

# Health and Social Care Scrutiny Commission

Wednesday 2 April 2025  
7.00 pm  
160, Tooley Street, SE1 2QH

## Supplemental Agenda One

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5.	<b>Independent Chair of the Southwark Safeguarding Adults Board</b> Anna Berry, Independent Chair of the Southwark Safeguarding Adults Board (SSAB), will attend for her annual interview. The Southwark Safeguarding Adults Board Annual Report is to follow.	1 - 20
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### Contact

Julie Timbrell on 020 7525 0514 or email: Julie.Timbrell@southwark.gov.uk

Date: 31 March 2025



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## 1. Message from the Chair of Southwark Safeguarding Adults Board

I am pleased to introduce the 2023-2024 Annual Report for the Southwark Safeguarding Adult Board (SSAB). The annual report is a strategic requirement for the Board and acknowledges the challenges and achievements of the previous year. I am grateful for the engagement of all our partners and the amount of work that has taken place over the last year, not only to safeguard people from abuse and neglect but also to support the activity of the Board.

The Local Authority, Integrated Care Board, Metropolitan Police Service, and many other organisations come together to form the SSAB. Collectively we are committed to addressing strategic safeguarding issues and share learning to improve adult safeguarding. It is important that together as members of the Safeguarding Adult Board we continue to challenge ourselves to deliver better services, ensure there is sufficient resource to support the work of the SSAB, support people who are at risk in our communities and further identify practices which provide a collective response to safeguarding.

Significant development work has taken place in this reporting period with a 3-year business plan to reset and refocus the areas of priority. Progress has been made against the approaches to complex safeguarding, wider partnership alignment, approaches to Safeguarding Adult Reviews (SARs) and resources. We have also seen some new and emerging thematic areas raised by our members. Importantly the SSAB continues to develop the mechanisms for assurance, learning and development. One of the key purposes of the annual report is to promote the role of the SSAB with the public and other local multi-agency partnerships as well as the profile of safeguarding adults in Southwark.

In conclusion, I would like to take this opportunity to acknowledge that these are challenging times for all, but through our shared commitment we can continue to strive to achieve our shared vision:

*We believe all adults at risk that are living in or visiting Southwark have the right to be safe and protected from harm. We will all work together to support these adults and their carers to make informed choices and to provide the highest quality services so they can live full, independent and self-determined lives.*

Please take time to read the detail within the report and feedback to us your views and thoughts on the work the SSAB does, and how we can ensure all agencies are working effectively to support and protect vulnerable adults in Southwark. I would like to acknowledge the work and commitment of our front-line practitioners in Southwark, and the significant contributions to the work of the SAB by all of its member agencies. I would like to finish by extending my thanks and appreciation to the Board Business Manager, the Board members and members of our various subgroups, for their continued support to developing and promoting the work of protecting adults.

Anna Berry, Independent Chair



## 2. Our Vision & Purpose

**We believe all adults at risk that are living in or visiting Southwark have the right to be safe and protected from harm. We will all work together to support these adults and their carers to make informed choices and to provide the highest quality services so they can live full, independent and self-determined lives.**

Southwark Safeguarding Adults Board's primary objective is to assure itself that local safeguarding arrangements and partners act to help and protect adults who are at risk of/or experiencing abuse or neglect.

The Board will hold agencies to account for their key safeguarding responsibilities, so that:

- All those who work with vulnerable adults know what to do if there are concerns about possible harm or abuse.
- When concerns are raised regarding an adult who is vulnerable to harm / abuse, action is taken in a timely manner and the right support is provided at the right time.
- Agencies which provide services for vulnerable adults ensure they are safe, and monitor service quality and impact.

### Key strategic questions for the Board

- Is the help provided effective? How will we know our interventions are making a positive difference?
- How will we know all agencies are doing everything they can to make sure vulnerable adults are safe?
- Are all partner agencies meeting their statutory responsibilities as set out in The Care Act?
- Do all partner agencies quality assure practice and is there evidence of learning and improving practice?
- Is safeguarding training monitored and evaluated and is there evidence of training impacting on practice?

### 3. Membership of the SSAB

The Southwark Safeguarding Adult Board (SSAB) is a partnership of statutory and non-statutory organisations, representing health, care and support providers and the people who use those services across the Borough. The three key statutory duties for Safeguarding Adults Boards in the Care Act are:

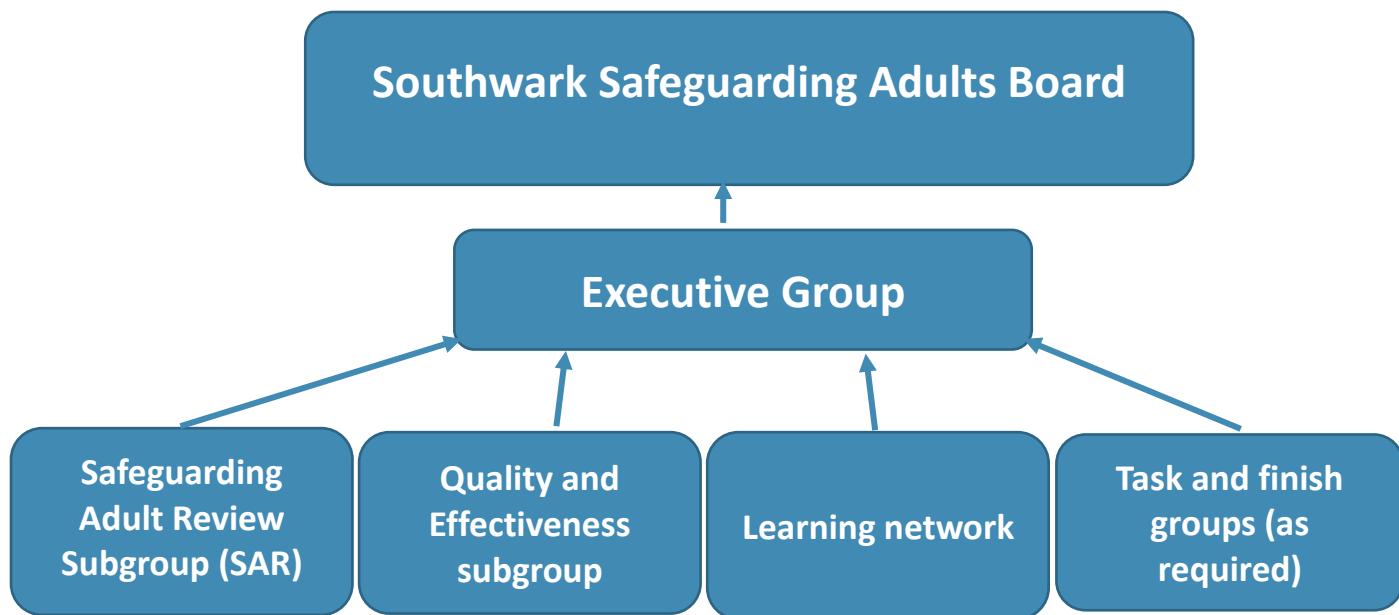
- Publish a strategic plan for each financial year that sets out its objectives and what members will do to achieve this;
- Publish an annual report detailing what the SAB has done in the year.
- Conduct any Safeguarding Adult Reviews in accordance with section 44 of the Act.

Membership comprises of the senior leaders across organisations, who under the leadership of the Independent Chair, work collaboratively to develop and improve safeguarding across the Borough. The partnership includes:

<b>Southwark Council</b>	<b>ICB/NHS</b>
Independent Chair, SSAB	Strategic Director for Integrated Health and Care/Southwark Place Executive Lead, Southwark, SELICB
Strategic Director of Children's and Adults Services	Designated Nurse for Adult Safeguarding (ICB)
Strategic Director of Housing and Modernisation	Named GP for Adult Safeguarding (ICB)
Strategic Director of Environment and Leisure	Head of Safeguarding Adults (GSTT)
Director of Adult Social Care	Safeguarding Adults Lead (KCH)
Director of Communities	Safeguarding Adult and Child Lead (SLaM)
Director of Public Health	<b>Police</b>
Director of Resident Services	Chief Superintendent Southwark and Lambeth BCU
Director of Commissioning, Children and Adults' Services	Detective Superintendent - Head of Public Protection
Assistant Director, Community Safety and Partnerships	<b>Other Organisations</b>
Principal Social Worker for Adults	Borough Commander, London Fire Brigade
Cabinet Member for Community Safety	Head of Probation Service, Southwark
Cabinet Member for Council Homes and Homelessness	Community Southwark
Cabinet Member for Health & Wellbeing	Provider Representatives



## 4. Governance Structure



## 5. Work of the Subgroups

The work of the SSAB is supported by the following Subgroups and linked forums:

**The SSAB Executive Group**- this group operates to provide multi-agency strategic leadership and direction to the SAB, overseeing the strategic aims within the context of wider system reform and national developments. The Executive Group also ensures development and maintenance of strong links with other strategic boards, with a focus on joint working and a holistic approach to safeguarding. These include, but are not limited, to the Community Safety Partnership, Safeguarding Children Partnership and the Health and Wellbeing Board.

**The SAR subgroup**- this is a forum to bring together referrals for cases to be considered for review. The Panel will also undertake the role of monitoring recommendations of completed reviews and ensuring that learning is shared across Southwark.

This has been a particularly prominent group during 2023/24 in its work to embed its processes, maintain active oversight of cases that are referred in for consideration, coordinate various types of learning from cases and seeking assurance from the partnership on progress of SAR recommendations and actions plans. In addition to making decisions whether the SAR threshold has been met, this group also reviews and implements recommendations regarding learning from the National SAR Analysis and takes forward priorities for sector led improvement.

**Learning network**- This group was reviewed in terms of its effectiveness in tandem with the Safeguarding Children Partnership and now has a distinct “adult” space with mechanism for alignment with other parts of the system for example the Safeguarding Children Partnership and the Community Safety Partnership. Therefore in its new format is in its development stage and is designed to lead on the development and implementation of learning from SARs and wider system cross partnership learning.

The SSAB is committed to promoting a culture which values and facilitates learning and in which the lessons learned are used to improve future practice and partnership working. This approach facilitates robust mechanisms to review, analyse and develop practice. We are confident that our approach to learning and development drives improvements in the wider safeguarding system as well as in the outcomes experienced by users of services.

**Quality and Effectiveness subgroup**- this group has also undergone a period of review and is in its development stage. It aspires to bring together core multiagency data across adult services to inform priorities and provide assurance on multiagency performance. The subgroup will also oversee multiagency audits and deep dives, seek assurance of emerging areas of concern and maintain system oversight of key related issues.

**Task and Finish Groups**- within the period of reporting there have been two emerging areas that have been identified with targeted activity commenced. These areas are Safeguarding Asylum-Seeking people and Strengthening Safeguarding

oversight of homelessness in Southwark. In addition, there has also been a tri-borough review and focus on the Complex Safeguarding Pathway which is ongoing.

## 6. Communication & Engagement

The SSAB is committed to continually strengthening our approaches to communication and engagement with services, frontline workers and the people who use our services. During 2023-24 we continued to embed our Communication and Engagement strategy. We developed and launched our refreshed SSAB website to ensure that key messages are shared as widely as possible.

### Looking ahead to 2024/2025

- We will continue to engage with frontline staff in Southwark to find out what is working well for them and where there are challenges or barriers.
- We will design better mechanisms together with our partner agencies to capture the messages and engage with people receiving services in Southwark, to learn from them what works well and what could be improved

## 7. Safeguarding Adults Partnership Audit Tool (SAPAT)

Under the Care Act (2014), Safeguarding Adults Boards must have an audit process to monitor and evaluate their performance and that of the member organisations. In Southwark we do this by using a self-assessment audit tool to all partner agencies and by holding a multi-agency challenge event to scrutinise the feedback.

The annual SAPAT tool was not repeated in 2023-2024, instead a decision was taken to review the key themes that were identified from the 2022/23 SAPAT to inform the ongoing work programme and changes that have been implemented:



### **1. Management of complex cases**

The complex case pathway is being utilised, but it was noted across several boroughs that there was further work to be done to successfully implement the pathway and maximise its use across the multiagency partnership. This work forms part of the 2023- 2026 business plan.

### **2. Engagement of Service users**

It is acknowledged that engagement of service users and listening to their lived experience is widely implemented across the agencies comprising the SSAB. However, the SSAB business plan outlines the ambition to create specific space with the structure of the SAB to enable those with lived experience to feed into reviewing and improving the systems in place in Southwark.

### **3. Dissemination of learning from SARs**

There has been significant work undertaken during this reporting period to strengthen SAR approaches as a continual cycle of learning from referral to dissemination and review. Whilst there have been no SARs published during this reporting period, there have been some commissioned and commenced and we look forward to sharing the learning gained from those reviews.

## **8. Financial Arrangements**

The work programme for the Board, Subgroups and that of the Independent Chair are funded through SAB contributions. A well-resourced Board is essential to enable it to deliver its statutory duties and supports the Board to fund Safeguarding Adult Reviews (SARs) and learning events and other Board activities. The current Independent Chair has requested additional resources to support the SSAB in the delivery of its statutory duties. The SSAB would benefit from having a dedicated data analyst to appraise, quality assurance, the delivery of learning and multi-agency training.

This last year has seen a significant increase in the number of SARs being referred into the SAB, considered and undertaken, which has increased the burden on the existing resource. The current resource for the SSAB is 0.5 (Full Time Equivalent) Board Manager, a 0.5 (Full Time Equivalent) administrative support role, and four days a month for the Independent Chair. The extra demands created by the additional SAR activity this year has served to highlight the gap.

SSAB receives financial contributions from a number of agencies and other forms of in-kind support.

Money received in 2023/24 is detailed here.

MOPAC Police - £5,000

ICB Southwark - £55,000

London Fire Brigade - £500

London Borough of Southwark - £63.421.50

Total £123.921.50

## 9. Core Adult Safeguarding Data

During 2023/2024, Adult Social Care (ASC) addressed a total of 1102 concerns, with 295 of these necessitating a S42(2) enquiry. The conversion rate from concerns to enquiries was 27%, demonstrating a 5% increase from the previous year and a 2.5% deviation from the national average, presently standing at 29.5% (NHS digital).

Concerns and Enquiries	2021/22	2022/23	2023/24
1. Safeguarding concerns received	1400	1145	1102
2. Safeguarding enquiries commenced	401	252	295
3. Rate of Concerns to Enquiries	29%	22%	27%
4. Safeguarding enquiries concluded	401	252	305
5. Safeguarding enquiries concluded within 30 days	277	183	207
% Prop	69%	73%	68%
6. Concluded enquiries where the individual assessed as lacking capacity	100	67	94

7. Safeguarding enquiries concluded where risk was identified	401	241	305
% Prop	100%	96%	100%
8. Where risk identified - risk reduced or removed	377	241	285
% Prop	94%	100%	93%
9. Safeguarding enquiries for which the individual expressed desired outcomes	268	195	204
% Prop	67%	77%	67%
10. Safeguarding enquiries for which the individual's expressed outcomes were fully or partially achieved	263	191	194
% Prop	98%	98%	95%

### Overarching messages from the data:

**Safeguarding concerns** have continued to fall from a Covid related peak in 2021/2021. Overall, there continues to be variability, year on year, and with Southwark's peer authorities, who also experienced significant internal variations year on year ([Safeguarding Adults Collection - NHS England Digital](#)). This primarily reflects the small sample sizes of adults eligible for Care Act safeguarding processes, with a small change in actual numbers making a substantial change in proportion.

**Mental capacity:** A noteworthy point from the last performance year, is the higher proportion of safeguarding enquiries that were undertaken with individuals who lacked mental capacity to engage fully in the process (an increase of 4%). The reduction in enquiries completed within the indicative timescale is likely to have been influenced by this, and the associated requirements for formal or informal advocacy and support to participate. The reduction in individuals expressing desired outcomes is also thought to have been influenced by this.

**Conversion rates** have increased from 22% to 27%. This continues to be lower than some, but not all of our near peers as defined by NHS England, reflecting the well-developed alternative safeguarding routes within Southwark. Encouragingly, some of the key example thematic areas include complex safeguarding themes. Key

examples are; assessment of care and support needs, hoarding and housing panels and forums, domestic abuse and modern slavery forums.

**The people-** for demographic reasons, the majority of the population eligible for Care Act Safeguarding processes are supported by staff from the Older People and Physical Disability Service. Changes in how the concern and enquiry stages are recorded and allocated to staff, are being trialled in this area. This is expected to lead to an increase in the conversion rates and improve data capture to track diversion from a section 42 process, into other forms of risk management, such as complex safeguarding pathway.

**Risk formulation-** we continue to resolve or reduce risk, through safeguarding processes, in a vast majority of these situations where risk has not been removed or reduced, this is generally because of the limitations of section 42 of the Care Act, as a vehicle to intervene in people's lives and decisions. This applies particularly in situations where the risks do not meet the threshold for High Court intervention, and a person with capacity is making an unwise or unsafe decisions.



## 10. Our Priorities

In March 2023, the newly formed Safeguarding Adult Executive came together to consider the priorities for the coming year. It was decided that there would be a 3-year business plan, with year one (2023/2026) to focus on embedding structures, building stronger foundations and getting the priorities for people right.

There are four strategic priorities which are outlined on the business plan on a page:

- **Strategic priority 1-** Communication and involvement
- **Strategic priority 2-** Strategic prevention and early intervention
- **Strategic priority 3-** Making Safeguarding Personal
- **Strategic priority 4-** Learning development and assurance



## SSAB BUSINESS PLAN ON A PAGE 2023-2026

**CURRENT VISION:**

We believe all adults at risk that are living in or visiting Southwark have the right to be safe and protected from harm. We will all work together to support these adults and their carers to make informed choices and to provide the highest quality services so they can live full, independent and self-determined lives.

**Safeguarding Adult Board****SAB Executive group**

SAR subgroup

QE subgroup

Learning network

T&amp;F groups

**SAB Responsibilities**

Publish Strategic Business Plan

Publish Annual report

Complete Safeguarding Adult Reviews

Strategic Priority 1	Strategic Priority 2	Strategic Priority 3	Strategic Priority 4
Communication and involvement	Strategic Prevention and Early Intervention	Making Safeguarding personal	Learning Development and Assurance
Improve awareness of safeguarding across all citizens, communities and partner organisations.	Developing strategies that reduce the risk of abuse, as well as seeking assurance from partners	Ensuring that adults with care and support needs are being supported and encouraged to make their own decisions	Ensure safeguarding arrangements work effectively and learning is shared
<ul style="list-style-type: none"> <li>- Review of Board resources and arrangements</li> <li>- Oversight of activity</li> <li>- Strengthening of tools and processes</li> </ul>	<ul style="list-style-type: none"> <li>- Strengthening oversight via a dataset and dashboard</li> <li>- Thematic priority re-launch and focus</li> <li>- Development of a multiagency framework</li> <li>- Review of Board Expectations</li> <li>- SAR action planning</li> <li>- Service user engagement</li> </ul>	<ul style="list-style-type: none"> <li>- Multiagency oversight</li> <li>- Multiagency Audits</li> <li>- Involvement of service users</li> <li>- Impact of activity</li> </ul>	<ul style="list-style-type: none"> <li>- Learning and development strategy</li> <li>- Dataset and dashboard</li> <li>- Sharing learning effectively</li> </ul>

**Thematic Priorities**

- MULTI AGENCY MANAGEMENT OF COMPLEX SAFEGUARDING
- TRANSITIONAL SAFEGUARDING

## Managing Complexity

Findings from local and national Safeguarding Adults Reviews (SARs) have identified concerns about how agencies worked together effectively to support adults at risk of self-neglect, where the risks (both known and unknown) are increasing, and where providing support for the person is either challenging or those support pathways are unclear. This has been a consistent message and has led to a review of previous work in terms of how effectively the pathways for complex safeguarding are being utilised in Southwark.

These risks and challenges can often be compounded as the adult may not meet the criteria for a formal adult safeguarding response, or the person may not be in receipt of a service with clear responsibility for overall care co-ordination that takes into account the entire well-being of the person, or the person may fall outside eligibility criteria for statutory services.

In response to this, the SSAB developed a Complex Case pathway, which seeks to;

- promote a *pro-active responsibility to act* on the agency that identifies the concern,
- encourage the facilitation of multi-agency conversations about risk
- develop on-going consideration of risk and actions through the identification of a lead agency

SSAB previously led the implementation of the complex case pathway as a tool to bring agencies together to assess and manage risk in complex situations relating to self-neglect. During 2023/2024 we started to explore a number of challenges such as how well the pathway is understood, used and how it aligned with existing policies, procedures and pathways. Towards the latter stage of 2023/2024 a tri-borough collective scoping exercise commenced to look at these challenges and consider the way agencies are utilising the Complex Case Pathway. This has led to a stocktake of the pathway and further work to ensure it is used to best effect. This work is scheduled to continue throughout 2024/2025/

## Transitional Safeguarding

SSAB facilitated workshops throughout 2023/2024 to explore the points of transition in the systems across Southwark, and to raise awareness of the full understanding of the challenges young people face when they transition from childhood into adulthood. It was encouraging that members could evidence a range of ways in which they consider and make provision for transitional points. Further work is planned to explore cross partnership thematic areas and thus strengthen approaches. In particular, engagement workshops are identified as a crucial way to gain insight and develop and strengthen systems.

## Homelessness

In 2022/2023 there was a SSAB homelessness task and finish group through which the “risk assessment toolkit to safeguard service users with multiple complex needs” was developed and implemented. Following Ministerial communications during 2023/2024 the SSAB has again reviewed its arrangements to strengthen oversight of safeguarding concerns within the homeless population, consider measurable outcomes and ensure that learning is captured from any serious incidents.

Therefore, a task and finish group is scheduled to coordinate this work in 2024/2025.

### **Other activity and things that worked well:**

- Consistent and good commitment and contributions from agencies at all levels of the SSAB have informed the activities throughout the year. In particular a strategic activity to develop the business plan, dynamic risk register and take forward the correct priority areas.
- Implementation of a new process for receiving, considering, commissioning and progressing Safeguarding Adult Reviews. This included the development of an active dashboard and a healthy and proportionate approach to learning.
- London wide PIPOT guidance has been reviewed and its implementation will be planned via a short task and finish group in 2024/2025.

- Launch of the SSAB Executive group to maintain oversight of progress, in particular this led to cross partnership alignment to consider the most appropriate way to use the financial budgets.
- Facilitation of task and finish groups to take forward emerging issues raised through the work of the SSAB and its partners members.

#### **Areas for development against the strategic priorities:**

- The Board recognises through its business plan that the use of tools to strengthen assurance and oversight is essential. This includes a multiagency core dataset and analysis functions. The Quality and Effectiveness subgroup have reviewed the resources required to develop a range of tools and will work with the Executive subgroup and the Board over the coming year to take this forward.
- The ways in which the SSAB captures the lived experience of people requiring service in Southwark and that of the frontline workers is an area of focus for the coming year. The communication and engagement strategy will be revisited to ensure this is captured in the most effective way.
- Multiagency audit work is acknowledged as a method of measuring impact and capturing the success of safeguarding work and a robust programme of audit across the agreed and emerging priority areas is planned in 2024/2025.
- Building on the success throughout 2023/2024 in the application of new and dynamic process for safeguarding adult reviews, the mechanisms for sharing learning effectively and impactfully will be reviewed through a relaunch of the learning functions of the SSAB in 2024/2025.

## 11. Learning from Reviews

### Safeguarding Adults Reviews (SARs)

The SSAB must carry out a SAR when an adult at risk dies or is seriously harmed, and there is concern that partner agencies could have worked more effectively to protect them.

During 2023/24 seven referrals were received for SAR consideration, of which it was agreed in the latter part of the year that four met criteria. Therefore, two distinct SARs will be commissioned, and two cases will be considered as part of a thematic examination, together with two of that cases that did not meet criteria. This thematic subject is that of “transfers of care”. The progress and findings from these SARs will be reported on in 2023/34.

There were two cases agreed to meet criteria at the end of 2022/2023 and independent reviewers/authors have been commissioned and those cases are actively taking place but not yet concluded. Learning from these two cases will also be included in the next annual report and implantation of their learning will be shared through the learning functions of the SSAB.

### Learning Disability Mortality Reviews (LeDeR)

LeDeR is a service improvement programme which aims to improve care, reduce health inequalities and prevent premature mortality of people with a learning disability (LD) and autistic people by reviewing information about the health and social care people received. All deaths of people with a learning disability and autistic people aged 18 years and over are eligible for a LeDeR review and the ICB responsible for making sure reviews are carried out for deaths in their area. ICBs are also responsible for changing the services provided in their area based on the findings of the reviews in their area, and nationally.

SSAB gratefully received the SEL ICB LeDeR annual report 2023/2024 and their 3-year strategy (2023-2026) which outline clearly the governance, oversight, audit and



reviews of the cases that were reviewed. This affords the opportunity for learning to be shared and where required, areas for action to be responded to by the SSAB.

To note, SEL notifications remained at the same level as the previous year and there were 11 Southwark LeDeR notifications in comparison with 12 last year. It is of note that the annual report articulated that whilst we know that SEL is significantly more ethnically diverse than England, there is still an under reporting into LeDeR from minority ethnic communities.

Evidence shows that people with learning disability and autistic people experience health inequalities, leading to preventable mortality compared to the general population and the data demonstrated that the life expectancy for both men and women with a learning disability is shorter than the general population.

SSAB will continue to listen to the messages from LeDeR reviews and respond where required.



## 12. Looking Ahead to 2024/25

As we move into 2024/25, the SSAB has agreed to a new business plan which outlines four key strategic priorities and two thematic areas.

This business plan places great emphasis on strengthening the current arrangements, developing assurance methodology and implementing the communication and engagement strategy to a greater degree within the arrangements.

## 13. Contact Information

If you have any questions about the content of this report, or thoughts about what we should include in future reports, please contact [ssab@southwark.gov.uk](mailto:ssab@southwark.gov.uk).

If you are concerned about an adult at risk in the borough of Southwark you should notify us immediately on [OPPDContactteam@southwark.gov.uk](mailto:OPPDContactteam@southwark.gov.uk).

If the adult has been injured you should seek advice from their GP, or in an emergency call 999.

If you believe a crime has been committed you should notify the police.



<b>Item No.</b> 12	<b>Classification:</b> Open	<b>Date:</b> 2 April 2025	<b>Meeting Name:</b> Health & Social Care Scrutiny Commission
<b>Report title:</b>		Health & Social Care Scrutiny Commission Work Programme 2024 - 25	
<b>Ward(s) or groups affected:</b>		N/a	
<b>From:</b>		Julie Timbrell, Project Manager, scrutiny.	

## RECOMMENDATIONS

1. That the Health & Social Care Scrutiny Commission note the work programme as attached as Appendix 1 Work Plan, and review scope in appendix A.
2. That the Health & Social Care Scrutiny Commission consider the addition of new items or allocation of previously identified items to specific meeting dates of the commission.

## BACKGROUND INFORMATION

3. The general terms of reference of the scrutiny commissions are set out in the council's constitution (overview and scrutiny procedure rules - paragraph 5). The constitution states that:

Within their terms of reference, all scrutiny committees/commissions will:

- a) review and scrutinise decisions made or actions taken in connection with the discharge of any of the council's functions
- b) review and scrutinise the decisions made by and performance of the cabinet and council officers both in relation to individual decisions and over time in areas covered by its terms of reference
- c) review and scrutinise the performance of the council in relation to its policy objectives, performance targets and/or particular service areas
- d) question members of the cabinet and officers about their decisions and performance, whether generally in comparison with service plans and targets over a period of time, or in relation to particular decisions, initiatives or projects and about their views on issues and proposals affecting the area

- e) assist council assembly and the cabinet in the development of its budget and policy framework by in-depth analysis of policy issues
- f) make reports and recommendations to the cabinet and or council assembly arising from the outcome of the scrutiny process
- g) consider any matter affecting the area or its inhabitants
- h) liaise with other external organisations operating in the area, whether national, regional or local, to ensure that the interests of local people are enhanced by collaborative working
- i) review and scrutinise the performance of other public bodies in the area and invite reports from them by requesting them to address the scrutiny committee and local people about their activities and performance
- j) conduct research and consultation on the analysis of policy issues and possible options
- k) question and gather evidence from any other person (with their consent)
- l) consider and implement mechanisms to encourage and enhance community participation in the scrutiny process and in the development of policy options
- m) conclude inquiries promptly and normally within six months

4. The work programme document lists those items which have been or are to be considered in line with the commission's terms of reference.

## **KEY ISSUES FOR CONSIDERATION**

- 5. Set out in Appendix 1 (Work Programme) are the issues the Health & Social Care Scrutiny Commission is considering in 2024- 25.
- 6. The work programme is a standing item on the Health & Social Care Scrutiny Commission agenda and enables the commission to consider, monitor and plan issues for consideration at each meeting.

## BACKGROUND DOCUMENTS

Background Papers	Held At	Contact
Health & Social Care Scrutiny Commission agenda and minutes	Southwark Council Website	Julie Timbrell Project Manager
Link: <a href="https://moderngov.southwark.gov.uk/ieListMeetings.aspx?Committeeld=518">https://moderngov.southwark.gov.uk/ieListMeetings.aspx?Committeeld=518</a>		

## APPENDICES

No.	Title
Appendix 1	Work Plan 2024-25
Appendix A	Review: Adult Safeguarding – how can this be implemented to better protect vulnerable adults, carers and paid staff?

## AUDIT TRAIL

<b>Lead Officer</b>	Everton Roberts, Head of Scrutiny	
<b>Report Author</b>	Julie Timbrell, Project Manager, Scrutiny.	
<b>Version</b>	Final	
<b>Dated</b>	31 March 2025	
<b>Key Decision?</b>	No	
<b>CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER</b>		
<b>Officer Title</b>	<b>Comments Sought</b>	<b>Comments Included</b>
Director of Law and Governance	No	No
Strategic Director of Finance and Governance	No	No
<b>Cabinet Member</b>	No	No
<b>Date final report sent to Scrutiny Team</b>	31 March 2025	

## **Health and Social Care Scrutiny Commission workplan 2024/ 25**

### **Potential reviews, topics follow up and standing items:**

#### **Review**

Adult Safeguarding – how can this be better implemented to protect vulnerable adults, carers and paid staff?

(This review started last year)

24

#### **Topics**

Damp and mould

Cancer prevention and early diagnosis

#### **Follow up 2024/25:**

- Access to Medical Appointments
- Orient Street/ Respite Care update on Short Break consultation and outcome
- Blue Badge – update on progress following an item last administrative year
- Pain management clinic - assurance around administration at GSTT
- Care Home model – Asylum Road site delivery
- Adult Social Care Vision - pre scrutiny of Cabinet report ( governance timeline to follow)

## **Follow up 2025/26 ( provisional )**

- Pain management clinic – with reference to good practice community model in Lambeth
- Care Home model pre-scrutiny of options under consideration ( scrutiny in a day)
- FGM follow up on work with adult survivors
- Children's respite care and cost impact of the ending the provision at Orient Street.
- Care Home model future deliver options ( mini review)

## **Standing items**

- Interview with the Independent Chair of the Southwark Safeguarding Adults Board (SSAB). The Safeguarding Adults Board is a multi-agency partnership which has statutory functions under the Care Act 2014. The main role of Southwark Safeguarding Adults Board (SSAB) is to ensure that local safeguarding arrangements work effectively so that adults at risk due to health needs, social care needs or disabilities are able to live their lives free of abuse or neglect.

## **Interview Cabinet member/s**

- Cabinet Member for Health and Well-being

## Dates

Meeting	Date	
Informal meeting to workplan	Tuesday 11 June	
1	Thursday 25 July	<p><b>Damp and Mould</b></p> <p>Request a report from Damp and Mould specialist in housing and the work of Public Health, with reference to:</p> <ul style="list-style-type: none"><li>• The work of Public Health , including outreach to check for respiratory health</li><li>• How to tackle damp and mould in different types of tenure including council homes, housing association, private rented and homeowners</li><li>• How the construction of buildings can impact on damp and mould</li><li>• Current and planned statutory housing duties that impact on damp and mould including Awaab's Law</li><li>• Advice and education that can be provided to supplement the landlord's primary responsibility to address the underlying causes of the problem, such as structural issues or inadequate ventilation.</li></ul>

		<p><b>Local Pharmacies</b></p> <p>A report will be requested from commissioners with reference to a petition and correspondence from a local pharmacy regarding the sustainability of current commissioning of pharmacy services. Commissioners will be asked to clarify to what extent problems can be addressed at a local, South East London and/ or national level.</p> <p><b>Access to Toilets scrutiny review report</b> – final report sent to July cabinet , arising from last year, to note.</p>
2	Monday 21 October	<p><b>Topic: Cancer prevention and early diagnosis : Rapid Diagnostics</b> Presentation on 'cancer of unknown origin / rapid diagnostic specialist cancer treatment centre'</p> <p><b>Access to testing – responding to the cyber-attack in Primary Care</b></p> <p><b>Refresh Partnership Southwark priorities – early discussion</b></p> <p><b>Access to Toilets scrutiny review report – cabinet report back</b></p>
3	Wednesday 13 November	<p><b>Topic: Cancer prevention and early diagnosis</b></p> <p><b>Primary Care Access</b></p>

		<p>GP appointments ( with particular focus on accessing face to face appointments and timely care ) and an update on 'collective action' by GPs in response to the new contract, and any Southwark specific action)</p> <p><b>Cabinet Member for Health and Well-being – annual interview</b></p> <p>Cllr Evelyn Akoto's portfolio includes supporting carers, improving health services and adult social care, as well as public health.</p> <p><b>Healthwatch</b></p> <ul style="list-style-type: none"> <li>• Annual report 2023 -24</li> <li>• Empowering Voices: Examining Healthcare Access for Adults with Learning Disabilities and Autistic Adults   Healthwatch Southwark</li> </ul>
4	Monday 3 February	<p>Blue Badge – follow up</p> <p>Damp and mould - including follow up on equalities data from Public Health</p> <p>Interview with the Independent Chair of the Southwark Safeguarding Adults Board (SSAB) tbc</p>
Informal	March	Care Home model - Asylum Road delivery
5	Wednesday 2 April	<p>Interview with the Independent Chair of the Southwark Safeguarding Adults Board (SSAB)</p> <p>Care Home model - Asylum Road delivery</p>

	<p>Damp and Mould report and presentation</p> <p>Pain Management update (GSTT written briefing update only)</p> <p>Update on Access to Medical Appointment recommendations (written briefing update only)</p> <p>Cancer mini review summary headline report</p> <p>Safeguarding review</p>



## **Scrutiny review scoping proposal**

### **1    What is the review?**

Adult Safeguarding – how can this be more consistently implemented to better protect and assist vulnerable adults, families, carers and paid staff?

The review is being conducted as members believe there is sometimes ambiguity, or different interpretations, over how Safeguarding is implemented for vulnerable adults and this can create difficulties for the people concerned: adults, staff, families, and carers.

These are some of the consequences inconsistent or poor quality Safeguarding approaches, including false accusations of abuse or neglect:

- Staff leaving the sector
- Staff staying but being resentful and demoralised (in the context of there already being a problem with recruitment and retention)
- In the case of family carers, them needing support and solutions but instead getting the opposite i.e criticism, leading to possible disengagement with services

### **2    What outcomes could realistically be achieved? Which agency does the review seek to influence?**

Goals:

- To make things clearer for staff so that they are not accused of abuse or neglect when it is not abuse or neglect, so as not to put people off working in the sector
- Introduce checks and balances to prevent vexatious accusations
- Make sure there is good systems in place for people to raise concerns / whistleblowing to report issues and ensure this is more transparent and accessible
- Improved guidelines for implementation of tricky safeguarding decisions

The review is aimed at improving outcomes for :

- Council safeguarding leads , social workers and commissioners
- Paid staff
- Care providers
- Vulnerable Adults
- Carers
- Family and friends of vulnerable adults

**3 When should the review be carried out/completed?**i.e. does the review need to take place before/after a certain time?

Completed by 2024

**4 What format would suit this review? (eg full investigation, q&a with executive member/partners, public meeting, one-off session)**

Full investigation.

**5 What are some of the key issues that you would like the review to look at?**

Would it be beneficial to:

- To make better use in Adult Safeguarding of PIPOT (Persons in a Position of Trust) and replicate the LADO process – used in safeguarding children .
- promote undercover boss type work experience for senior managers to gain a better understanding of the work of care workers
- Recommend that social workers spend a week as a front line care worker ( for example) as part of their training?
- SCIE training for local care home staff?

Conduct case studies and examine examples of where things are unclear:

- Some consider turning people every two hours during the night is necessary in order to prevent pressure sores, others consider this to be abuse. <https://hellocare.com.au/two-hourly-repositioning-prevent-bedsores-abuse-study/>
- Some staff are told that it is abuse to wake care home residents up, but sometimes staff are then told to do this
- Is it abuse or neglect to leave someone in bed all day?
- Call bells in care homes - disconnection considered to be abuse but there are cases where it could be necessary
- When looking after someone at home, families are often told that they should not lock the front door, but they do because they want to keep their relative with dementia safe. How can the approach of experienced practitioners be championed ? ( see case study SLaM nurse)

**6 Who would you like to receive evidence and advice from during the review?**

- A. Hourglass (elder abuse charity)
- B. SCIE (Social Care Institute for Excellence)
- C. Chair of the Southwark Safeguarding Adults Board
- D. Officers from adult safeguarding department
- E. Managers of a local homes attend meeting to discuss i) Safeguarding ii) Disciplinary policy , with a view to discussing how investigations are carried out , and how to best balance fairness and valuing workers with the need to safeguard residents

Agincare

Greenhive Care Home (Peckham)  
 Waterside Care Home (Peckham)  
 Rose Court Care Home ( Rotherhithe)  
 Bluegrove House Care Home ( Bermondsey)

Country Court

Camberwell Lodge Care Nursing Home

HC One

Tower Bridge Care Home

Mission Care

The Elms Residential Care Home

- F. Unions – to consider how investigations are conducted
- G. Care home resident ( case study)
- H. SLAM dementia nurse ( case study)
- I. Carer / former carers ( case study)

Workshop / structured interviews addressing two themes:

- How are safeguarding investigations into allegations about workers being conducted and how can the right balance be found between being fair and valuing staff, whilst safeguarding vulnerable adults
- How to best reach consensus / balance safeguarding and autonomy over definitions e.g. people with dementia leaving home and turning people in the night

**7 Any suggestions for background information? Are you aware of any best practice on this topic?**

London Safeguarding Policy and Protocol

**8 What approaches could be useful for gathering evidence? What can be done outside committee meetings?**

e.g. verbal or written submissions, site visits, mystery-shopping, service observation, meeting with stakeholders, survey, consultation event

Interviews with organizations with expertise in this area.

Case studies – through a workshop.



## Health & Social Care Scrutiny Commission

**MUNICIPAL YEAR 2024-25**

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		<b>Dated: July 2024</b>	