Open Agenda

Health and Social Care Scrutiny Commission

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

Supplemental Agenda

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Contact

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

Date: 26 June 2025

Agenda Item 8

Collated minutes Safeguarding review

HEALTH AND SOCIAL CARE SCRUTINY COMMISSION MINUTES of the Health and Social Care Scrutiny Commission held on Monday 5 February 2024 at 7.00 pm at 160, Tooley Street, SE1 2QH

6. INTERVIEW WITH THE INDEPENDENT CHAIR OF THE SOUTHWARK SAFEGUARDING ADULTS BOARD (SSAB)

The chair welcomed Anna Berry, Independent Chair of the Southwark Adult Safeguarding Board, and Pauline O'Hare, Director of Adult Social Care.

Independent Chair of the Southwark Adult Safeguarding Board presented the report and the chair then invited members to ask questions. The following points were made.

- In response to a question on the impact of the Covid pandemic on the workforce the Director of Adult Social Care said that all operational workers come into office. There is also a process for requests for flexible work, and this has been in existence from before the pandemic. There are vacancies within adult social care and a rolling programme of recruitment with a micro site. Covid did mean the council lost a cohort of older experienced staff who took early retirement because of underlying health conditions or caring responsibilities.
- A member asked about the Safeguarding stats, trends and meaning. The Independent Chair said that Southwark's are broadly reflective of national position. The board is looking for an enhanced data set from a wider range of partners. The Director of Adult Social Care added that the reduced number on concerns which may well be because of a new complex pathway so she is less concerned about this, they would

however expect more expect more referrals. A member requested a breakdown of categories of abuse and place.

 The Director of Social Care said that they are looking at innovation to the front door to older peoples' services. They have changed how the telephone system works to make it more digitally friendly and more regular phone calls. They are also looking at team locations. A Project Manager has been appointed today looking at bottle necks and good practice in other boroughs.

 Member asked about progress in replicating the Persons In a Position of Trust (PIPOT) work of children's in adult service. The Independent Safeguarding Chair said that for children's services there is a LADO - local authority designation officer. This person pulls together information around allegations. There is an emerging London PIPOT framework. This is a framework to manage allegations and how Safeguarding process intersect with HR disciplinary processes. It will help coordinate different processes, which is helpful. Currently it is a being looked at by a sub group of the board, with a view to adopting. One of the issues is the governance arrangement for holding the data. There are also training requirements. It is a good framework and no objections have been raised and as such the board is addressing the logistics. A couple of examples were given about when it could come into play:

a) Someone is accused of abusing their mother and works in care home of with people with Learning Difficulties

b) Someone has used social media to contact a client and overstepped a line with someone who is vulnerable

 Members asked if there are there protections against vexatious complaint. The board chair said not specifically but

would help generate a proportionate response.

 Members asked how the lived experience can feed into training of social workers. The Director of Adult Social Care said often social workers will have older relations, or family or personal experience of Learning Difficulties and Mental Health. There is also an apprenticeship scheme for care leavers. She added that often people do front line work for experience. The Independent Chair added that there is a sub-group that is focused on learning, and referred to the Cuckoo package that pulls through the lived experience.

 There was a discussion on definition of abuse and that this includes neglect.

RESOLVED

Members requested a breakdown of both the “concerns” and the “enquiries” in terms of:

- Who are the people being investigated around safeguarding issues – care homes / home care agencies / family members
- What types of abuse – financial / physical / emotional / neglect e.t.c

7. HOURGLASS

The chair invited Kyra Gonzales, Community Response Officer and Independent Domestic Violence Advisor (IDVA) to provide a presentation.

Members were then invited to ask questions and the following points were made:

 The Community Response Officer said that often cases involve a diagnosis of dementia. Hourglass share information across professional disciplines and encourage looking at family relationships dynamics.

 A member asked if there are ever professional differences on if a matter is a safeguarding issue or a quality of care issue. The Community Response Officer said that there is often a fine line between quality of care and safeguarding. Sometimes people do not meet a threshold and there is not always a consensus on this.

 The differences can arise from differences in triage as well as insufficient understanding around Domestic Abuse and family members – including a lack of understanding of the nature of family abuse dynamics. However, she added, that professionals are keen to train and also to take a multiagency approach.

 Members asked if the statistics accurately reflect where people live and experience abuse, given the much higher levels of abuse recorded in the home. The Community Response Officer said that referrals are often from friends and family rather than individuals. It is therefore possible that there are less people to do this in care homes and hospitals. More support in institutions would help increase referrals.

 Community Response Officer was asked if there are situations where you encounter situations of abuse and insufficient action. She confirmed there were and gave an example of where a women whose carer was her son with mental health problems, however she was not considered vulnerable enough for intervention.

 A member asked what can be done to reduce abuse in care homes. The Community Response Officer recommended increasing training and increasing opportunities for open communication and professional curiosity. More multi agency working can facilitate this as care homes often feel closed off from the community.

Hourglass

Older People and Domestic Abuse

Kyra Gonzales

Community Response Officer (IDVA)

Helpline - 0808 808 8141

Hourglass

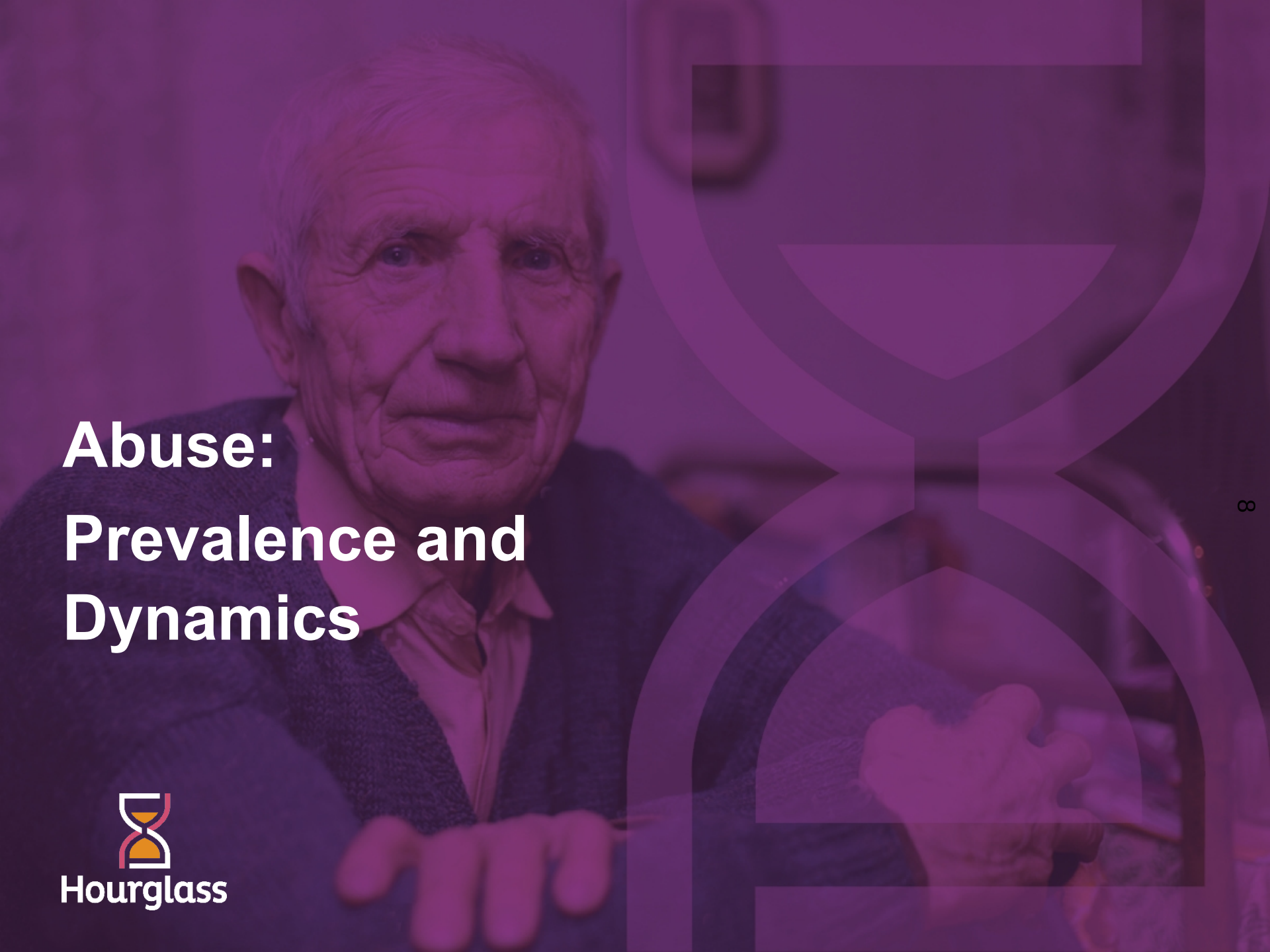
Hourglass

The Hourglass mission is simple:

end the harm, abuse and neglect of older people in the UK.

As the UK's only charity focused on stopping the abuse and neglect of older people, we staff a free 24/7 helpline. It's an absolute lifeline for older people suffering from all forms of abuse and other concerned individuals.

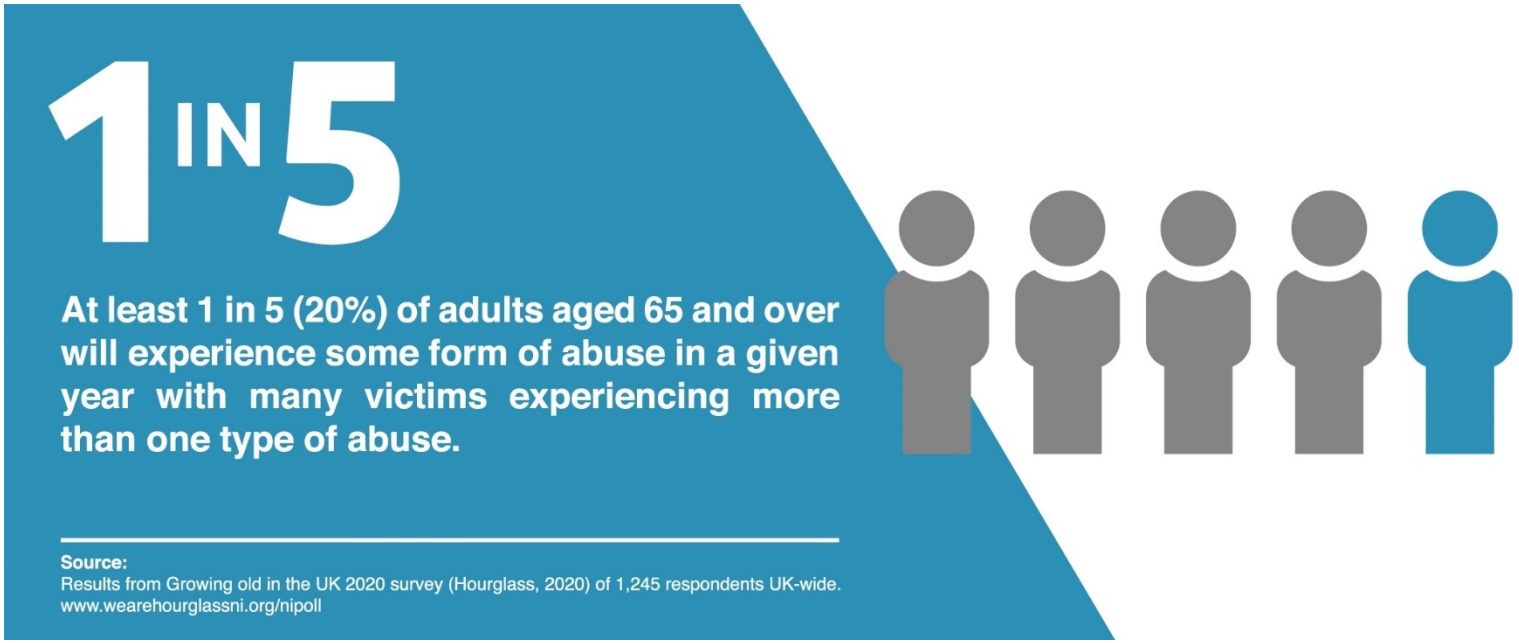
Hourglass



Abuse: Prevalence and Dynamics

Hourglass

Prevalence of abuse

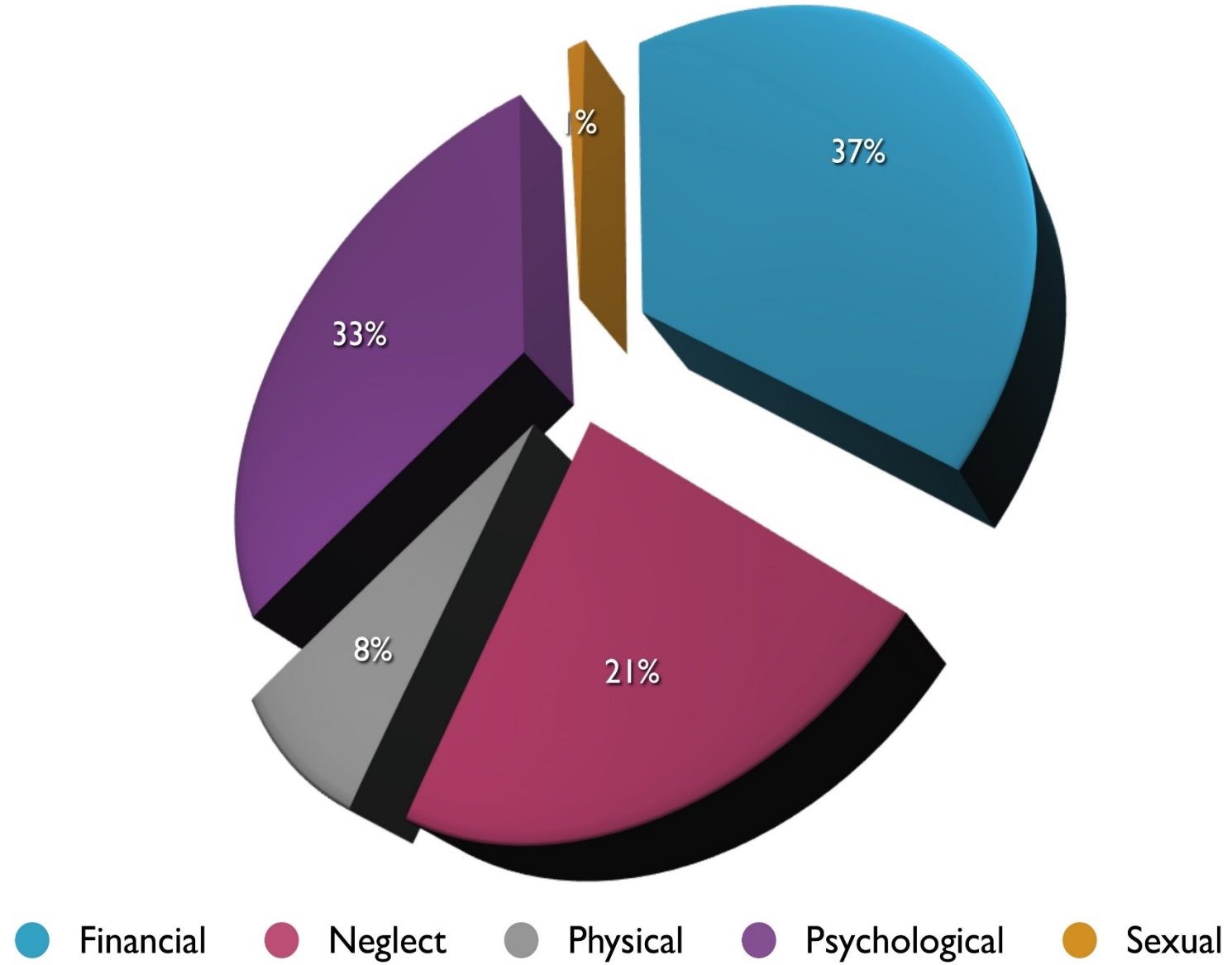


As many as **2.7 million people** in the UK are affected by the abuse of older people.

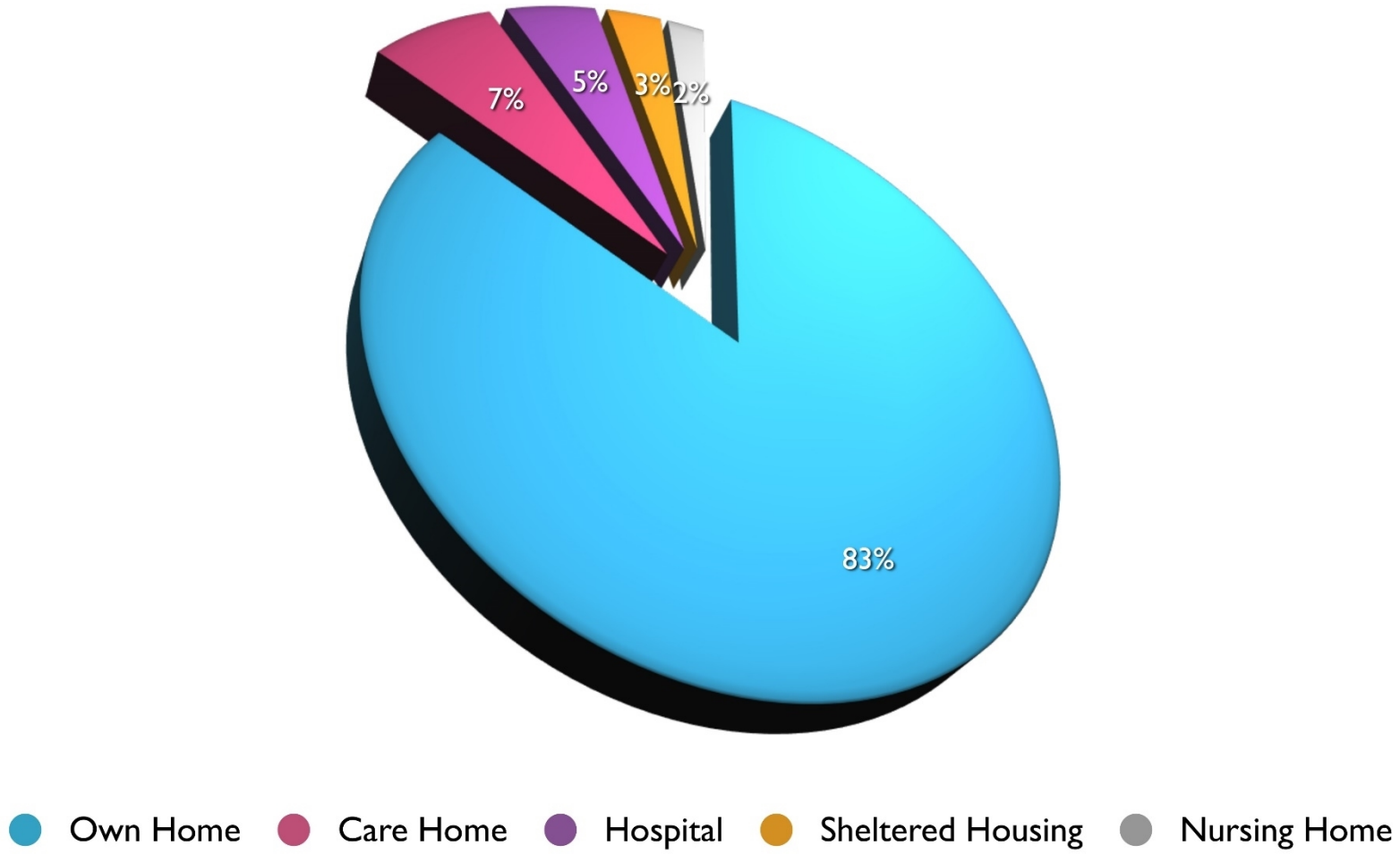
The Abuse of Older People

A single or repeated act or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person.

Types of abuse 2021/22

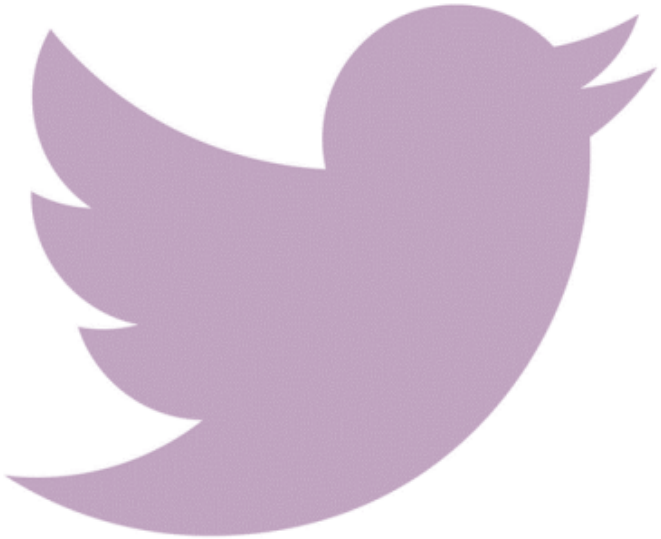


Location of abuse 2021/22



- On twitter, abuse of animals was mentioned **6 times** as much as abuse of older people

- Out of over **500,000 tweets** mentioning domestic violence and abuse only **0.3%** also referenced older people



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Examples of Abuse

- Isolating you from friends or family
  - Monitoring your communications
  - Controlling where you go and who you can see
- Controlling your finances
- Attending personal appointments

- Making threats
- Putting you down
- Dehumanising you
- Depriving you of basic needs
  - Moving walking aids of out reach
  - Withholding medication or overmedicating

Hourglass

Hourglass Services

Hourglass

Hourglass Services

National – Helpline + Online

Helpline
- 24/7 telephone helpline service
- Instant messenger and text service
- Email

Website
- Policy and research
- Regional updates
- Information and advice

Knowledge bank
- Regional specific information
- Signposting
- Law and legislation
- Webinars

Local – Community Response

Casework
- 1-1 support with a dedicated worker
- Advocacy and tailored advice
- Localised expertise

IDVA
- Independent domestic violence advocacy/advice
- Safety planning
- Risk assessment
- Client led support

Safer Ageing Service
- Awareness Raising
- Training
- Pop Up Clinic

Hourglass

Making a referral

24/7 Helpline

External Professional Referral Form

Hourglass

HOW TO GET IN TOUCH

24/7

Call our 24/7 helpline
0808 808 8141

Text message our helpline
07860 052906

Email us
helpline@wearehourglass.org

Talk to us live on our **INSTANT MESSENGER** at
www.wearehourglass.org

Get information from our **CHATBOT** at
www.wearehourglass.org

Get information from our **KNOWLEDGE BANK**
knowledgebank.wearehourglass.org

Our helpline is entirely confidential and free to call from a landline or mobile. The number will not appear on your phone bill. Our lines are open 24/7 – including evenings and weekends and bank holidays. You can also interact with us via our Chat Bot and Instant Message or get useful information from our Knowledge Bank. Find out how to get in touch 24/7 www.**wearehourglass.org**/hourglass-services.

Email, text and instant message options are currently only available during business hours.

Text messages from outside the UK will be charged at their standard international rate which will differ depending on location and service charges of your phone provider. The number will appear on your bill and in your phone records but will not be identified as Hourglass.

Please email us at enquiries@wearehourglass.org for more details and sign up to our newsletter to get regular updates.

Hourglass
Safer ageing · Stopping abuse

Balancing Autonomy and Liberty

Think about Professional Curiosity

- Be aware of professional bias
- Do not assume – trauma responses differ

Understand the Complexity

- Think about terminology
- Learn about current and past familial relationship dynamics

Communication

- Liaise with other third sector organisations and specialist services.

Safeguarding Concerns and Enquiries 22-23

Location of safeguarding incident

Concerns		
Location	**Count**	**%**
Own home	679	59.3%
Care home	166	14.5%
Service within community	89	7.8%
Hospital	63	5.5%
Other - any other setting not defined above	51	4.5%
Other - public place	36	3.1%
Community (excluding community services)	34	3.0%
Other persons home	26	2.3%
Other - retail setting	1	0.1%
Grand Total	1145	100%

Enquiries		
Location	**Count**	**%**
Own home	125	55.6%
Care home	35	15.6%
Service within community	22	9.8%
Hospital	14	6.2%
Community (excluding community services)	12	5.3%
Other - public place	7	3.1%
Other persons home	7	3.1%
Other - any other setting not defined above	3	1.3%
Grand Total	225	100%

Relationship of person /organisations alleged

Concerns		
Rel'ship of pers/orgs alleged	**Count**	**%**
Other family member	182	15.9%
Other - known to individual	153	13.4%
Domiciliary Care Staff	134	11.7%
Self	122	10.7%
Residential Care Staff	76	6.6%
Neighbour / Friend	74	6.5%
Health care worker	66	5.8%
Social Care Staff - Other	62	5.4%
Partner	61	5.3%
Other - unknown /stranger	60	5.2%
Other vulnerable adult	41	3.6%
Social care support or service paid; contracted or commissioned - public sector	41	3.6%
Stranger	29	2.5%
Other professional	27	2.4%
Day Care Staff	11	1.0%
Social Worker / care manager	2	0.2%
Voluntee /Befriender	2	0.2%
(blank)	1	0.1%
Self Directed Care staff	1	0.1%
Grand Total	1145	100%

Enquiries		
Rel'ship of pers/orgs alleged	**Count**	**%**
Other - known to individual	42	18.7%
Other family member	23	10.2%
Domiciliary Care Staff	22	9.8%
Residential Care Staff	21	9.3%
Social Care Staff - Other	21	9.3%
Neighbour / Friend	17	7.6%
Health care worker	14	6.2%
Self	14	6.2%
Partner	12	5.3%
Other - unknown /stranger - community health care	11	4.9%
Social care support or service paid; contracted or commissioned - public sector	8	3.6%
Stranger	6	2.7%
Other professional	5	2.2%
Other vulnerable adult	5	2.2%
Day Care Staff	3	1.3%
Self Directed Care staff	1	0.4%
Grand Total	225	100%

The Type of Abuse

Concerns	
Type of abuse	**%**
Neglect and Acts of Ommision	25.7%
Financial and Material	16.9%
Psychological/Emotional	15.9%
Physical Abuse	13.4%
Self Neglect	10.3%
Organisational Abuse	6.6%
Domestic Abuse	5.3%
Sexual Abuse	3.5%
Sexual Exploitation	1.1%
Discrimantory	0.9%
Modern Day Slavery	0.4%
Total	100%

Enquiries	
Type of abuse	%
Neglect and Acts of Ommision	23.7%
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Psychological/Emotional	14.3%
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Discrimantory	0.9%
Modern Day Slavery	0.3%
Total	100%

Structured interview with Grant Malyn , SLaM.

23 January 2024

Overall purpose: to contribute to the scrutiny Safeguarding Review on how to best reach consensus / balance safeguarding and autonomy over definitions e.g. people with dementia leaving home and turning people in the night

Present:

- Grant Malyn,
- Cllr Esme Dobson
- Cllr Maria Linforth Hall
- Cllr Suzanne Abachor
- Julie Timbrell, scrutiny project manager– note taker

Safety Netting

The interview began with a member relaying concerns from her own experience and an informal carers group . Safeguarding issue that that frequently come up are being told by a health care professional not to use the following, or being provided with contradictory advice from professionals around :

- Locking doors
- Using cameras, including motion detector cameras
- Bed rails
- Leaving a person with dementia alone
- Using air tags (mobile tracking devices)

The SLaM dementia nurse agreed these were common issues and that his approach is to recommend keeping people safe with the least restrictive option, and that might mean a camera etc. He agree there did tend to be a presumption away from use of cameras etc , however there were also occasions where technology has been sanctioned and enabled people to live safely in their own homes.

The nurse said there is often a black and white of approach of denying the use of bed rails, doors locks, cameras, air tags etc whereas often there needs to be a more personalised approach.

He gave an example where someone struggled with locking the door and rather than exploring safety netting with motion settings the default position of social workers was to move the person with dementia into a care home – which was more restrictive.

A member recalled a situation where the family wanted the door locked to prevent someone wandering at night but social services prohibited this. She commented that there are other interventions like offering to make a cup of tea to distract someone or automated prompts on doors that are also ways of discouraging leaving the homes but are not seen as bars to freedom. It was noted that in Care Homes the default setting is locked doors, but in these cases there are ‘depravation of liberty’ (DOTs) in place.

The SLaM nurse said there is a Telecare assessment device that is very useful but frowned upon as continual assessment, when it could actually be a useful tool for safety netting. He referred to a case where a person with severe dementia lived at home with lots of sensors and locked doors. This arrangement evolved over time.

It was noted that often families are told not to let people with dementia out of their sight which is contradictory and can place a strain on the carers which ultimately can lead to a move to Care Home – which is more restrictive and often less desirable for the person with dementia and their families.

Members spoke about constituent cases where families have received contradictory advice for example an OT says get a camera but mental health social worker raised safeguarding alert.

The nurse spoke about the importance of training in social work . The Social Care Institute for Excellence (SCIE) has guidance on supervision including continuous restriction.

The nurse was asked if it would be beneficial to develop policies on issue such as bed rails, locked doors , continues monitoring and Assistive Technology (eg GPS)to improve knowledge and consistency . He said that while guidance can be helpful it is important not to be overly prescriptive , and more important is a collaborative approach and a positive attitude to risk.

The SlaM dementia nurse encouraged a positive approach to risk and personalised assessment. He emphasised that an approach to Safeguarding that is proactive and supportive rather punitive.

<u>Assessments</u>

Members spoke about cases where there is masking by the person with dementia, and social workers will accept answers as face value, rather than probing function, and conclude that the person does not require care. The nurse said this can be because of a lack of insight by less experienced social workers. He said he will also ask families to corroborate function and to get a better picture and emphasised the importance of professional curiosity to get a wider picture and accurately access care needs.

The nurse said that there can be occasions where there is an initial assessment of capacity by older care social worker and following this SLaM is asked to do an assessment .

<u>Understanding the needs of people with dementia and carers</u>

Members spoke about the problems of families being disengaged from social and health care professional because they may be perceived as coping, or there are fears that an adult might be sent to care home or that 10 minute care slots are not working, when they would like 30 minutes. This can be particularly an issue for self funders who are not actually that wealthy.

The nurse referred to the need for better training and ongoing professional development including input from people with lived experience, including carers and

people with dementia. SLaM has user forum to that us able to share materials and insights run by Nuala Conlan (who formally led the community engagement unit in the council).

Information sharing

The nurse said that there are problems with the notes system which means information is not visible through local care system . Previously the London Local Care Record (LCR) was much better . The local trusts have lots of documentation and a huge depository , plus had scant notes from Social Care . He said the best situation would by LCR plus enriched notes from Social Care.

Carer experience letter

This happened more than 10 years ago. I hope Social Workers who work in Older People's services know more now about dementia and about the plight of unpaid family carers than they knew then.

My mother, who died in December 2018 was afflicted by dementia for over 10 years; at first quite slowly by vascular dementia and then more rapidly by Alzheimers. I didn't feel supported by Social Workers but then I didn't feel particularly supported by any professionals until she received homecare by a culturally and ethnically appropriate service (which I sourced by myself, not by Social Services) and then when she had to go into a care home when I no longer felt able to provide the care she needed. It was only front line, face to face workers who understood & were supportive to us both, something I felt very grateful for.

On one occasion when my mother was still living in her own home and receiving her annual review….again, requested by me, rather than arranged by Social Services, I was told off by the attending Social Worker for locking my mother's door at night after putting my mum to bed and leaving to go home to my own house.

She told me that she couldn't support my decision to do this as it was unsafe, a possible Health & Safety issue and also possibly a safeguarding issue. What would happen, I was asked if there was a fire in the house.

My response was that I had already carried out my own risk assessment of the situation and the risk of any fire was minimal. I explained that there were no gas or electric fires in the house and that central heating radiators heated the house, that my mother could no longer use any kitchen appliances and that the cooker had a gas supply cut off button and a glass lid. Furthermore, there was a service contract on the boiler, which meant it was checked & serviced annually. The Social Worker said that fires could start from electrical appliances. My reply was that I always ensured all electrical appliances were switched off & unplugged before I left the house and that Homecare workers would turn them on in the morning. Also, as the person who was most familiar with my mother's behaviour and support needs, I felt that I was the most suitable person to make this decision. Despite this, the Social Worker still said it was unsafe, that she could not support my decision and would have to get back to me about it.

I asked what would happen if my mother opened the unlocked front door at night and went outside in her pyjamas and bare feet, wandered outside in the cold and got hypothermia. The Social Worker didn't respond. My mother had indeed previously wandered around lost and in a panic but thankfully this had been in the daytime and in warm weather. On other occasions, she'd knocked on neighbours' doors in a panic . Based on these occurrences, I came to the decision that my locking her in at night was safer for her than leaving her door unlocked and I explained this to the Social Worker. She still told me she couldn't support my decision and would be getting back to me about it.

I felt outraged that a Social Worker who had just met us (no continuity, no named Social Worker, different ones most times) felt that she knew better than me, the

daughter who’d put her own life on the back burner for many years to look after her mother with dementia and who spent several hours of nearly every single day doing so. I also felt outraged & upset at what I perceived to be her belittling and disparaging attitude towards me. Did I complain? No. Why not? Because I was exhausted. Caring for someone with dementia is exhausting. By the way, she never got back to me.

Hoarding cases – Councilor case work

Case one

A resident sought help from a councilor regarding hoarding. The councilor was able to assist the resident with more find suitable accommodation. The resident moved , however the resident still had far more belongings than could fit in her accommodation. The mental and social stresses continued unaddressed and these were likely the root cause.

Case two

A resident was approach by housing officers with a threat of legal proceedings because of their belongings. The resident then sought help from a community organization who contacted a councilor . In the councilors view the amount of belongings did pose a fire risk, and in addition there were concerns with health. Previously the resident had declined help from the housing officer, however they did subsequently agree to help and this did result in an improvement. It was noted that the resident may have been more willing to work with a more specialist hoarding team earlier, if that had been offered.

Case three

A resident with significant belongings and complex physical and mental health problems came to the attention of a local councilor in 2023 . The councilor was able to arrange some community help to clear pathways. In the same year district nurses and an Occupational Therapist were engaged with the residents health needs and the housing provider with the hoarding problem, however the OT assessment found the resident to be “independent with all activities of daily living” and on this basis housing provider decided the main problem was cleaning, which did not require intervention.

In 2025 a full care assessment did find eligibility for care by a social worker, but the resident did not want to accept all or any of the services offered. The councilor remains concerned about the resident and that the amount of belongings pose a significant safeguarding risk. In addition there is a concern from the councilor that the resident’s mental health needs are not being attended to and there has been more emphasis on physical health. The resident is thought to have been living like this for 20 years.

Case four

A resident contacted a councilor regarding a threat to eviction regarding hoarding, as the housing officer considered the matter to be a fire risk. Social services had been in contact with the resident offering assistance , however the resident felt harassed and declined the help offered. Later a health worker who saw the home told the resident that they “would need to report her for hoarding”. Less punitive language would have been more helpful. The housing officer referred the case to a Complex Case Worker , who offered to visit with support of the councilor . The councilor assisted the resident remove belongings prior to the visit ; this then motivated the resident to make some big improvements; including clearing pathways. The home is now much safer. The Complex Case Worker then visited, and offered further help, which the resident agreed to although requested a slower timetable as she continued to feel under pressure.

Health and Social Care Scrutiny Commission 2025/26

Reviews

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

2. Cancer prevention and early diagnosis (mini review)

Topics

Damp and mould (continue 2024/25)

Follow up and new items 2025/26

- ~~Pain management clinic – with reference to good practice community model in Lambeth~~
- Blue Badge – update on progress following an item last administrative year
- Care Nursing Care Home model delivery (mini review) cabinet response and tracking delivery (including looking at Nursing Home Space standards)
- FGM update on work with adult survivors
- Children's respite care and cost impact of the ending the provision at Orient Street
- GP appointments (with reference to work Partnership Southwark are doing to improve access to timely appointments)
- Improving access to toilets – update on previous scrutiny review
- Overcrowding and the impact on the mental health of children (with reference to Partnership Southwark work neighbourhood work with complex children)
- TFL :a) explore an earlier than 9am Freedom bus pass starting time (see if older peoples organisations and groups such as Age UK / National Pensioners Convention / Southwark Pensioners Centre/ SPAG have a view or ongoing campaigns)
  b) driver behaviour (eg allowing people to sit down and embark safely) .

Partnership Southwark / South East London Integrated Care Board (SELICB) suggested items

Update on government reform of the ICB

Update on local priorities:

Frailty

Mental health and complex needs of children with reference to

- Neurodivergence (ADHD and autism)
- Neighbourhood work with children with complex needs (see above item on overcrowding)

GP Appointments – report back on engagement with local practices to improve access to timely appointments , with a focus on ensuring people who are not digital natives or have communication difficulties have alternative and easily accessible methods to book appointments (see above item on GP appointments)

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

Health and Social Care Scrutiny Commission		
	Date	
1	Wednesday 2 July	• Children's respite care and cost impact of the ending the provision at Orient Street. • Cancer prevention • Safeguarding review – recap • Nursing care home delivery scrutiny review report • Workplan
2	Monday 13 October	• Blue Badge – update on progress following an item last administrative year

		• Headline / final report on cancer prevention and early diagnosis • Safeguarding review – Hoarding officer report • Nursing care home delivery – cabinet response
3	Monday 1 December	
4	Tuesday 27 January	
5	Monday 2 March	

Scrutiny review scoping proposal

1 What is the review?

Adult Safeguarding – how can this be more be 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 the 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 2025-26

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