeguarding concerns received in both Boroughs, with plans to do a deep-dive into Mental Health and Substance Misuse referrals.
- Organised learning event of Trauma-informed practice, which was attended by over 50 participants from a wide range of agencies, including voluntary and community sector.
- Promoted sharing of best practice, tools and wider training to practitioners across the partnership via the Newsletter and direct emails.
- Had a comprehensive audit on repeated S42 safeguarding concerns around self-neglect cases, which offered good assurance around MSP, triggering and completing Mental Capacity Assessments where required, good preventative and multi-agency work, timely completion of immediate safety actions and escalation to other multi-agency panels where relevant. Some more work was needed around awareness of disguised compliance and need to strengthen recording of risk.
- Updates on Mental Capacity Act training compliance were provided, with discussions on the importance of bridging gaps in training.
- Sent out the Safeguarding Adults Partnership Assessment Tool (SAPAT) audit in November 2024 and held Peer Support and Challenge Events for each Borough in February 2025.

SAR Sub-group

Met six-weekly and considered two SAR referrals, both for Wandsworth, one of which met the mandatory criteria for a SAR and will be commissioned in the new financial year. The other referral did not meet the mandatory or discretionary criteria, however a Reflective Practice session was recommended and completed via an independent facilitator. More details on this are in the Learning from SARs section further below.

Followed up on action plans from SARs, getting assurance on Transitional arrangements and out-of-Borough placements for young people.

Signed off and started using a Decision-Making Tool for improved governance around decisions about SARs.

Considered Regulation 28 Coroner's Prevention of Future Deaths reports with

recommendations for partners and received updates and assurance on how they have been addressed from the relevant partners.

Considered the local Richmond and Wandsworth LeDeR data breakdown for 2023/24, presented by the ICB. Ensured the data was discussed at the local Learning Disability Partnership Boards.

Considered and disseminated learnings from other reviews and SARs from other Boroughs with themes around neurodiversity and risky behaviour; complex medical needs, and out of borough care coordination. Recommendations for improved communication, advocacy, and legal support access are being taken forward by multi-agency partners.

Boroughs with themes around Transitions and Fabricated or Induced Illness, which have also been shared widely across the RWSAB.

Richmond and Wandsworth Community Forums

The Community Forums in Richmond and Wandsworth are the main multi-agency meetings for each local area, involving wider representation from the local voluntary services and focussing on local Safeguarding issues. Both Community Forums met quarterly.

They helped deliver regular quarterly Newsletters, with articles from partners, training opportunities and updates and kept the website up to date. They organised communications for National Safeguarding Adults Week 2023, which provided professionals and volunteers with an opportunity to update themselves on relevant best practice.

The Forums reviewed Business Plan actions to meet identified outcomes; they had updates and disseminated messages on recent Scams from Trading Standards and discussed various topics and services, including Rough Sleepers, information on Galop – a charity offering Domestic Abuse advocacy and support to LGBT+ community, the Sexual and Reproductive Health needs assessment and consulted on Public Health's 2025 strategy in both Boroughs.

The following is a message about the work of the Richmond Community Forum from its current Chair, Heather Mathew:

"The Richmond Community Forum is chaired by a member of the voluntary sector and includes representatives from a local social housing provider, volunteers from the police Safer Neighbourhood Board, health colleagues from a local community provider, Richmond Healthwatch, the Local Authority Safeguarding team, Community Safety, the ICB and others. The broad range of expertise provides reach into local communities, and brings insight and challenge to the data from the perspective of organisations working at a grassroots level. Our purpose was well expressed in the 2024 National Safeguarding Adults week theme "Working in Partnership".

We have used community mechanisms and events such as The Full of Life Fair to share safeguarding messages including a range of information to help individuals protect themselves from financial scams, an online safety leaflet aimed at people with learning difficulties developed by Mencap and Your Healthcare, and the support available to keep warm in winter in the wake of government

cuts, and the concerns this raised.

We worked with SAB to refresh the safeguarding adult's leaflet and to develop self-neglect information to help local businesses know what to do if they had a concern about someone in the community.

Our consistent focus across the year has been to share knowledge of safeguarding, learn from good practice, promote professional curiosity and connect with our residents. Our aim remains to build safer communities, and to raise awareness of the support available if people need help."

Heather Mathew
Richmond Community Forum Chair
Richmond Council for Voluntary Services

Business Plan achievements

Some significant achievements in relation to the priorities in our Strategic Plan are:

Prevention and early intervention

- Training – promoted available training with partners, introduced level 3 Safeguarding e-learning. Discussed how to provide better training for voluntary sector, with plans for face-to-face training next year.
- Collaborated with the Police on using "Trigger Plans" similar to Children, which proved to be less useful for adults.
- Increased awareness of the Self-neglect and Hoarding Panels with GPs, professionals and volunteers.
- Coproduced an easy-read leaflet on Staying Safe Online.

Making Safeguarding Personal

- Audit of S42 repeat concerns on self-neglect cases.
- Created an easy-read leaflet to help people with learning disabilities and autism stay safe online.
- Obtained better feedback following Safeguarding S42 process via increased efforts from the Safeguarding Team, with a report presented at the Quality & Improvement sub-group in June 2025

Quality assurance on learning lessons and shaping practice

- Drafted information on Self-neglect for the public, local businesses and volunteers.
- Held and event focussed on Trauma-informed Practice and learning from a newly completed SAR.
- Considered the overlap and whether there were trends between safeguarding location of abuse and MARAC data, will consider geographical data of areas of deprivation next.

Safeguarding is Everybody's Business

- Completed joint audits of Transitions pathway in Richmond and Wandsworth, showing good consideration of wellbeing principles, signposting, sharing of

information at Panels and consideration of out-of-borough placements.

- Shared priorities with strategic partnerships and attended joint interface meetings to promote closer working relationship with other Boards and Partnerships.
- The Board's work around a multi-agency Framework on Safeguarding in the Criminal Justice Pathway has now been signed off.

The above achievements were discussed at the RWSAB's Annual General Meeting (AGM) in March 2025, and the new Business Plan was developed by the partnership. It outlines several key priorities and areas of focus:

- Promoting safeguarding awareness and understanding within faith communities and the voluntary sector.
- Addressing actions from SARs and other reviews.
- Providing resources and training on the Mental Capacity Act in complex cases and self-neglect.
- Exploring safeguarding referrals involving mental health and substance misuse to understand their prevalence.
- Mapping the correlation between safeguarding incidents, locations of abuse, and areas with health inequalities.
- Collaborating with Community Safety to address the rise in adult children abusing parents.
- Seeking collaborative opportunities with South West London SAB Chairs and Managers and working together with local Safeguarding Children's Partnerships.

3 RICHMOND AND WANDSWORTH PERFORMANCE INFORMATION

RICHMOND

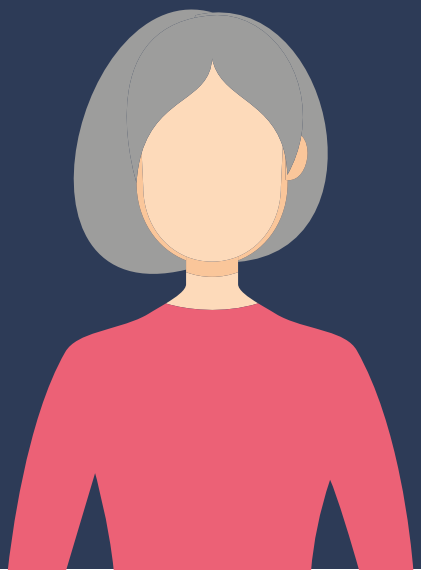
Case study*

A safeguarding concern was raised for Ms Taylor in 2024 by London Fire Brigade (LFB) due to concerns around self-neglect. She is an 83-year-old white woman living in her own home. Ms Taylor had previously received support from the Local Authority to help her manage her possessions and the annual visit by LFB was part of the previous safety plan. During the 2024 visit, it was identified Ms Taylor had resumed collecting items and there was significant clutter which had serious impact on her ability to use her home space. There were concerns about Ms Taylor not being able to access rooms in her home and for the structural integrity of the property.

The case was discussed at the Richmond Self Neglect and Hoarding panel to ensure the risks were being shared at across key partners. At a local level, the social worker continued to build rapport with Ms Taylor and work at her pace to meet her desired outcomes. Ms Taylor was receptive to receiving advice and signposting, but she was clear she did not want formal support from the Local Authority to remove items. She identified her friend as someone she trusted to help her. With this in mind, and over a period of several months the multi-agency network was able to support Ms Taylor to slowly remove items and look at how else her home environment could be made safer.

As progress was made in removing items, Ms Taylor became more receptive to accepting help from people other than her friend. A referral was made to Occupational Therapy; a grant was provided to aid with disposal of rubbish; Ms Taylor accepted a referral to Community Matrons and specialist teams for necessary reviews; a hospital bed and care tech were provided, and her friend has started an insurance claim to address the structural issues within the property.

The social worker visited Ms Taylor in May 2025 and reported a significant improvement in her environment. Based on this and Ms Taylor's continued positive engagement with professionals, the decision was made to close the safeguarding enquiry. Professionals have fed back that Ms Taylor now smiles when they visit, and she seems much happier in her home.



*names and details may be changed to preserve the anonymity of the people involved

Concerns received in 2024/25

17%

2297

17% increase
(1970 in 2023/24)

Enquiries in 2024/25

17%

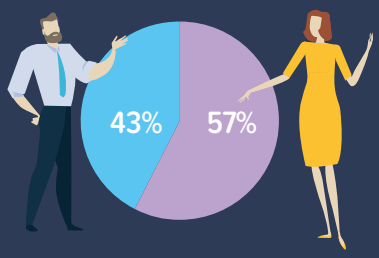
588

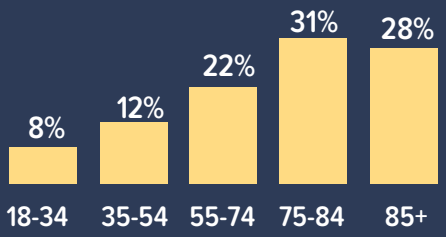
17% increase
(502 in 2023/24)

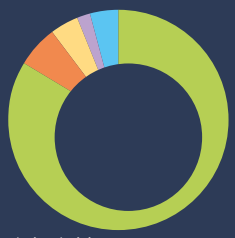
Conversion from concerns to enquiries

26%

25% in 2023/24







83% White
6% Asian
4% Black
2% Mixed
4% Other Ethnic Groups

3 people did not state their ethnicity

TYPES OF ABUSE

- **30%** (192) Neglect
- **24%** (154) Self-neglect
- **14%** (91) Domestic Violence
- **10%** (61) Physical

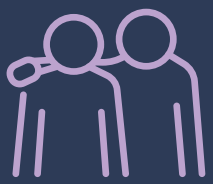
67% (337) Own Home

17% (84) Care Home Residential and Nursing

5% (24) In the community

(excluding community services)

38% (190) Known to Individual



13% (65) Care, health or other Professional

1% (5) Not known to individual or no person alleged to have caused harm

99% (480) Risk Reduced or removed

77% (387) Expressed Desired Outcomes

99% (383) Outcome fully or partially achieved

77% (386) Felt safer after safeguarding

100% Support from advocate, family or friend

Safeguarding in numbers – Safeguarding figures

Safeguarding Concerns and Enquiries[1]

The number of concerns (up by 17%) and enquiries (up 17%) in Richmond has had a considerable increase. The percentage of concerns which progress to enquiries has remained similar at 26%, which is on par with the average rate for London and shows submitted concerns have not been any less appropriate. 85% of the enquiries were completed within the year. Enquiries not completed within the year were raised and logged close to the end of the year, taking their timelines for completion into next financial year.

The percentage of sex, age and ethnicity-related enquiries is consistent with the population of the borough. Since according to the Care Act 2014, safeguarding duties apply when individuals cannot protect themselves due to care and support needs, we compared those characteristics against the characteristics of the population of adults with care and support needs on the Council's care records. This comparison showed there is slightly more safeguarding activity in older-aged people (71% aged 65 and over in safeguarding enquiries, compared to 55% aged 65+ on care records). Older adults are more likely to face cognitive decline, including dementia, impairing their ability to protect themselves from abuse or neglect. Ethnicity is almost completely in line, and there is slightly more prevalence of females in safeguarding (57% female, 43% male), compared to the population of people with care and support needs in the Council's records in Richmond (53% female, 47% male), which could be explained with the increase in females with age.

In relation to location of abuse, since most people reside in their own homes, the majority of abuse occurs there (67%), which is consistent with both the national and regional average. There are 42 care facilities in Richmond upon Thames, and their good awareness of their duties to report any safeguarding concerns, which is reflected in the second-highest rate of abuse (17%) happening in residential and nursing care homes.

Slightly over half of the cases (54%) involved people who receive physical support, followed by people who receive social support 15%. People requiring Mental Health support and support with memory or cognition represented each 10% of enquiries.

The most referrals were received from service providers (25%), followed by various NHS Trusts (17%) and the Police (17%). Referrals from the public, including family, friends, neighbours and self-referrals was 9% of all referrals received in Richmond. This shows good awareness of how to report safeguarding.

Types of Abuse[2]

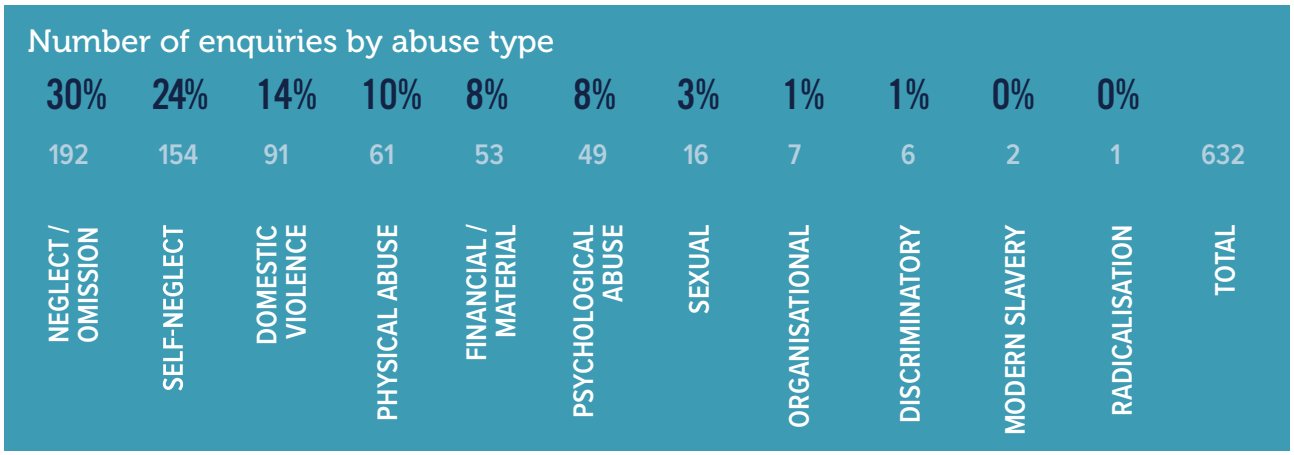
Over the past six years, the most common type of abuse documented has been Neglect or Acts of Omission. This is understandable given that the category includes a wide range of aspects. Neglect/Acts of Omission in 2024/25 made up 30% (up from 29% in 2023/24) of enquiries. Over the past four years, there has been a consistent rise in Self-Neglect, up by another 4% to 24% and keeping it in second place. There is focused work on promoting local understanding of self-neglect. In 2024/25 there has been a marked increase of Domestic Abuse cases, which have climbed up to being the third highest type

1 A safeguarding concern is any issue raised with Adult Social Services which is identified as being about an adult safeguarding matter. Concerns are reviewed, risk assessed and resolved, or when deemed to not concern a safeguarding issue – dealt with through another appropriate route. If assessed to meet the criteria for an adult safeguarding, a Section 42 Enquiry is raised, which involves fuller investigation and formal intervention.

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

Richmond and Wandsworth Safeguarding Adults Board

Number of enquiries by abuse type



of abuse with 14% of enquiries. There has been a real focus this year of violence against women and girls, which resulted in increase in safeguarding concerns.

Making Safeguarding Personal

The Care Act of 2014 mandates that all agencies with safeguarding responsibilities implement Making Safeguarding Personal (MSP). MSP focuses on making safeguarding work person-led, outcome-oriented, and supportive of participation, choice, and control. It aims to enhance individuals' quality of life and promote their safety and well-being.

The effectiveness of achieving the desired outcomes is a key performance metric of the Making Safeguarding Personal initiative. Safeguarding practice follows MSP principles and focuses on being person-centred. Locally, 77% of participants in a Safeguarding Enquiry stated their desired outcomes, with 99% of those outcomes being either fully (71%) or partially (28%) met. When outcomes are not expressed or achieved, it is often because the individual chose not to participate in the process or was unwell at the time of the inquiry.

All 137 people lacking capacity had support from family, friend or advocate during the Safeguarding process.

> "I was happy with it all, the outcome was very good, lots of support. Before it felt like I was totally alone, but good things to report. Very satisfied with it. Relief after so many years of managing it myself, now mum is safe. I felt listened to, they made an effort to get mum's views too. The Social Worker who chaired the meeting took time to explain things clearly, and mum is definitely safer."
>
> **said: xxxxx**

Impact on risk and sense of safety

The London Borough of Richmond upon Thames has consistently sought feedback from individuals and their representatives regarding the perceived safety as a result of the assistance provided during safeguarding enquiries. Among the 485 individuals for whom enquiries were completed, 386 (77%) reported feeling safer following the process. In the remaining 114 cases (23%), the nature of the concern and its impact did not result in an improved sense of safety. These situations are monitored closely to ensure risk management is effectively maintained. However, for some people the trauma they have experienced can mean that it would take a lot longer before they can feel safe.

The goal of adult safeguarding is to minimise or eliminate the risk to the adult. In 99% of cases, safeguarding reduced or removed the risk. Where the risk remains, it is typically because people have chosen to accept it and are aware of its consequences.

Deprivation of Liberty Safeguards (DoLS)

The Deprivation of Liberty Safeguards (DoLS) are a legal framework in England and Wales designed to protect individuals who lack the mental capacity to consent to their care or treatment arrangements, ensuring that any deprivation of liberty is in their best interests and properly authorised.

The total number of DoLS applications received in Richmond has continued to increase, and while the increase is slight (31 cases), it continues to demonstrate an upward trajectory. Performance has also increased with a rise in the number of authorisations granted, while the number of not granted has also increased, which demonstrates that most applications are appropriate – predominately authorisations not granted are as a result of people failing one of the qualifying assessments such as being assessed as having capacity or the person leaves hospital before the assessment process is completed or the person dies. All requested authorisations are reviewed, monitored, and triaged in accordance with the Association of Directors of Adult Social Services (ADASS) priority ensuring that the most urgent are prioritised. There is a process in place to guarantee renewals are addressed to minimise breaks in the authorisation. A summary of the number of Deprivation of Liberty Safeguards requests and authorisations in Richmond during 2024/25 is shown in the table below.

Community DoL

Community Deprivation of Liberty (Community DoL) refers to situations where a person who lacks mental capacity is under continuous supervision and control and not free to leave, while receiving care in a domestic or community setting, and where authorisation must be sought from the Court of Protection to ensure the arrangement is lawful and in their best interests.

Currently there are 20 Priority 1 cases in Richmond. Priority 1 Community Deprivation of Liberty (DoL) refers to the most urgent cases where individuals living in community settings—such as supported living, extra care housing, or their own homes—are subject to restrictions that may amount to a deprivation of liberty. These individuals lack the mental capacity to consent to their care arrangements, and their situation requires swift legal authorisation through the Court of Protection.

Richmond DoLS	23/24	%	24/25	%	Change 2023/24 to 2024/25	
Granted	575	64.2%	582	62.8%	7	1%
Not Granted	244	27.2%	258	27.8%	14	6%
Not yet signed off by Supervisory Body	77	8.6%	87	9.4%	10	13%
Total Number of Requests Received	896		927			

Provider Quality

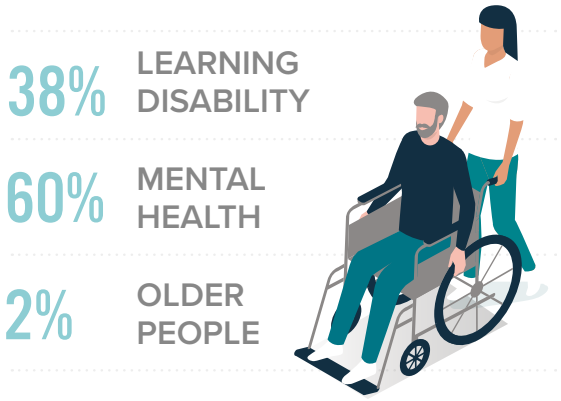
In Richmond there are 42 local Care Homes and 27 Care-at-home Services Providers registered with the care regulator the Care Quality Commission (CQC). 38 Care Homes (90%) are rated Good by the CQC and one is Outstanding. Two require improvement and one is rated inadequate, with action plans and regular quality monitoring by the Local Authority's Quality Assurance Team in place to help improve this rating. 16 (59%) of the Homecare Service Providers are rated Good. There are eleven homecare providers which are not yet rated by the CQC, but the overall quality of both Care Home and Homecare services across the borough remains good.

INADEQUATE 0%

Care-at-homes Services CQC Rating (Richmond)	No	%
Outstanding	0	0%
Good	16	59%
Requires improvement	0	0%
Inadequate	0	0%
Not yet rated	11	41%
Total	27	

INADEQUATE 2%

Care Homes CQC Rating (Richmond)	No	%
Outstanding	1	2%
Good	38	90%
Requires improvement	2	5%
Inadequate	1	2%
Total	42	



Care Home Type (Richmond)	No	%
Learning disabilities	16	38%
Mental health	25	60%
Older people	1	2%
Total	42	

Learning from Lives and Deaths of people with a Learning Disability and Autistic People

The purpose of this section is to share an overview of reported deaths, demographics and findings from LeDeR reviews for people with a Learning Disability and/or Autism within the Borough of Richmond which were undertaken by the SW London LeDeR Team in 2024/25.

LeDeR is not an investigation process into the deaths of people, rather a service improvement programme with its purpose to review the care and treatment of people prior to and during the last phase of life. It acknowledges and promotes good practice, as well as highlighting areas of learning to providers at Local LeDeR Steering Group Meetings.

We would like to acknowledge family members, friends, health and social care staff and many others who have contributed to a LeDeR review by sharing their experience of the life and death of a loved one or someone in their care.

Overview of LeDeR Reviews

Type	Number
Total Reviews Completed	4
Initial Reviews	4
Outstanding Reviews	6
Review on Hold (awaiting coroner's report)	1

LeDeR Review Breakdown	Number
Learning Disability (LD)	3
LD & Autism	1

Age	
Average Age	66
Range	39-79

66 AVERAGE AGE

3 MALE

1 FEMALE

4 WHITE BRITISH

Gender	Number
Female	1
Male	3

Ethnicity	Number
White British	4

MAIN CAUSES OF DEATH

- ASPIRATION PNEUMONIA
- PNEUMONIA
- HAEMORRHAGE

Place of Death	Number
Hospital	3
Usual Place of Residence	1

ANNUAL HEALTH CHECKS (AHC)

Completed: 4/4

100% (Above the national average)

Themes

Positive Practice

- Evidence of good reasonable adjustments to ensure equal access to health and social care and timely referrals.
- Supportive advocates that ensured persons views were known and respected allowing personalised care options.

System-wide Learning

- Pneumonia the most common cause of death for the last two years.
- Autism LeDeR Review reporting remains low.
- Nursing home placements are difficult to find for people with a learning disability that have the facilities, skills and training to support someone with a learning disability.

Operational/Local Learning

- Need for improved End of Life Care and Discharge planning to ensure preferences around place of care and death are achieved.
- Training for care home staff on recognising and acting on signs of health deterioration.

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

WANDSWORTH

Case study*

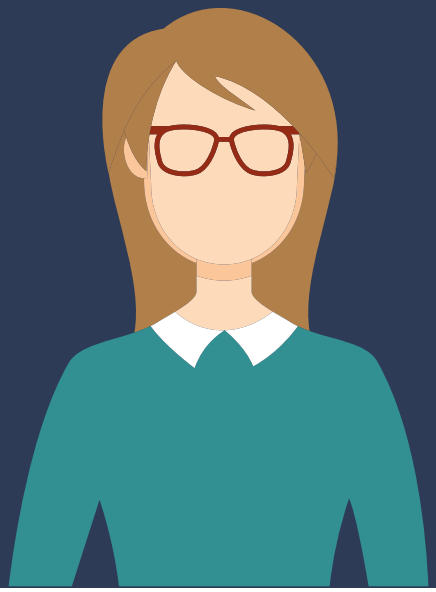
Marie is a 50-years-old white Irish woman who lived with her son. Marie called the police and disclosed her son had physically assaulted her and was taking her phone and keys. Marie said she felt scared when her son was drinking. Without her phone she couldn't call for help when her Multiple Sclerosis made her unwell and this worried her. When the police visited Marie to discuss the assault, they also saw her home needed repairs, and Marie may need support to maintain her environment.

Marie was invited to participate in multi-agency meetings to discuss what she wanted to happen, and how agencies could support her to feel safe at home. Marie was referred to an Independent Domestic Violence Advocate (IDVA) service and they supported her to present her views. Housing, the police and her GP also attended.

Marie wanted to secure her home; she did not want her son to return. Marie shared that family dynamics made it difficult for her to prosecute him but the police progressed with an evidence led prosecution and he was issued with a Domestic Violence protection order prohibiting him from returning to her home.

Marie was provided with technology to support her to feel safe at home, she received a SMART watch and panic alarms. Her doors were also repaired, with the locks changed so her home was secure. Marie was reassured that the police would respond to any calls as a priority, and this made her feel safe. She was subsequently supported to apply for a non-molestation order.

Marie has since received a care act assessment and has been assisted to access services to support her in maintaining her home and maximising her benefits.



*names and details may be changed to preserve the anonymity of the people involved

Concerns received in 2024/25

3885

15% increase

(3366 in 2023/24)

Enquiries in 2024/25

1117

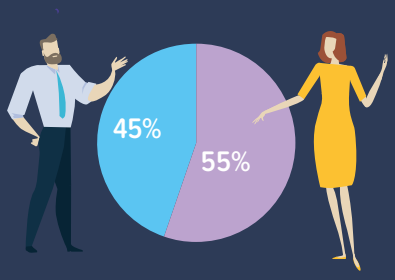
11% increase

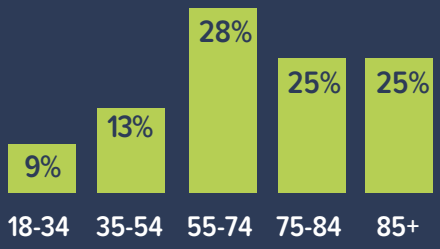
(1005 in 2023/24)

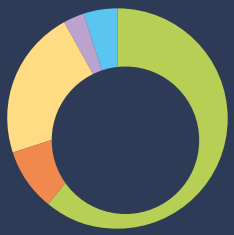
Conversion from concerns to enquiries

29%

30% in 2023/24







61% White
9% Asian
22% Black
3% Mixed
5% Other Ethnic Groups
2 people did not state their ethnicity

TYPES OF ABUSE

- **24%** (324) Self-neglect
- **22%** (287) Neglect
- **16%** (209) Financial/Material
- **10%** (134) Domestic Violence

60% (591) Own Home

16% (158) Care Home Nursing and residential

6% (63) Hospital

44% (314) Known to Individual

15% (109) Care, health or other Professional

7% (53) Not known to individual or no person alleged to have caused harm

98% (941) Risk Reduced or removed

76% (744) Expressed Desired Outcomes

98% (728) Outcome fully or partially achieved

80% (788) Felt safer after safeguarding

100% Support from advocate, family or friend

Safeguarding in numbers – Safeguarding figures

Safeguarding Concerns and Enquiries

2024/25 saw an increase in both Concerns (up by 15%) and enquiries (up by 11%) for Wandsworth. The rate of concerns progressing to enquiries remains steady at 29%, matching the London average. 88% of the enquiries were completed within the year. The remaining enquiries, logged near year-end, will be completed in the next financial year.

The percentage of sex, age and ethnicity-related enquiries is consistent with the population of the borough. As safeguarding concerns and enquiries are raised for people with care and support needs, we compared those characteristics against the characteristics of the population of people with care and support needs on the Council's records. This comparison showed there is slightly more safeguarding activity in older-aged people, with 65% of safeguarding enquiries being for people aged 65 and over, who comprise 53% of the people with care and support needs on Wandsworth Council's records. Older adults are more likely to face cognitive decline, including dementia, impairing their ability to protect themselves from abuse or neglect. According to the Care Act 2014, safeguarding duties apply when individuals cannot protect themselves due to care and support needs, which is more common among older people. The gender distribution is consistent with the population of residents with care and support needs in Wandsworth. There is underrepresentation of Asian/Asian British individuals (9% vs. 12%) and Black/Black British individuals (22% vs. 30%) in safeguarding enquiries compared to care records. Raising awareness and understanding of safeguarding within certain communities remains challenging, and the RWSAB has planned sessions to address this issue and enhance awareness among these groups.

60% of abuse takes place in an individual's own home, which reflects the fact most people live in their own home. Wandsworth has many care homes, including some of the biggest in the Country, and a number of hospitals in its territory, which reflect the second and third highest locations of abuse (16% and 6% respectively).

42% of safeguarding enquiries involved people who receive physical support. People with Mental Health support represent 18% of cases, followed by people with social support (16%) and people with Learning Disabilities (11%).

Service providers made the most referrals (24%), followed by hospitals (18%) and police (15%). Public referrals, including family, friends, neighbours, and self-referrals, accounted for 9% in Richmond. This indicates good awareness of safeguarding reporting in Wandsworth.

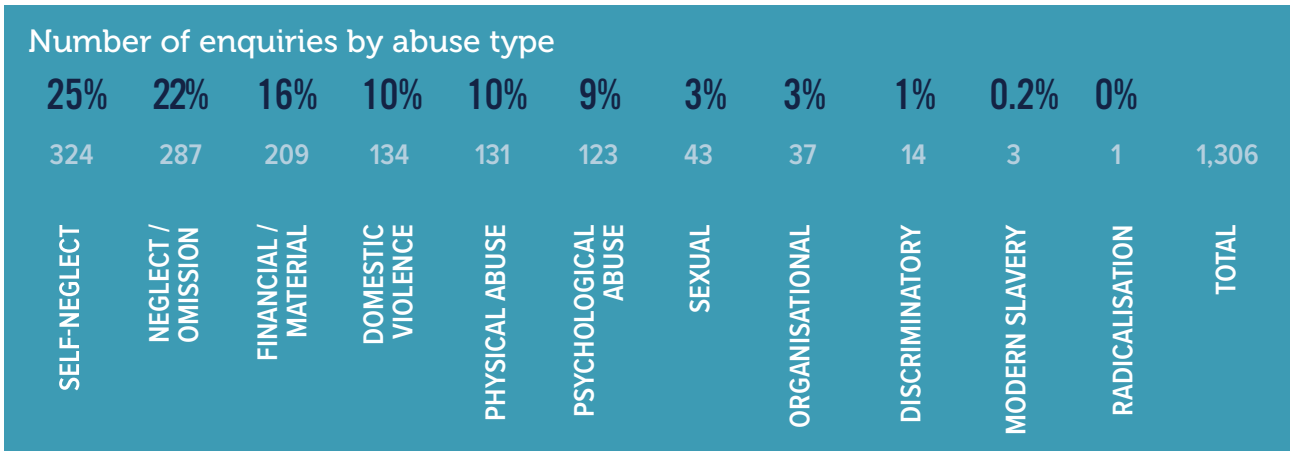
Types of Abuse[3]

For second year in a row, Self-neglect is the highest reported type of abuse in Wandsworth with 324 (25%) of safeguarding enquiries. As a result of the continued rise of self-neglect safeguarding cases, the safeguarding team did a deep-dive of repeat safeguarding concerns around self-neglect, which offered good assurance around Making Safeguarding Personal, triggering and completing Mental Capacity Assessments where required, good preventative and multi-agency work, timely completion of immediate safety actions and escalation to other multi-agency panels where relevant. Neglect and acts of omission remain

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

Richmond and Wandsworth Safeguarding Adults Board

Number of enquiries by abuse type



second highest reported abuse with 287 (22%) of enquiries in Wandsworth. They are followed by Financial/Material abuse (209, 16%) and Domestic Violence (134, 10%).

Making Safeguarding Personal

The Care Act of 2014 requires all agencies with safeguarding responsibilities to implement Making Safeguarding Personal (MSP). MSP aims to ensure that safeguarding is person-led, outcome-oriented, and supports participation, choice, and control. It seeks to improve individuals' quality of life and promote their safety and well-being.

One of the key performance metrics of Making Safeguarding Personal (MSP) is how well individuals' desired outcomes are achieved. Safeguarding practice follows MSP principles and is person-centred. Locally, 76% of participants in a Safeguarding Enquiry specified their desired outcomes, and 98% of these outcomes were either fully (78%) or partially (19%) met. When outcomes are not expressed or met, it is usually because the individual chose not to participate in the process or was unwell at the time of the inquiry.

All 148 people lacking capacity had support from family, friend or advocate during the Safeguarding process.

> "I was kept fully informed throughout, they always wanted my point of view and it was accepted, whereas in the past it hasn't always been. Whenever I put my hand up I was given the chance to speak in meetings, they always wanted to hear my take and my views. it was excellent. The multi-agency team is excellent, they all continue to communicate well with me. I know exactly what the plan is, what social care is, what we are organising and what my part is. The safeguarding has reduced a lot of the risks – we got a new front door, we did a lot to make sure she was safe. I think mum is safe, yes."
>
> **said: xxxxx**

Impact on Risk and sense of safety

The London Borough of Wandsworth has consistently sought feedback from individuals and their representatives regarding the perceived impact of safeguarding interventions on their sense of safety. Among 983 completed enquiries, 788 individuals (80%) reported feeling safer following the intervention. In the remaining 195 cases (20%), the nature of the concern and its impact resulted in no improvement in the individual's sense of safety. These cases are closely monitored to ensure risk management strategies are effectively implemented. However, for some people the trauma they have experienced can mean that it would take a lot longer before they can feel safe.

The goal of adult safeguarding is to minimise or eliminate the risk to the adult. In 98% of cases, safeguarding reduced or removed the risk. Where the risk remains, it is typically because people have chosen to accept it and are aware of its consequences, with the cases monitored to ensure the risk is managed as well as possible.

Deprivation of Liberty Safeguards (DoLS)

The Deprivation of Liberty Safeguards (DoLS) are a legal framework in England and Wales designed to protect individuals who lack the mental capacity to consent to their care or treatment arrangements, ensuring that any deprivation of liberty is in their best interests and properly authorised.

The total number of DoLS authorisations received in Wandsworth has increased over the past year by 293, which shows a significant increase of 24% in activity. Performance has increased with a rise in the number of authorisations granted. The number of not granted authorisations has also slightly increased, which demonstrates that most applications are appropriate – predominately authorisations not granted are as a result of people failing one of the qualifying assessments such as being assessed as having capacity or the person leaves hospital before the assessment process is completed, or the person dies. A summary of the number of Deprivation of Liberty Safeguards requests and authorisations in Wandsworth during 2024/25 is shown over the page.

Community DoL

Community Deprivation of Liberty (Community DoL) refers to situations where a person who lacks mental capacity is under continuous supervision and control and not free to leave, while receiving care in a domestic or community setting, and where authorisation must be sought from the Court of Protection to ensure the arrangement is lawful and in their best interests.

Currently there are 16 Priority 1 cases in Wandsworth. Priority 1 Community Deprivation of Liberty (DoL) refers to the most urgent cases where individuals living in community settings—such as supported living, extra care housing, or their own homes—are subject to restrictions that may amount to a deprivation of liberty. These individuals lack the mental capacity to consent to their care arrangements, and their situation requires swift legal authorisation through the Court of Protection.

Wandsworth DoLS	23/24	%	24/25	%	Change 2023/24 to 2024/25	
Granted	757	62.8%	788	53%	+31	4%
Not Granted	360	29.9%	590	39%	+230	64%
Not yet signed off by Supervisory Body	88	7.3%	120	8%	+32	36%
Total Number of Requests Received	1205		1498		+293	

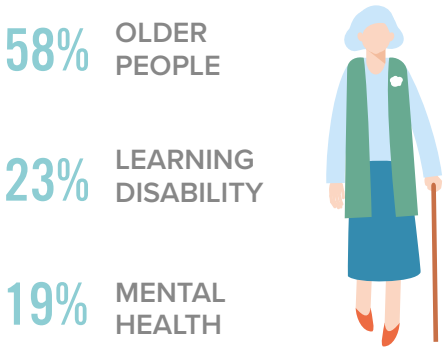
Provider Quality

There are 26 Care Homes in Wandsworth, and 42 Care-at-home Services Providers which are registered with the care regulator the Care Quality Commission (CQC). 1 Care Home is Outstanding, 25 (96%) are rated Good, with no care homes rated Requires Improvement or Inadequate. 2 of the Care-at-home Services Providers have been rated Outstanding, 32 (76%) Good, and 8 service has not been rated yet. Overall quality of service provision for both Care Homes and Homecare providers across the borough remains very good.

Care Homes CQC Rating (Wandsworth)	No	%
Outstanding	1	4%
Good	25	96%
Requires improvement	0	0%
Not yet rated	0	0%
Total	26	

INADEQUATE 0% - UNRATED SERVICE 19%

Care-at-home Services CQC Rating (Wandsworth)	No	%
Outstanding	2	5%
Good	32	76%
Requires improvement	0	0%
Inadequate	0	0%
Unrated service	8	19%
Total	42	



Care Home Type (Wandsworth)	No	%
Older people	15	58%
Learning disabilities	6	23%
Mental health	5	19%
Total	26	

Learning from Lives and Deaths of people with a Learning Disability and Autistic People

The purpose of this section is to share an overview of reported deaths, demographics and findings from LeDeR reviews for people with a Learning Disability and/or Autism within the Borough of Wandsworth which were undertaken by the SW London LeDeR Team in 2024/25.

LeDeR is not an investigation process into the deaths of people, rather a service improvement programme with its purpose to review the care and treatment of people prior to and during the last phase of life. It acknowledges and promotes good practice, as well as highlighting areas of learning to providers at Local LeDeR Steering Group Meetings.

We would like to acknowledge family members, friends, health and social care staff and many others who have contributed to a LeDeR review by sharing their experience of the life and death of a loved one or someone in their care.

Overview of LeDeR Reviews

Type	Number
Total Reviews Completed	4
Initial Reviews	3
Outstanding Reviews	1
Review on Hold (awaiting coroner's report)	17

LeDeR Review Breakdown	Number
Learning Disability (LD)	2
LD & Autism	2

Age	
Average Age	68
Range	58-83

68 AVERAGE AGE

2 MALE

2 FEMALE

3 WHITE BRITISH

1 BLACK/BLACK BRITISH – CARIBBEAN

Gender	Number
Female	2
Male	2

Ethnicity	Number
White British	4
Black/Black British – Caribbean	1

MAIN CAUSES OF DEATH

- PNEUMONIA
- ASPIRATION PNEUMONIA
- NON-ALCOHOLIC LIVER CIRRHOSIS

Place of Death	Number
Hospital	2
Usual Place of Residence	2*

* both in Care Home

ANNUAL HEALTH CHECKS (AHC)

Completed: 4/4

100% (Above the national average)

Grade of care for the Focused Review

(where 1 is Care that fell far short of expected good practice and this contributed to the cause of death and 6 is excellent care that exceeded expected good practice)

Category	Ratings (out of 6)
Quality of Care	3
Effectiveness of Care	3

Themes

Positive Practice

- Evidence of good reasonable adjustments to ensure equal access to health and social care and timely referrals.
- Supportive advocates that ensured person's views were known and respected.

System-wide Learning

- Pneumonia the most common cause of death for the last two years.
- Autism LeDeR Review reporting remains low.
- Nursing home placements are difficult to find for people with a learning disability that have the facilities, skills and training to support someone with a learning disability.

Operational/Local Learning

- Following a raised safeguarding concern and enquiry – this highlighted a need for greater awareness and reporting of health deterioration and requires care staff to follow professional care plans and guidance.

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

4 LEARNING FROM SAFEGUARDING ADULT REVIEWS

Richmond and Wandsworth Safeguarding Adults Board

SAFEGUARDING ADULTS REVIEW REFERRALS

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

One of the referrals received by the SAR Sub-group throughout the year showed multi-agency working was in place and good efforts were made to work with the person. The RWSAB felt there would be benefit in multi-agency learning from good practice, and exploring in more detail some of the issues around Mental Capacity Assessments and risk management. A Reflective Practice session was commissioned for the case, led by an independent facilitator, which showed that robust multi-agency collaboration, early legal consultation, and effective risk and capacity management are essential for managing complex cases and ensuring decisions are in the individual's best interest.

The other case involved self-neglect and lack of engagement with the person, and met the statutory criteria for Safeguarding Adults Review. It will be commissioned and due to be completed in 2025/26.

One Safeguarding Adults Review previously commissioned in Richmond was completed in 2024/25 – Simon SAR, details on the next page.

‘Simon’ (Richmond)

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

Who was Simon?

Simon was a 54-year-old white British man who had a history of alcohol and physical health problems, associated with sustained alcohol use and a diagnosis of paranoid schizophrenia. Simon was known to the Recovery and Support Service and was seen at home by the service for monthly injections of prescribed antipsychotic medication. Simon was not recorded by professionals as having a learning disability, but his sister told the SAR reviewers he had attended a special school and had a severe learning disability; he was also illiterate. Simon had experienced many traumas in his life, including the loss of his grandparents with whom he had lived, and following admission to intensive care in 2016 due to his chronic liver disease. Simon’s sister and his nephews had moved in with him so they could support him.

Simon accessed his general practitioner (GP), when prompted to do so by his sister, but then did not attend hospital appointments for urgent assessment and treatment when referrals were made for him in November 2022. He was articulate and charismatic and professionals seeing him considered he had mental capacity and so his refusal to accept care was deemed to be an unwise decision and/or self-neglect. There did not seem to be consideration of his traumas when he was not engaging, and professionals did not seem to see him beyond his alcohol dependency.

Why was this SAR commissioned?

The RWSAB Executive agreed that Simon’s case met the criteria for a mandatory SAR on the grounds that there was evident self-neglect, which likely contributed to his death and there appeared missed opportunities to and potential learning as to how agencies shared information and worked together.

What were the findings from the review?

1. Lack of routine, specific mental capacity assessments across health and social care agencies.
2. Individuals with alcohol dependency who are not homeless are often overlooked, leading to inadvertent discriminatory practices.
3. Available tools for communication about clinical deterioration are not being used.
4. Professionals lack awareness that the palliative care pathway includes non-malignant diagnoses

What will we do?

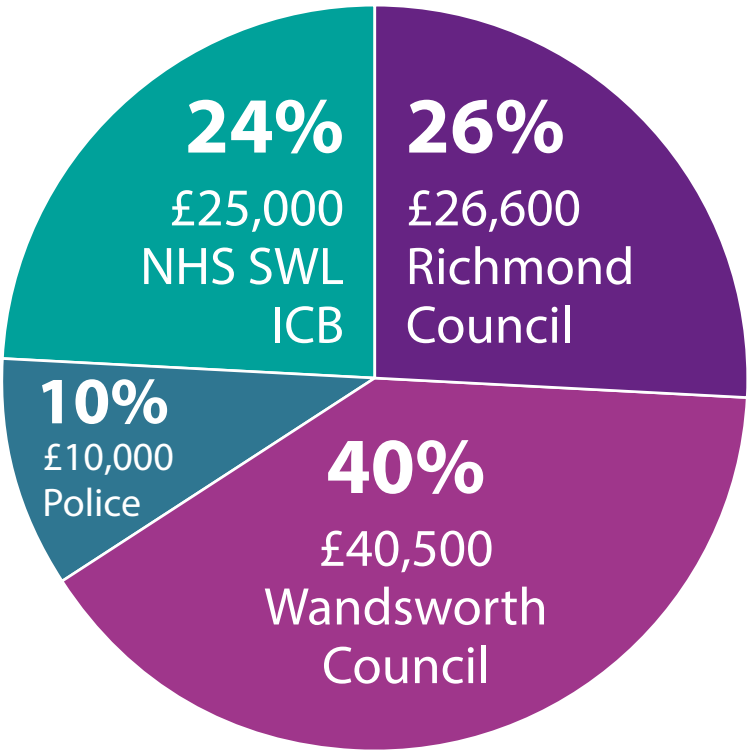
- Ask all statutory organisations to provide evidence on how they ensure Mental Capacity Act training is embedded in practice.
- Promote best practice in Mental Capacity Assessments.
- Audit of Carers Assessments for carers of people with substance misuse/alcohol dependency, to ensure they are robust and convey the voice of the carer with clarity and attention.
- Audit safeguarding referrals related to people with alcohol dependencies which are closed after initial screening, to get assurance of sufficient managerial oversight.
- Seek assurance that the housing provider follow their overcrowding policy.
- Mental Health Trust has provided assurance that the NEWS2 tool is used across health to support clinicians in accessing timely care, support and transfer for patients who are seriously ill.
- SAB and ICB to raise the profile with GPs and other health and social care professionals of the palliative care pathway and ensure they are aware it applies to cases with non-malignant diagnosis including those with terminal conditions following substance misuse such as liver disease.

5 FINANCIAL SUMMARY

Although Richmond and Wandsworth Councils hold primary responsibility for Safeguarding Adults, key statutory partners are anticipated to equitably contribute to the partnership's resources. This contribution is essential to ensure effective safeguarding practices and responses.

As illustrated in the chart above, Richmond and Wandsworth Councils contributed 66% of the funding for the Richmond and Wandsworth Safeguarding Adults Board (RWSAB). Additionally, the South-West London Integrated Care Board and the Metropolitan Police provided direct financial support. Ongoing discussions aim to achieve a more equitable distribution of funding among the three statutory partners of the RWSAB over time. Section 6 of this report details some of the non-monetary contributions made by partners towards safeguarding efforts in the boroughs of Richmond and Wandsworth.

Who gave money to the RWSAB?



6 PARTNERS' CONTRIBUTIONS

While Richmond and Wandsworth Councils are responsible for safeguarding adults in their respective boroughs, all partners contribute to our strategy. This section describes how the partners have worked towards achieving the strategic plan and improving Safeguarding arrangements in Richmond and Wandsworth.

HEALTH, CARE AND POLICE STATUTORY SAB PARTNERS

Adult Social Care – covering Richmond and Wandsworth Councils

1. In line with feedback from Partners in Care and Health, our internal system has been redesigned to streamline the safeguarding process and how we record our safeguarding work. The new workflow is designed to be intuitive and is underpinned by the values of Making Safeguarding Personal. The new process will streamline our safeguarding work, ensure we continue to prioritise addressing immediate safety issues, and practitioners can focus more on their direct interactions with families and residents.

2. Completed a comprehensive update on repeat safeguarding concerns for self-neglect cases. This update provided good assurance on Making Safeguarding Personal, that Mental Capacity Assessments were triggered and completed where required, showed good preventative and multi-agency work, timely completion of immediate safety actions, and escalation to other multi-agency panels where relevant. Some more work is needed to raise awareness of disguised compliance and there is a need to strengthen recording of risk.

3. Following the adoption of the SWL Joint Protocols on Medication Errors, Falls and Pressure Ulcers, we are working on their implementation and promotion with front-line staff.

4. We worked with Police on implementing and now monitoring the new Adult Decision-Making tool of the Multi-Agency Safeguarding Hub (MASH) which improved the quality and efficiency of referrals.

5. We monitored and achieved good compliance in mandatory Safeguarding and Mental Capacity Act Training.

6. We completed joint audits of the Transitions pathway in Richmond and Wandsworth, which showed good consideration of the wellbeing principle, positive signposting, and sharing of information at Panels, and robust assurance of out-of-borough placements.

7. We obtained better feedback from people following Safeguarding process via increased efforts from the Safeguarding Team.

8. We worked closely with and supported the Drug and Alcohol Related Deaths Panel (DARD) with their comprehensive report and final recommendations.

9. We worked collaboratively with Community Safety to promote awareness of Violence Against Women and Girls (VAWG), Domestic abuse, and participated in Domestic Homicide Reviews.

Metropolitan Police South-West Basic Command Unit (SW BCU)

A key achievement within the Metropolitan Police Service (MPS) this review period has been the embedding of Right Care, Right Person protocols. Audits have shown persons suffering mental health crises have received the correct response from medically trained professionals.

MASH review with the introduction of Terms of Reference: Collaboration between the MPS and Adult Social Care for Safeguarding Adults across London which has led to a police staffing increase in the MASH Teams.

Police remain a standing member at Adult Safeguarding Board executive and SAR sub-group.

Key Performance Indicators are set for each team with data centrally supplied within the MPS. Team leads and Public Protection SLT monitor and challenge these indicators. The MPS have Lead Responsible Officers at Superintendent rank leading oversight across safeguarding.

SW BCU has a dedicated Mental Health Team consisting of one sergeant and five police constables. Three police constables are liaison officers with the local Mental Health Trust hospitals engaging on a daily basis to ensure correct process is followed by both police and Mental Health practitioners and to enable discussion over any identified issues and to further close working relationships. Any high risk or complex issues are raised to Mental Health Team Detective Inspector for oversight, management and escalation where necessary with the Mental Health Trust. Two police constables are responsible for conducting daily reviews of all S135/MCA across the SW BCU ensuring the appropriate forms are completed and process followed. The Mental Health Team also lead regular training/awareness across the SW BCU to police officers for Right Care, Right Person, Mental Health Act and Mental Capacity Act.

Safeguarding Adults Reviews and learning practice reviews are attended by SW BCU Safeguarding Detective Inspector. All learning is shared across the BCU and SW BCU Organisational Learning Team to include in team training days/events.

An initial barrier to effective safeguarding within the MPS this year was the introduction of Connect integrated computer programme, having moved away from the 'Merlin' system for safeguarding referrals. This has meant training all police officers across the MPS in 'Connect' and completing referrals. It had been found some referrals were not being passed on to social services. This has since been fixed but as a safety measure, officers check referrals have been passed on.

Officer resourcing and budget constraints continue to contribute to barriers to effective safeguarding. The MPS is currently undergoing a Met-wide review of BCU blueprint design to put the right officers in the right places.

South-West London Integrated Care Board (SWL ICB) – Richmond and Wandsworth

NHS SWL ICB Chief Nursing Officer (CNO) delegates safeguarding responsibilities to the Directors of Quality as senior leaders who are Executive members of the RWSAB. The Directors of Quality is also the SRO for Safeguarding across SWL ICB.

The Pressure Ulcer, Falls and Medication Error Protocols have been led by the designates of the SWL ICB jointly with providers and Local Authority which was shared widely in Richmond and in Wandsworth to be adopted by the wider health and social care providers.

The strategic safeguarding priorities are jointly developed by the RWSAB and the designate safeguarding adult's professional following the challenge events from the SAPAT.

Wandsworth

The Wandsworth Designated Safeguarding Adults Professional is an active member of the RWSAB's sub-groups and chairs the Wandsworth Community Forum. During the year 2024/25, the ICB has contributed by delivering the Joint Safeguarding Strategic Objectives such as training sessions with Wandsworth GP practices on the Self-neglect and Hoarding Panel including the new hoarding framework, Mental Capacity including transitions from children to adulthood with practical guidance and a three-hour joint safeguarding adults level 3 with the ICB and Wandsworth Local Authority Safeguarding manager to around 40 GPs.

As an active member on the statutory panels such as Safeguarding Adults Reviews and Domestic Homicide Reviews, the Wandsworth Joint Intelligent Group (WJIG), the Community Safety Partnership Boards (VRUs), and the Prevent and Protect Strategic group, the designated safeguarding adults professional contributes and helps ensuring that action plans, recommendations are completed in a timely manner and lessons learnt are shared with relevant agencies such as Primary Care to promote learning and shaping practice across SWL and beyond.

Good practice, recommendations and lessons learnt are also shared with our RWSAB to ensure that people with Learning Disabilities and autistic people have equal access to healthcare and improving services as detailed in the learning from the lives and deaths of people with learning disabilities and autistic people.

Richmond

The Richmond Designated Safeguarding Adults Professional is an active member of the RWSAB's sub groups and co-chairs the Richmond Community Forum. During 2024/25, the ICB has contributed by jointly delivering training on self-neglect and hoarding to Richmond GPs together with the Named Safeguarding GP for Richmond.

GP training has been delivered at Kingston University, and a financial abuse training package has been developed specifically for the Mental Health Trust. This package will be more widely disseminated and aligns with the Safeguarding Adults Board (SAB) priorities, particularly as financial abuse remains a significant issue in Richmond.

There is a commitment from the Richmond Safeguarding Adults designate to attend the Community Safety Partnership meetings and contribute to the development of strategies and pathways to address abuse and neglect, especially where it intersects with criminal activity.

Dissemination of learning from Safeguarding Adults Reviews (SARs) and Domestic Homicide Reviews (DHRs) continues at both regional and national levels. Two new DHRs are due to be published shortly. Richmond Council has committed to ensuring that the learning from these reviews is shared with local professionals through targeted training sessions and supported by a '7-minute briefing' to enhance accessibility and engagement.

As an active member on the statutory panels such as SARs and DHRs, the Richmond Joint Intelligent Group (WJIG), and the Prevent Channel Panel, the self-neglect and hoarding panel (used to be the VAMA panel) the designated safeguarding adults professional contributes and helps ensuring that action plans, recommendations are completed in a timely manner and lessons learnt are shared with relevant agencies such as Primary Care to promote learning and shaping practice across SWL and beyond.

HEALTH PARTNERS

Central London Community Healthcare NHS Trust (CLCH)

1 Prevention and early Intervention

a) Pressure ulcers remain the highest reported category of abuse by CLCH staff. The CLCH Pressure Ulcer Audit in 2023 identified that the criteria for making a safeguarding referral sometimes changed when information was validated at the weekly pressure ulcer meetings e.g., category of pressure ulcer and/or safeguarding pressure ulcer score differed when case reviewed by a tissue viability nurse. The Department of Health and Social Care published revised guidance Safeguarding adult's protocol: pressure ulcers and raising a safeguarding concern in March 2024 and the Associate Director of Safeguarding used this guidance to develop a process for making safeguarding referrals based on having accurate and validated information when a safeguarding referral in relation to pressure ulcers is being made. The Associate Director of Safeguarding has proposed that a safeguarding referral would be made following discussion at the weekly pressure ulcer meeting, which is attended by the safeguarding team, which is in keeping.

2 Making Safeguarding Personal

a) The CLCH Safeguarding Team supports the Trust in fulfilling its statutory duty to safeguard our service users and staff, promoting a culture of personalisation and 'think family' when assessing risk, planning safe care and preventing harm.

b) Safeguarding supervision delivered by the safeguarding team has supported staff in decision-making and prioritising the needs and wishes of vulnerable adults, where there is a high level of

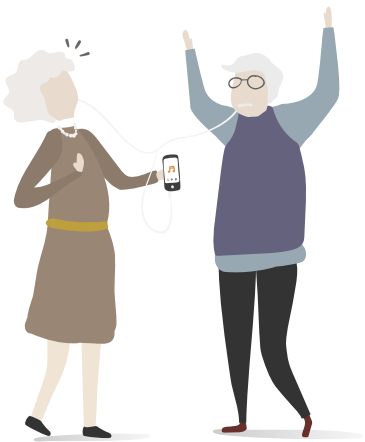
complexity, risk, and vulnerability. A supervision audit will be completed in 2024-2025 to provide assurance regarding the quality of safeguarding supervision.

3 Quality Assurance and Embedding Learning

CLCH demonstrated safeguarding assurance in 2023/24 by having:

a) Lead safeguarding professionals, to meet the statutory requirements as identified in the NHS England Safeguarding accountability and assurance framework (2022), Care Act (2014), Domestic Abuse Act (2021) and the Health and Social Care Act (2022).

b) The application of the Mental Capacity Act (2005) continues to present challenges for some staff. The Safeguarding Team are introducing MCA competencies for sign off by managers in the bedded units with the Named Professionals for Safeguarding Adults signing off ward managers/matrons, who will then undertake the process with their staff. A Mental Capacity Act (MCA) audit has been completed in Quarter 2 in 2024 to establish the quality of MCA assessments and documentation when a person lacks capacity.



c) Compliance with level 3 adult safeguarding and level 3 MCA training in Wandsworth is 92% and 98. The Named Professionals for Safeguarding Adults have been asked to deliver two sessions per months (including face to face sessions) so there are sufficient sessions in place for staff to access, and a training needs analysis has been completed to plan for 2024/25 training sessions. Prevent Training compliance (all levels) remain above the 95% Trust target. Training compliance will be monitored at Safeguarding Committee.

4 Cross-sector working

a) Continued multiagency partnership working by the safeguarding team to assure CLCH staff are compliant with statutory processes to safeguard and protect children, young people, and adults in their care in a proportionate, compassionate, and timely way.

b) Attendance at Multi-agency Risk Assessment Conference (MARAC) meetings to support the multiagency response to high-risk domestic abuse cases to support and protect those who are experiencing or witnessing this abuse from further harm. The CLCH safeguarding team had 100% attendance at MARAC meetings in Wandsworth in 2023/24.

Richmond and Wandsworth Safeguarding Adults Board

Hounslow and Richmond Community Healthcare (now part of the Kingston and Richmond Foundation NHS Trust)

In 2024-25 ongoing pressures on community healthcare required responsive advice and support from the HRCH Adult Safeguarding team.

To address the RWSAB priorities, we have:

- Kept our intranet content under review to ensure staff have access to up-to-date information and resources for prevention of harm, early intervention and making safeguarding personal to balance risk with rights.
- Added to our searchable library of 7-minute case summaries to enable achievable self-directed reflective practice on lessons learned for teams
- Added more short and powerful animations on emerging risk themes e.g. consent, capacity and Deprivation of Liberty for our community Ward.
- Delivered Team Talks (brief refresher re Safeguarding, consent and recording) and completed the proactive rollout of training for Routine Enquiry about domestic abuse.
- Provided case by case advice and support to frontline staff, Managers and partners with regard to prevention of harm, risk assessment and our legal framework for action.

In July and October 2024, HRCH underwent two major stages of restructure which required extensive preparation for Safeguarding business continuity.

This process also took account of a forthcoming merger to create a new Foundation Trust with a Safeguarding remit across both the acute hospital (Kingston) and Richmond community.

Chelsea and Westminster NHS Foundation Trust

Throughout 2024/25, the Trust has strengthened its safeguarding framework across adult services, aligning closely with the SAB priorities.

1. and Early Intervention: The safeguarding team delivered targeted training and awareness campaigns, including Prevent and WRAP, achieving over 90% compliance in Level 1 and 2 training. Early identification of safeguarding risks was supported through enhanced EPR functionality and proactive staff consultations, contributing to a 20% increase in referrals.
2. Making Safeguarding Personal: The team embedded a person-centred approach, ensuring that safeguarding responses reflected individual needs and preferences. This included tailored support for patients with learning disabilities and complex discharge planning involving family and community input.
3. Quality Assurance and Embedding Learning: Internal audits and supervision structures were strengthened, with quarterly audits identifying and addressing documentation gaps. Learning from SARs and DHRs was disseminated via newsletters, training,

and team debriefs, fostering a culture of continuous improvement.

4. Cross-Sector Working: The Trust maintained active participation in multiple Safeguarding Adults Boards and subgroups across London, contributing to statutory reviews and collaborative initiatives. Strong partnerships with local authorities and community providers ensured coordinated responses to safeguarding concerns.

This integrated approach has enhanced safeguarding visibility, responsiveness, and outcomes across the Trust, with continued focus on training, supervision, and partnership working into 2025/26 .Our commitment to safeguarding adults remains unwavering, and we continue to strive for excellence in our practices. We look forward to further strengthening our partnerships and building on the progress we have made over the past year.

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

We continued to monitor for safeguarding alerts related to the changes under Right Care, Right Person. There have not been any specific concerns identified and will continue to review as business as usual.

Interrogating data in relation to EDI & health inequalities has proven challenging due to the lack of consistent recording within our system. However, the 6 monthly and annual reports have contained greater analysis and consideration of our data.

Ongoing webinars and bespoke training on responding to domestic abuse through a trauma-informed approach. Training incorporates supporting staff to recognise patients who may be at greater risk from DVA such as children, LGBTQ+, global majority, and male victims. In turn this supports a key action of the Trust's Suicide Prevention Strategy in ensuring staff know how to address concerns about response from partner agencies such as children's social services and co-ordinating complex cases.

Organised Annual Domestic Abuse Conference (over 200 attendees).

Held Annual Safeguarding Conference (circa 200 attendees).

Focus on the application of Mental Capacity Act with patients refusing physical health care interventions. This is learning from local SARs and trust incidents. The Safeguarding Team delivered bespoke training to the Physical Health team and added this topic to the Mental Capacity Act (MCA) Management and Supervision Tool training. The physical health team have focused on ensuring the MCA is properly applied to patients' physical health care and linked in the Safeguarding team when necessary. It has been agreed that the MCA will become a Fundamental Standard of Care for the Trust.

The Safeguarding team have worked closely with the SAR sub-groups in the ICS to identify the learning from self-neglect & MCA themed SARs for the Trust.

Richmond and Wandsworth Safeguarding Adults Board

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

Prevention and early Intervention

Adult Safeguarding posters are displayed across the Trust, providing clear contact details, including the names and telephone numbers of the safeguarding team. For more complex safeguarding cases, a designated member of the safeguarding team is assigned as a key point of contact for the patient or their representative. This individual provides continuity of care.

The safeguarding team maintains a visible and accessible presence across all Trust sites, supporting staff and promoting a culture of safety and vigilance. Learning is reinforced through the use of local case studies and case discussions in training and supervision.

Key safeguarding messages and updates are also shared through multiple channels, including a safeguarding conference, and bespoke training sessions tailored to specific teams or services.

Increased visibility of the Safeguarding Team has resulted in:

- Increased staff engagement and early consultation with the safeguarding team.
- Improved accessibility and responsiveness to frontline concerns.

Making Safeguarding Personal

Comprehensive workforce training and sustained awareness-raising among staff and service users remain core components of safeguarding work. All staff have access to mandatory safeguarding training tailored to their role and aligned with the Intercollegiate Adult Safeguarding: Roles and Competencies Framework. In addition, the safeguarding team delivers bespoke training sessions informed by learning from serious incidents, Section 42 enquiries, LeDeR reviews, Safeguarding Adult Reviews, and Domestic Homicide Reviews. Training materials and updates provided by the Safeguarding Adults Boards are widely disseminated.

In the past year, a dedicated MCA/DoLS Lead was appointed to strengthen the application of the Mental Capacity Act (MCA) in practice. This role supports the ongoing development of systems and processes to embed best practice, alongside providing targeted training and direct assistance with the most complex patient cases.

Bespoke care pathways have been established across Trust sites for people with learning disabilities.

Quality Assurance and Embedding Learning

Workforce Engagement and Education – Safeguarding Conference:

The annual conference focused on Transitional Safeguarding within the context of both adults and children's safeguarding. The event fostered multi-agency collaboration, enhanced staff understanding, and highlighted the importance of continuity of care during transitional periods.

The safeguarding team regularly shares audit outcomes and learning with SAB sub-groups and disseminates regionally coordinated training through newsletters, bulletins, and supervision forums. This ensures safeguarding remains a live, evolving area of practice across the workforce.

Cross-sector working

The Trust plays an active role in local and regional safeguarding activities, such as:

- Multi-Agency Adults High Risk Panel:
- South West London Protocol on Pressure Ulcers, Medication and Falls:
- Learning from Safeguarding Adult Reviews:

The Trust's Safeguarding Workplan is closely aligned with the priorities set out in the Richmond and Wandsworth Safeguarding Adults Board (RWSAB) Vision and Strategic Plan. This alignment is maintained through regular attendance and active participation in RWSAB sub-groups, including the Quality and Improvement sub-group and Community Forum.

The safeguarding team contributes directly to shared improvement activities and implementation of local actions.

Your Healthcare (YH)

The safeguarding agenda is an integral part of clinical practice, and Your Healthcare's (YH) safeguarding team works with services to review incidents and consider preventative measures in the pre-safeguarding space. The safeguarding team offers support related to mental capacity and multi-disciplinary engagement. We are also members of local Multi-disciplinary meetings, high-risk panels and local and sector wide safeguarding strategic groups.

Your Healthcare has brought in routine domestic abuse enquiry questions for all new episodes of care, where deemed safe to do so. This increases the opportunity to help people at risk access support.

We have robust internal processes and fully investigates and responds to all safeguards, incidents, concerns, complaints or feedback related to service provision. Learning from these and communication with our service users is fundamental to the services we provide.

Your Healthcare trains all its staff to share any concerns they have with the service user and to seek the persons views and wishes. Our staff know that their role is to be a bridge to support engagement in the safeguarding process.

Your Healthcare ensures that our staff know that reporting a safeguard is only one step in a far bigger process of support, empowerment and risk management. Where we provide a service to a person who has an open safeguarding enquiry, Your Healthcare services will be part of the safeguarding action plan and review. Where our services do not have an ongoing involvement, but representation is requested this is provided. Where learning from safeguards recommends changes to systems or practice this will be acted upon.

Safeguarding cases and Multi agency reviews such as Safeguarding Adults Reviews and Domestic Homicide Reviews provide important learning and Your Healthcare aims to include this in our reviews of policy, practice and staff training. As an organisation we are committed participants to both local and sector wide initiatives regarding the prevention, response to and learning from safeguarding.

Richmond and Wandsworth Safeguarding Adults Board

VOLUNTARY SECTOR PARTNERS

Age UK Richmond

Age UK Richmond upon Thames continue to ensure Safeguarding is treated as a priority throughout the organisation and within our partnerships, focusing on early intervention and continuous learning. We support staff, volunteers, partners and the older people to feel confident and able to report any signs of abuse.

We have a policy of providing safeguarding training to all staff and volunteers, which is regularly refreshed. Service Managers and Senior staff are also asked to complete Safeguarding for Managers & Safeguarding Leads training. Safeguarding practices are regularly reviewed and evaluated – this includes the maintenance and regular review at board level of safeguarding policies and register.

In order to support continuous learning, full staff and service meeting are be used to reflect on how cases have been handled and where improvement can be made. We also look to encourage improved approaches to safeguarding with the charities we work with across the borough.

Age UK Wandsworth

Age UK Wandsworth remains committed to being a partner in the RWSAB and participate in the Wandsworth Community Forum.

We completed the yearly self-assessment questionnaire and engage in relevant learning and development events.

All of our volunteers and staff must complete an online safeguarding training course as part of the recruitment process, and we provide guidance on how to recognise and report abuse, making referrals where appropriate. All of our staff who complete home visits complete mandatory Safeguarding Children training and line managers also complete Safeguarding for Managers and Safeguarding Leads training. Safeguarding training is renewed annually.

Safeguarding is a standing agenda item at all of our staff meetings with all staff encouraged to raise any concerns, no matter how small, as soon as possible.

RWSAB Safeguarding Newsletters and relevant updates are shared with all of our staff and also volunteers when appropriate.

Alzheimer's Society – Richmond and Wandsworth

Prevention and Early Intervention – Alzheimer's Society launched a Resource Pack for our non-operational colleagues. Staff use the pack to signpost individuals to early support when they have conversations which indicate issues around safety or wellbeing that do not require a safeguarding response. Use is quality assured. We have also initiated a project focussed on early intervention which aims to develop tools and guidance to prevent people reaching crisis.

Making Safeguarding Personal (MSP) – the Society introduced a new safeguarding record management system which improved our ability to risk assess, monitor themes and trends and makes consideration of MSP a mandatory field. Training for the system focussed on MSP and is included in our updated training suite.

Quality Assurance and Learning – the Society reviewed all compliance training focussing on "Keeping Safe". Themes and practice issues identified by our centralised Safeguarding Team are shared with our Quality & Learning Team to target their work. They carry out desktop and in-person audits to ensure they are safe, effective, caring and responsive. Our Safeguarding Team then complete targeted audits focussed on the safe theme.

Cross-Sector Working – our community-based teams continue to act as key touchpoints between health, social care, and families.

Richmond and Wandsworth Safeguarding Adults Board

Richmond Council for Voluntary Services (CVS)

Richmond CVS is the commissioned infrastructure organisation for the borough supporting the voluntary and community sector (VCS) in all aspects of their activity. Our primary function, relating to safeguarding adults at risk, is to promote an environment where not for profit organisations and their governance structures understand their responsibilities, have effective policies and procedures in place, feel confident in their knowledge and updated in their learning, and know how to respond where there is a concern.

We continue to support the principle that "Safeguarding is everybody's business" regardless of the type of charitable activity delivered and we recognise and support the prevention role of the sector and the benefit of intervening early. This year we have worked with 23 groups on a 1:1 basis to develop or update adult at risk safeguarding policies and procedures and answer queries relating to DBS check eligibility and implementation. The groups operate across a wide range of activity such as community centres, surplus food provision, bereavement and counselling, cost of living support and neighbourhood care groups.

Our membership of the Richmond Safeguarding Community Forum enables us to benefit from the insight of community partners, and to highlight the trends and challenges we are seeing at a grassroots level including the profile of particularly vulnerable groups. This helps to inform the development of services, and strengthens the partnership understanding of the variety of needs of our residents, and the local communities that they live in. Our aim is to work together to foster inclusion, and to create safe and nurturing environments, where people feel comfortable to share their experiences, and staff and volunteers feel confident to respond appropriately. The Voluntary and Community Sector is often the first point of contact for residents, and our membership of the Richmond and Wandsworth Safeguarding Adult Board allows us to share knowledge and build confidence to help identify needs early and make every contact count.

Healthwatch Richmond

Healthwatch Richmond has continued to provide independent insight and constructive challenge as an active member of the Safeguarding Adults Board and its working groups. A central element of our contribution has been encouraging collaboration to enhance joint communication and engagement activities to broaden our ability to convey vital safeguarding messages and cultivate a more informed and vigilant community.

As well as encouraging awareness raising, we have actively promoted safeguarding through inclusion of key messages in a 60,000 circulation Guide delivered to homes across Richmond. We have challenged the safeguarding practice of a national organisation and raised alerts where we have encountered concerns through our work.

We are committed to achieving our common safeguarding goals, which includes ensuring that all staff are appropriately trained and supported around safeguarding and enabling community members to recognise and raise appropriate safeguarding alerts.

Wandsworth Care Alliance (WCA) and Healthwatch Wandsworth

Wandsworth Care Alliance has continued to collaborate closely with partners to leverage integrated communication and engagement capabilities. This has enabled us to strengthen our collective efforts to promote safeguarding messages and raise awareness within the community.

Our dedication to safeguarding remains aligned with the collective objectives of the Board and over the past year, we have also participated in a range of RWSAB partner events and learning opportunities to enhance our offering, including:

- Wandsworth Peer Support & Challenge Event
- Wandsworth Community Forum (virtual, via MS Teams)
- RWSAB Annual General Meeting
- Publicity and support for the "Tackling Discriminatory Abuse Through Collaboration & Innovation" webinar
- Engagement with learning around "Understanding Perpetrators of Domestic Violence"

Participation in these events has significantly enriched our internal knowledge base and has strengthened our understanding of emerging safeguarding issues, including the complexities of discriminatory abuse and domestic violence. This learning has directly informed us on how to better support vulnerable individuals and contribute more meaningfully to safeguarding practice across the borough.

Richmond Carers Centre

Prevention and early Intervention

- All staff are trained to support carers with minimising the risk of abuse and signpost to support services/referrals where needed to avoid escalation of concerns. All signposts and referrals are recorded and reported quarterly.
- RCC runs a counselling service for unpaid carers, where there has been a request for support around more complex emotional needs. Volunteers supporting the counselling service are required to complete mandatory safeguarding training and BACP registered.
- RCC runs a bi-monthly Dementia Carers Information and Support Session in partnership with Richmond Memory Assessment Service. This session is for carers caring for someone with a new diagnosis of Dementia within the past two years. This session aims to support carers with early intervention, prevent escalation and how to manage challenging behaviour.

Making Safeguarding Personal

- In addition to mandatory safeguarding training, as part of their ongoing professional development, all staff are expected to access additional training courses to support in their knowledge and understanding. RCC is committed to staff development and learning.
- Training opportunities are regularly shared with staff and records kept updated.

- RCC has recently updated its Code of Conduct for Adult Carers Service Users that also references when confidentiality needs to be broken if there is a concern about safeguarding, how they can be supported and where to go for information/ legislation.

Learning lessons and shaping practice

- Safeguarding policy reviewed March 2025 and next review scheduled for March 2026. This will be shared on our website and there are signs within the centre to inform carers of who the Designated Safeguarding Leads are and how to contact them.
- Internal safeguarding audit was conducted by trustees and Senior Leadership Team in March 2025. The focus of the audit this year was to look at the induction and training of new staff around safeguarding policies and procedures. The results showed that we have a comprehensive training and induction programme, in particular around safeguarding and that new staff know who to contact and how to raise a concern. This audit is scheduled annually.

Cross-sector working

- RCC has provided induction sessions for social care staff regarding the services available.
- RCC attends bi-monthly Carers Champions meetings and has good working relationships with those working within Adult Social Care.

Wandsworth Carers Centre

Prevention and early intervention

- All staff attend mandatory adult and children safeguarding training and know how/where to report safeguarding issues accordingly.
- All volunteers receive safeguarding awareness training at induction before starting volunteering. All volunteers have an allocated staff member to discuss any concerns with and are taken through our safeguarding policies and procedures.
- We have a designated safeguarding lead who has attended DSL training – level 3.

Making Safeguarding Personal

- Staff understand the principles of MSP, Understanding Individual Needs and Preferences, Co-producing Solutions, & Promoting Choice and Control and apply these principles in practice in their work and record safeguarding conversations accordingly. All staff have easy access to their line manager or other member of the Senior Leadership Team and are encouraged to seek advice and/or support if they have any concerns.
- Staff & volunteers understand the confidentiality policy and know when it may need to be broken after speaking to a senior staff member.

Quality assurance and embedding learning

- Safeguarding training is regularly retaken to ensure staff are up to date.
- Safeguarding is a standing item on our Board of Trustee and Team Meeting agenda
- Information from the SAB is shared with staff as appropriate
- Safeguarding policies are reviewed every 2 years, and the next adult policy review is later this year

Cross-sector working.

- The CEO is a member of the Wandsworth Community Forum

OTHER PARTNERS

Community Safety – Richmond and Wandsworth Councils

Prevention and early intervention

The Community Safety Team has contributed to and/or overseen a range of interventions and multi-agency approaches to ensure that our work intervenes early to prevent harm. Below is a sample of these efforts, both those led by other agencies and those led by Community Safety for areas within our core strategy, for example serious violence and VAWG:

- Community Multi Agency Risk Assessment Conference (CMARAC) – both boroughs
- ASB Case Reviews – both boroughs
- Wandsworth Children's - Youth Justice Board, Marve Plus
- Richmond Children's - Youth Justice Board, Vulnerable Adolescents Supported into Adulthood (VASA Panels)
- Rough Sleeper's Forum
- Self-Neglect and Hoarding sub-group
- Problem Solving Plans
- Multi Agency Risk Assessment Conference (MARAC) for high-risk domestic abuse cases – both boroughs
- Contribution to Combatting Drugs Partnership work
- Channel Panel
- Contribution to ad hoc professionals' meetings for complex case work where appropriate.

Making safeguarding personal

Community Safety has been taking an increasingly tailored approach to our work, recognising that support and safeguarding needs present differently for different individuals, identity groups, and stages of crisis. Below are several examples of our key work in this area:

- The Wandsworth Bereavement Service offers immediate counselling and therapeutic support to victims, witnesses, loved ones and communities impacted by serious violence incidents.
- We received funding for a new commissioned Holistic Post-Crisis Service for domestic abuse victim-survivors, recognising that support needs go beyond the period of immediate crisis for these individuals.
- Victim-centred approaches are used throughout our service, including e.g. ASB Case Reviews
- Commissioning of an Enhanced Needs service in addition to our mainstream IDVA service, which provides advocacy and refuge accommodation tailored for individuals with complex needs, e.g. complex mental health, substance abuse, etc.
- DASH RIC/MARAC training including Trauma Informed Practice and Victim Survivor centred approaches

- We have commissioned specialist services to advise and upskill our MARAC representatives around Harmful Practices

Quality assurance and embedding learning

- We have reviewed the ToR, membership and delivery structure under the CSP to ensure we maintain the highest standards for quality and partnership working in our delivery model, strengthening capacity to embed learning across services.
- Commissioning and delivering of training for multi-agency partners for high risk/ vulnerable groups and issues including around Harmful Practices, Domestic Abuse in the Deaf Community, DASH RIC, Domestic Abuse, MARAC, Prevent
- We have reviewed process with ASB Case Reviews
- We have reviewed CMARAC case reviews
- Partnership learning exercises
- Community Safety oversee cross-borough, multi-agency Strategic Delivery Groups across all CSP strategic priority areas, e.g. the VAWG Strategic Delivery Group and the Prevent and Protect Steering Group
- Community Safety organises and convenes Community Forums for Violence Against Women and Girls and Serious Violence, providing key linkages and opportunities for cross-learning between agencies and VCS
- Drug and Alcohol Death Related Panel learning – both boroughs
- • Domestic Abuse Related Deaths Reviews learning (previously DHRs), including sharing of 7-minute learning – both boroughs

Cross Sector Working

- CSS collaborates closely with key operational partners including the Met Police, Probation Services, LFB, HMP Wandsworth, Integrated Care Board, Registered Social Landlords, Children Services, Adult Social Care, Public Health, Education, and NHS England.
- Community Safety has reviewed and collaborated with statutory and non-statutory partners around a range of refreshed strategies, including the Community Safety Strategy, Collaborative production of 3-year VAWG Strategies for Richmond (to be released in June) and Wandsworth
- Multi-agency Critical Incident Process
- As noted previously, CSS contributes to and oversees and range of multi-agency forums. In addition to those previously mentioned, this also includes the Harmful Practices Working Group, the Modern Day Slavery Working Group and the SAB.
- CSS also attends the SWBCU VAWG Board to support the Met in its efforts to increase community confidence and ensure progress is being made on VAWG.
- CSS provides trainings across the CSP and VCS, and staff participate in trainings offered by other agencies to ensure skills are kept up to date with emerging safeguarding research and best practice.
- CSS collaboratively develops and brings cross-sector papers and presentations to the Richmond and Wandsworth CSP meetings, focusing on key pieces of partnership work.

Department for Work and Pensions (DWP)

Prevention and early intervention

During 2024-25, the Department for Work and Pensions (DWP) has undertaken several initiatives to ensure that adults at risk are at the core of their work to prevent harm.

Advanced Customer Support (ACS):

- The primary focus of ACS is to provide support, learning, services, and strategy to service DWP's most vulnerable customers. This includes ensuring that all service lines have processes and tools in place to facilitate customer support needs at all stages of the customer journey.
- ACS aims to support the identification, access to, and engagement with relevant support for customers who have barriers to accessing services or where there is a significant risk of harm. By empowering colleagues to take the right action at the right time, ACS looks to prevent cases from escalating to a point of risk.
- DWP colleagues are trained to support our most vulnerable customers and have access to a wide range of guidance and signposting to support them. Where further specialist help is required, DWP has a national network of Advanced Customer Support Senior Leaders who can provide additional advice and support through the local networks they have built with external partners and organisations.
- Through the national DWP Visiting Service the Department (c. 600 Visiting Officers) provides additional face-to-face support across all service lines to customers who cannot access DWP services in any other way. A visit can be arranged for a customer if they need extra help to claim benefits, for example because they have complex needs, are disabled, are a vulnerable young person making a claim for the first time, have nobody else to support them or cannot claim benefits in any other way.

Supporting customers at risk of harm

- Across DWP's services we often support customers facing challenges linked to their mental health. We have established processes and guidance for DWP colleagues to follow when they identify a customer who may be at risk of harming themselves, whether that be face-to-face (such as in a Jobcentre) or during a telephone call.
- The Six Point Plan (which is often referred to as 6PP) is the DWPs primary response to instances where customers either make an intent to take their own life or harm themselves.

Making Safeguarding Personal

The Making Safeguarding Personal (MSP) programme emphasises that safeguarding adults should be person centred, and outcomes focused.

How has DWP supported effective engagement and safeguarding?

- DWP financially supports millions of people financially across the UK, but it does not have a social care function and therefore has limited insight into customer circumstances and no legislative duty under the Care Act. Our comments will be general rather than on individual cases due to the nature of the questions asked.
- Where DWP staff do have concerns like those described under S.42 of the Care Act, they will engage with benefit claimants or their representatives and, where appropriate, direct or refer them to agencies – including local authorities, social services, and the police – who can

investigate those concerns.

- DWP colleagues are trained to support our most vulnerable customers and have access to a wide range of guidance and signposting to support them. Where further specialist help is required, DWP has a national network of 37 Advanced Customer Support Senior Leaders who can provide additional advice and support through the local networks they have built with external partners and organisations.
- Where a claimant or a child faces clear and significant risks to their welfare or safety DWP explicitly empowers its staff to proactively disclose information to the relevant body without the claimant providing explicit consent and to take any reasonable steps felt necessary to address those risks. It expects that staff will take action to volunteer to disclose information without any undue delay.

Support for DWP agents

- All DWP agents across all benefit lines have access to the intranet-based District Provision Tool (DPT) which is a directory of provision and support available to all agents to use to support customers. The DPT is split into sections for each local authority area and has specific sections for crisis and welfare support and complex needs. This enables agents to signpost customers to the right support organisation or agency for issues. The DPT also contains links and information on how/where to complete a safeguarding referral for each local authority.
- DWP recognises the barriers that vulnerable people face getting back into work and accessing welfare support. Strengthening the existing DWP offer, in line with the priorities identified through the government's Mission work.
- DWP continues to look for opportunities to upskill colleagues to provide support for vulnerable customers, examples include:
- DWP is investing in developing the front-line skills of staff to support diverse customer groups. This includes routeway training for front-line colleagues.
- Resources are available to support customer engagement including guidance on customer accessibility including reasonable adjustments colleagues can make to support customers, particularly in Job Centres.
- The Oliver McGowan Mandatory Training on Learning Disability and Autism Part 1 (this is a valuable addition to ensure our health care assessors understand more about our disabled and vulnerable customers.
- DWP are currently rolling out The Customer Additional Needs (CAN) Framework across the Jobcentre Plus network. This includes a refresh of Single Points of Contact for a variety of circumstances. The CAN supports districts in taking a place-based approach to developing customer support via joined up working and collaboration with local partners.

DWP Strategy – Trauma Informed Approach

- The DWP is continuously working on ways to support vulnerable customers, including raising awareness around domestic abuse, we are committed to fostering a compassionate and supportive environment for all.
- As part of this dedication, the DWP is committed to becoming a more Trauma Informed organisation to understand and respond to the needs of individuals who have experienced adversity and trauma. We have a dedicated programme which will integrate the six pillars of the Trauma

Informed Approach which are safety, trustworthiness, choice, empowerment, collaboration, and cultural consideration (Office for Health improvements and Disparities, December 2022).

- Our programme looks at these six pillars within the contexts of application to our colleagues, our customers, our culture, and the context of the interaction – whether that is physical, telephony, digital or postal interaction.

Quality assurance and embedding learning

- DWP works with SABs, supporting the identification of learning themes through SARs in line with the national protocol. We know that even small changes that we make can have a big impact on our customers, especially those with additional needs that are trying to navigate the complexity of our systems or processes.
- Learning is channelled through an internal governance route which has senior oversight through the Serious Case Panel.

Serious Case Panel (SCP):

- The SCP is the senior level of governance which is chaired by a Non-Executive Director and includes the Permanent Secretary, Executive Team, Chief Medical Advisor and Independent Case Examiner. The panel review's themes arising from serious cases, such as Internal Process Reviews, and ensure support for vulnerable customers is continuously improved. The SCP is subject to scrutiny at Ministerial level and through the Work & Pensions Select Committee. More information on the Serious Case Panel is available on Gov.uk at: DWP Serious Case Panel - GOV.UK

Cross-sector working

- Although DWP has no statutory duty of care, we lead and believe safeguarding is everybody's responsibility.
- We continue to build capability around signposting to professionals/organisations to support our most vulnerable customers.
- We continue to share and use free training sought and shared through partner organisations to further build knowledge, confidence and understanding of subject areas falling under the safeguarding umbrella.
- We pride ourselves on our joined-up partnership/multi-agency approach to supporting our most vulnerable customers.
- We have a national network of Advanced Customer Support Senior Leaders (ACSSL) who support all benefits lines looking at improvements, lessons learnt, prevention and capability building.
- We have built capability around how to identify and refer to safeguarding teams. We have (locally) designed an easy to access map to enable colleagues across London and Essex to access and respond quicky.

Richmond and Wandsworth Safeguarding Adults Board

London Fire Brigade (LFB)

Richmond and Wandsworth Boroughs' London Fire Brigades work in partnership to identify, refer and assist the most vulnerable – assistance given in Home Fire Safety Visits (these are now prioritised and streamlined to target those at most risk), fire retardant bedding and equipment supplied, alongside linked smoke detection (Tunstall alarms) and arson proof letter boxes.

We ensure attendance at the Self-neglect and Hoarding Panels and other relevant RWSAB meetings.

Providing training to frontline care staff in fire safety awareness and risks associated with clients.

Setting up priority initiatives within the borough around Dementia, Alzheimer's, Bluebird Care.

Giving advice where appropriate to partners in the boroughs. Engagement with Age UK and more awareness of the assistance that LFB can give to those who are vulnerable.

We have also assisted in evidence gathering and reporting on self-neglect (hoarding) and attended court to assist in de-cluttering and making homes safe by assisting in expert witness testimony.

National Probation Service

- Use of Offender Personality Disorder (OPD) Pathways to create case formulations on vulnerable adults with Physical Disability/ Mental Health traits/diagnosis. This is led by local practitioners with psychologists from NHS to aid knowledge and interventions.
- All cases within Richmond and Wandsworth Probation Delivery Units have Offender Assessment System (OASys) assessments completed which identify the potential for vulnerable adults with risk management plans to manage the risk they pose along with supports to address safeguarding of both individuals and those known adults potentially at risk.
- Engagement with some chairing responsibilities for Violence against Women and Girls (VAWG), Multi-Agency Risk Assessment Conferences (MARAC), Multi-Agency Public Protection Arrangements (MAPPA) and Youth Justice Boards (YJB) to identify vulnerable adults at risk of serious harm and partnership engagement to reduce risk posed to them.
- Single Point of Contacts for Safeguarding Adults Board are to be identified to aid dissemination of practice changes and case discussions.
- Mandatory Safeguarding Adults at Risk e-learning is required by all practitioners and managers to be completed by end of March 2025 to comply with our internal Competency Based Framework (appraisal process).
- Use of our bespoke Commissioned Personal Well-Being service to support vulnerable Adults.
- Monthly Resettlement Panel Meetings to aid those at risk of homelessness and use of commissioned services to support temporary accommodation in attempts as a preventative action.

Housing and Regeneration Department – serving Richmond and Wandsworth Councils

Housing are committed to the priorities of the SAB and facillitate these through their strategies and processes. The department aims to participate constructively in SAB events, relevant sub-groups and multiagency meetings to provide a housing perspective on issues and ensure policies and procedures reflect decisions made in addressing Safeguarding issues and meeting the needs of vulnerable residents.

We raise awareness of safeguarding issues through our resident communication, including a revised Homesafe home safety and home security booklet and publishing relevant articles in the residents magazine, Homelife.

This year our processes were scrutinised through a regulatory inspection with particular focus and feedback on Housing's approach to vulnerable residents. This includes reviewing policies and procedures on anti-social behaviour and hate related incidents, mental capacity and approving a new policy for vulnerable residents. New training has been developed for all housing staff to identify and record signs of vulnerability. Specialist courses in safeguarding adults and children is available and staff, and new starters are required to complete their mandatory courses.

Contractors, including a new contractor appointed for a full stock condition survey programme, are periodically reminded to complete their Safeguarding training responsibilities and to report concerns of neglect or abuse.

Richmond Housing Partnership (RHP)

At RHP, we continue to work in partnership with other agencies to ensure customers in our homes are supported and can access both our services and those provided by other organisations. We recognise that safeguarding is a collective responsibility, and we are committed to playing a proactive role in supporting the wider work of the Safeguarding Adult Board.

As part of National Safeguarding Week in November 2024, our employees actively participated in a range of safeguarding events, hosted both internally and externally by partner agencies, to raise awareness and deepen our understanding of safeguarding responsibilities across our teams. These sessions have enhanced our ability to recognise, respond to, and refer safeguarding concerns effectively.

Safeguarding training is mandatory for all operational teams, including caretakers and operatives who regularly interact with customers in their homes and out and about on our estates. This training is enriched by the use of real-life case studies focusing on issues such as hoarding, cuckooing, anti-social behaviour, and isolation—highlighting the hidden risks these situations can pose to individual wellbeing.

We are proud to be an active partner supporting Richmond and Wandsworth Safeguarding Adult Board and a member of the subgroup, Richmond Community Forum. We also support other safeguarding committees and events promoting and raising awareness of safeguarding so that people can live safely free from neglect and abuse. Our close contact with customers enables us to bring valuable insight into the lived experiences of vulnerable individuals, contributing to better-informed safeguarding strategies and prevention efforts.

Through a multi-agency approach, we carry out joint risk assessments which have helped safeguard vulnerable adults and reduce harm. These efforts often involve collaboration with the police, adult social care, community mental health teams, and voluntary sector partners. Our ability to act as an early warning system—by spotting concerns during routine visits—means we can escalate issues swiftly and work with the right partners to intervene.

We also carry out a number of activities and events to increase our accessibility this includes door knocking, face to face hubs in our communities and our winter warmer campaign where we contacted all our customers over 80 and carried out home visits to all customers over 90. These visits are carried out by experienced employees to ensure our customers are living safely free from neglect and abuse, have appropriate heating, no outstanding repairs and have access to services and agencies as required and escalate any risks or concerns.

Kingston and Richmond Safeguarding Children Partnership (KRSCP)

During 2024-25 KRSCP has continued to work collaboratively with our partners on a wide range of safeguarding activities can see progress against our priorities for 2025-26 which are:

1. Child Sexual Abuse & Exploitation
2. Neglect
3. Adolescent/Transitional Safeguarding & Serious Youth Violence
4. Implementation of Working Together and associated guidance

These priorities have been highlighted through the activities of all our subgroups' broader workstreams.

We have been working throughout the year to implement Working Together to Safeguard Children 2023 Guidance, have met all of the key deadlines, clarified our governance structure and have held engagement events with faith, voluntary, community and sport sectors in Kingston and Richmond. We have continued to deliver our multi agency safeguarding training programme to disseminate and embed learning across the partnership on a wide range of national and local safeguarding themes.

We are particularly proud of our work with other partnerships including engagement with Richmond and Wandsworth SAB and have led in the instigation and production of the Joint South West London Neglect Strategy which has been developed in collaboration with Merton, Croydon and Wandsworth Safeguarding Children Partnerships.

We have received positive assurance from our Section 11 and Section 175 audits around safeguarding practice across Kingston and Richmond, and the findings of the Joint Targeted Area Inspection on the Multi-Agency Response to Identification of Initial Need and Risk (Front Door) that took place in July 2024.

Richmond and Wandsworth Safeguarding Adults Board

Wandsworth Safeguarding Children Partnership (WSCP)

The WSCP delivered a wide range of multi-agency safeguarding initiatives aligned with the Safeguarding Adults Board's strategic priorities, with a strong focus on prevention, child-centred practice, and continuous learning.

Prevention and Early Intervention

The WSCP prioritised early intervention by improving access to support services for vulnerable and disadvantaged families. The implementation of the Family Safeguarding model, alongside streamlined referral pathways, led to a reduction in the number of children subject to Child in Need and Child Protection plans. Notably, Early Help interventions achieved a 65% improvement rate at closure, clearly evidencing positive impact.

The partnership has also made significant progress in utilising multi-agency data from health, education, and police to proactively identify vulnerable children and emerging patterns of concern. This intelligence led approach supports regular analysis of local trends and helps shape targeted prevention strategies across the borough.

Key thematic priorities have been identified through subgroup discussions, influencing both good practice development and multi-agency training programmes. Themes such as Child Sexual Abuse, Neglect, Anti-Racist Practice, and Online Safety have been central to shaping our safeguarding response and strategic direction.

Making Safeguarding Personal

The WSCP is committed to ensuring that the voice of the child is at the heart of all safeguarding practice. Through the work of our Young Scrutineers, children and young people have played a meaningful role in shaping services. Initiatives have included co-produced surveys, involvement in recruitment panels, and participation in service planning, embedding their lived experiences into key safeguarding decisions.

Children's voices have also been amplified through youth-led podcasts, providing powerful insights into their experiences and perspectives, and reinforcing our commitment to child-centred practice.

A strong focus on anti-racist practice has continued throughout the year. This included a well-attended multi-agency conference and strengthened representation from diverse community voices across our partnership activities.

Looking ahead, our next annual safeguarding conference scheduled for November 2025 will focus on Intra-Familial Child Sexual Abuse, aligned with national thematic learning. Planning is well underway, with a focus on embedding lived experiences into the design and delivery of the event.

Learning Lessons and Shaping Practice

Over the past year, the WSCP have one open Local Child Safeguarding Practice Review. The learning from this review has directly informed multi-agency training, the revision of local protocols, and improvements in safeguarding practice across the partnership.

The WSCP has also embedded a robust Practice Assurance Framework to drive continuous improvement and ensure accountability. Over 1,000 professionals accessed multi-agency training, which covered key areas including domestic abuse, child

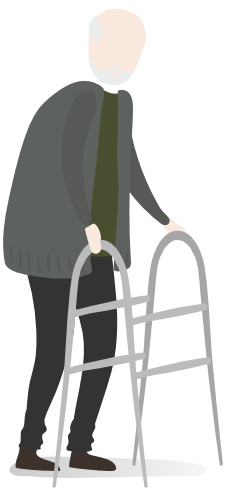
exploitation, and anti-racist practice.

In May 2025, the WSCP hosted a full-day learning event focusing on Child KK, bringing together professionals from health, children's social care, police, and education. Each partner contributed to a comprehensive narrative of the child's journey, identified lessons learned, and developed shared recommendations to strengthen future practice.

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

We continued to take a proactive approach regarding scams/fraud. Attending several community events to speak with residents about their concerns, providing advice on individual issues and signposting them to organisations where they can learn more. Our partnerships have continued to grow with local organisations; we have been delivering talks to service users as well as staff. Helping staff identify individuals who may need further support in this area.

When complaints have been received, we have provided advice and reassurance to residents helping them not to feel embarrassed or scared, ensuring they can continue to live independently. Where appropriate we have assisted them in obtaining refunds. This work has helped return over £95,000 to residents.



Richmond and Wandsworth Safeguarding Adults Board

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Questions about this report

If you have any questions about this report, please email sab@richmondandwandsworth.gov.uk

Richmond and Wandsworth Safeguarding Adults Board

Remember, safeguarding is everyone's business

Designed and produced by wdp@wandsworth.gov.uk CS1975 (7.25)