Open Agenda

Health, Adult Social Care and Community Safety Scrutiny Commission

Wednesday 21 October 2026
7.00 pm
Ground Floor Meeting Room G02B - 160 Tooley Street, London SE1 2QH

Supplemental Agenda One

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

Date: 19 October 2026

HEALTH, ADULT SOCIAL CARE AND COMMUNITY SAFETY SCRUTINY COMMISSION

MINUTES of the Health, Adult Social Care and Community Safety Scrutiny Commission held on Thursday 23 July 2026 at 7.00 pm at Ground Floor Meeting Room G02B - 160 Tooley Street, London SE1 2QH

PRESENT:
Councillor Dean Peters (Chair)
Councillor David Noakes (Vice-Chair)
Councillor Sam Dalton
Councillor Esmé Dobson
Councillor Natasha Ennin
Councillor Pascale Mitchell
Councillor Lina Usma

OTHER MEMBERS PRESENT:

OFFICER & PARTNER SUPPORT:
Darren Summers, Strategic Director Integrated Health and Care/Southwark Place Executive Lead
Ruman Kallar, Research and Projects Officer, Healthwatch Southwark
Anthony Lewis, Interim Director of Community Safety and Integrated Enforcement
Julie Timbrell, Project Manager

1. APOLOGIES

There were no apologies.

2. NOTIFICATION OF ANY ITEMS OF BUSINESS WHICH THE CHAIR DEEMS URGENT

There were none.

3. DISCLOSURE OF INTERESTS AND DISPENSATIONS

There were none.

4. MINUTES

The minutes were noted.

5. HEALTH SCRUTINY

Julie Timbrell, the scrutiny Project Manager, summarised the paper circulated with the agenda, covering Health scrutiny's role, requirements, and best
Practice. This outlined the statutory basis for health scrutiny, including the ability to request information, require attendance of NHS representatives, and make recommendations. The importance of early engagement with NHS partners and stakeholders, evidence-based scrutiny, and community engagement was highlighted.

6. PARTNERSHIP SOUTHWARK

Darren Summers, Strategic Director for Integrated Health and Care/ Southwark Place Executive Lead, provided a presentation setting out local health provision and priorities.

This covered the following points:

- **Partnership Southwark:** was established in its current form in 2022, bringing together representatives from the council, public health, children and adults' services, the Integrated Care Board, NHS trusts, GPs, the voluntary sector, Healthwatch, and care providers. The partnership aims to agree shared priorities and oversee their delivery, focusing on integration across the health and care system.
- **Recent Meeting and Governance:** The partnership meets every two months, with the latest meeting chaired by Councillor Chamberlain and Dr Nancy Kuchemann. Key agenda items included integrated neighbourhood health and care teams. Partnership Southwark operates as a subcommittee of the South East London Integrated Care Board.
- **Financial Challenges and ICB Reform:** The Strategic

Director highlighted that the Integrated Care Board is undergoing a 35% reduction in running costs, part of a national target, and faces an underlying deficit of over £100 million. Funding convergence is reducing budget allocation, creating significant financial pressures similar to those faced by local authorities.

- **Strategic Priorities:** The partnership has agreed five priorities: mental health (children, young people, and adults), primary care access (especially GP access), prevention and health inequalities, services for the elderly, and developing neighbourhood health and care services. These priorities were set in September 2024 and align with national NHS policy directions.
- **Neighbourhood Health and Care Services:** Significant progress has been made in developing neighbourhood health teams, now aligned with council neighbourhoods. These teams focus on children with complex needs, people with multiple long-term conditions, and frail elderly populations, with plans to expand to serious mental illness and preventative services, including piloting financial shield workers.
- **Physical Premises and Shared Spaces:** Some health centres, such as Tessa Jowell Health Centre, are being repurposed to allow shared use by multiple organisations, moving away from siloed operations. New health centres are planned in Canada Water, Falkland Street, Southwark Park Road, and Elephant and Castle, with regeneration funding supporting these developments.
- **Service Expansion and Pilots:** Neighbourhood teams are piloting the inclusion of financial shield workers to address wider determinants of health, such as financial insecurity, which impacts both mental and physical health. The teams plan to expand their focus to serious mental illness and preventative care.
- **Outcomes and Metrics:** While system-level outcomes are not yet available due to the recent launch of the teams, metrics being tracked include emergency department attendances, hospital admissions, and care home placements. Early case studies are being collected to assess impact.

The chair invited questions and the following points were made:

- **Workforce Shortages and Causes** The Strategic Director clarified that workforce shortages are primarily due to pay not keeping pace with inflation, increased job pressures, and insufficient staff numbers, rather than direct impacts from Brexit or immigration reforms. There is concern about the supply of key professionals, such as speech and language therapists and midwives.

- **Financial Pressures and Service Delivery:** The Integrated Care Board is implementing significant cost reductions, which may lead to stopping or reducing some activities. While efforts are made to avoid negative impacts on patient outcomes, the scale of the challenge means some services may be affected.

- **Joint Commissioning and Efficiency:** Opportunities exist for joint commissioning between the council and the ICB, allowing for more efficient service delivery and reducing duplication of contracts with providers.

- **Health Inequalities:** Members highlighted the biases towards men in developing prescriptions and treatments , rather than women. The Strategic Director said that the partnership recognises significant inequalities in health outcomes related to deprivation, sex, gender, race, and sexual orientation. Efforts are underway to address these through targeted outreach and service improvements.

- **Variation in Service Quality:** There are acknowledged variations in service quality across different providers and services, with some rated as outstanding and others requiring improvement. Regular reporting and follow-up with providers such as Kings and SLAM are planned.

- **Language and Accessibility:** Translation and interpreting services are commissioned for primary care and other health services, with a wide range of languages covered. However, gaps remain, particularly for certain communities, and feedback from residents is used to identify and address these issues.

- **Mental Health Services and Waiting Times:** The commission discussed long waiting times for mental health services, funding challenges, and the effectiveness of partnership working, with the Strategic Director providing updates on investments and ongoing pressures.

- **Investment and Demand:** Despite increased investment in children and young people's mental health services, demand

has risen sharply, particularly since the pandemic, leading to continued long waiting times.

- **Service Redesign and Outcomes:** Efforts are being made to redesign care pathways and reduce very long waits, with some success in reducing waits over a year. However, overall waiting times remain longer than desired.
- **Partnership Working and Funding Responsibilities:** There are ongoing discussions between the council and the ICB about funding responsibilities for services like the NEST, aiming to avoid cost-shifting and promote joint decision-making.

RESOLVED

An update will be provided on the neighbourhood health case studies, with a report back on the outcomes of the pilots, including when adult mental health will be included

7. HEALTHWATCH

Ruman Kallar, Research and Projects Officer, Healthwatch Southwark, presented the following reports circulated with the agenda :

Annual Report 2025–26

Healthwatch Southwark engaged over 7,000 residents, collected feedback from over 300 people, and provided signposting and advocacy support. Research focused on health inequalities, including work with Latin American communities, disabled and autistic adults, and Black African and Caribbean men.

Housing, health and hope: Experiences of living in and moving on from asylum accommodation report

The report examined the experiences of refugees and asylum seekers moving on from Home Office accommodation, highlighting poor conditions, lack of information, and significant health impacts, especially for single adults and disabled individuals.

Findings included poor food quality, overcrowding, lack of privacy, and barriers to securing housing. Recommendations were made to improve conditions, provide early information, prevent homelessness, and enhance coordination between services. The

council has begun implementing some recommendations, such as a singles housing needs pathway**.**

Healthwatch requested the commission's support in holding the council and partners accountable for implementing recommendations, suggesting six- and twelve-month follow-ups.

The chair invited questions and the following points were made:

- The commission discussed the potential impact of Healthwatch's decommissioning and the loss of statutory powers, particularly powers to Enter and View care homes. Healthwatch said that once the Healthwatch ends there is no similar set up in place and rather the functions move to the Integrated Care System to commission.

- There was a discussion with the Research and Projects Officer on the refugee rent deposit scheme to ensure its effectiveness and address issues with landlord confidence and timely payments by the council.

- Members commended the Housing, health and hope report and its accuracy.

RESOLVED

Healthwatch will come back to the commission on the ability of the council to commission a service to conduct Enter and Views, after Healthwatch is abolished.

8. CRIME AND DISORDER SCRUTINY

Anthony Lewis, Director for Community Safety and Integrated Enforcement, provided a briefing on the statutory roles, powers, and best practices for community safety scrutiny.

The Director explained the statutory framework for community safety partnerships and the role of the ‘Crime and Disorder Committee‘ scrutiny commission in holding the partnership to account. The focus is on strategic, multi-agency collaboration rather than individual cases.

The chair invited questions and the following points were made:

- The November meeting will be dedicated to scrutinising the Crime and Disorder Partnership, with key partners in attendance including the Police Borough Commander.
- Members requested access to previous community safety partnership documents and suggested these were published going forward to improve transparency.

9. ASYLUM ROAD CARE HOME DELIVERY UPDATE

The report was noted.

10. WORK PROGRAMME

Members discussed the work programme and noted this was to be agreed by OSC in October.

Agenda Item 7

Adult Safeguarding Review: Carers Workshop

Health, Adult Social Care and Community Safety Scrutiny Commission

Date: 20 August 2026
Time: 12.30pm – 2.00pm
Format: Online workshop with carers
Facilitators: Members of the Scrutiny Commission and scrutiny officer
Participants: Carers supporting relatives and family members with a range of needs including old age, mental ill health including personality disorder, self harm & instability, neurodiversity, including ADHD and autism, physical disabilities, trauma and the effects of domestic abuse.

Purpose of the Session

The workshop was held as part of the Commission's review of Adult Safeguarding. Participants were invited to share their experiences of supporting adults who may be at risk of harm, abuse, neglect, self-neglect or exploitation. The discussion explored what helps people remain safe and independent, barriers encountered when seeking support, and suggestions for improving safeguarding services and practice.

Key Themes

1. Access to Carers' Support and Assessments

Participants expressed concern about the closure of the previous commissioned carers' service and uncertainty about what support is currently available. Several people reported continuing to receive referrals from professionals to a service that no longer exists. Carers felt there was a lack of clear communication about the interim arrangements and uncertainty about how to access support, advice and carers' assessments.

There was discussion about carers' assessments and whether carers are entitled to regular reassessments yearly when circumstances change. Participants understood that carers should generally be able to request an annual assessment, but experiences varied. Some carers described repeatedly seeking reassessments without success, while others had only received an assessment after considerable persistence.

One participant contrasted these experiences with a very positive example of practice from a Southwark social worker who had completed a thorough assessment, took time to understand the family's circumstances and coordinated support effectively. Participants felt that this type of holistic and proactive social work practice was not consistently available but was highly valued when it was delivered well.

Information was shared after the session on the current status of recommissioning Southwark Carers service and Mobilise.

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2. Communication and support by housing providers with vulnerable adults

A participant described difficulties several people she knows have encountered in arranging routine safety-related activities with their landlord such as repairs, gas safety inspections and fire safety checks for vulnerable adults.

One example involved repeated attempts to arrange a front door repair for a vulnerable adult who required a trusted family member to be present to feel safe. Appointments were often offered with little notice or contractors arrived outside agreed times, creating anxiety and making it difficult for relatives to provide support. Participants suggested that services should make greater efforts to communicate in advance with vulnerable adults and coordinate appointments with relatives, advocates or trusted supporters where this is necessary to enable the person to engage safely.

A participant raised the concerns around problems accessing re-housing by a housing association because of the trauma associated with the perpetration of Domestic Abuse in the home, and explained the continued negative impact this is having on family mental health.

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3. Mental Health, Trauma and Continuity of Support, and Communication

Participants supporting relatives with mental ill health described significant challenges navigating health and social care systems, particularly when there were complex family dynamics.

Participants reported situations where information was not shared effectively between agencies, notes were not read thoroughly, or previous concerns and assessments were overlooked. This sometimes resulted in carers feeling they had to repeatedly explain complex situations to different professionals.

Several participants highlighted missed appointments as a potentially important safeguarding indicator rather than simply a sign of disengagement. They noted that people experiencing severe mental ill health, trauma, autism or ADHD may struggle to attend appointments when unwell and may require additional outreach and support. Concerns were raised about difficulties obtaining information when appointments were missed and the challenges created by data-sharing restrictions. One difficulty was the sharing of information between the carer and professionals , when the carer does not have power of attorney or the relationship is with the vulnerable adult strained.

One participant described supporting an adult child experiencing serious mental health difficulties, periods of homelessness and repeated housing instability. The carer reported feeling excluded from discussions despite playing a central role in supporting the individual. Concerns were raised about difficulties obtaining information when appointments were missed and the challenges created by data-sharing restrictions.

Participants discussed the need for better continuity when individuals move between boroughs, as care plans, waiting-list positions and professional relationships can be disrupted.

There was strong support for more trauma-informed approaches and better recognition of the impact of domestic abuse, family trauma and long-term adversity on people's wellbeing and ability to engage with services.

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4. Autism, ADHD, Personality Disorders and Neurodiversity

Several participants felt that professionals did not always understand how autism, ADHD, personality disorders and related conditions can affect communication, behaviour and decision-making, and the importance of increasing awareness.

Participants reported situations where family members appeared capable and articulate during assessments but struggled significantly in their day-to-day lives. Carers felt that professionals sometimes underestimated risks or misinterpreted family dynamics because they did not fully understand how certain conditions present.

Examples included:

- difficulties with communication and information processing.
- understanding about how people with personality disorders present.
- apparent agreement during assessments that was not fully informed.
- heightened vulnerability to exploitation or coercion.
- challenges navigating services independently.

Participants recommended additional training for social workers and other professionals on personality disorders, autism, ADHD, trauma and communication differences.

There was particular discussion about older adults whose autism or ADHD may never have been formally recognised and whose needs may therefore be overlooked.

5. Advocacy and Independent Support

The group discussed the value of advocacy services, particularly for people who struggle to communicate their wishes, understand information, challenge decisions or with chaotic lives because of mental health conditions.

Participants reported that advocacy appeared easier to obtain in some neighbouring boroughs than in Southwark.

A number of examples were shared where carers felt that advocacy could have helped:

- during assessments.
- when challenging decisions.
- when navigating safeguarding procedures.
- during transitions between services.
- for people with hearing difficulties, autism or learning disabilities.
- for people with mental health needs and chaotic lives, where mentoring and advocacy could bring stability through a focus on meeting basic needs such as housing.

Participants felt that independent advocates can play an important role in safeguarding by helping individuals understand their rights and ensuring their views are heard.

6. Safeguarding Investigations and Evidence Gathering

A number of carers described concerns about how safeguarding allegations and family disputes were handled.

Participants highlighted situations where allegations were made between family members, all of whom had a caring role. Some carers felt that concerns had not been investigated thoroughly enough or that professionals had accepted one account without fully examining available evidence.

Examples were given where carers believed that information from medical records, police records, documented evidence or previous concerns had not been adequately considered before decisions were made. Carers said that this is particularly important when a vulnerable adult is more liable to exploitation because of cognitive issues or poor mental health and can find it harder to be assertive and / or the family dynamics may mean that that people will not disclose information as they do not wish to lose access to other family members such as grandchildren. Participants emphasised the importance of objective evidence gathering, professional curiosity and balanced investigation when safeguarding concerns arise.

Several contributors stressed that safeguarding situations can be highly complex, particularly where there are family disagreements, questions about capacity, differing views about risk, or allegations of coercion and abuse.

There was a strong view that safeguarding practitioners should make efforts to gather and assess evidence carefully before reaching conclusions.

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7. Quality of care by providers and quality / safeguarding concerns

Serious concerns were raised about the quality and reliability of some home care services.

One participant described occasions where an individual receiving multiple daily care visits appeared not to have received all the support recorded by the provider. Concerns included missed visits, poor personal care and insufficient monitoring of wellbeing and insufficient action to address exploitation and abuse.

Participants highlighted the emotional toll of repeatedly reporting concerns and felt that complaints mechanisms can be difficult to navigate.

There was agreement that concerns about care quality should be reported and that information gathered from complaints can help regulators and commissioners to identify patterns and areas requiring improvement.

Conclusion

The discussion identified a number of potential areas for further exploration by the Scrutiny Commission:

a) Clearer information about support available to carers during the recommissioning of carers' services.
b) Greater consistency and clarity on access to carers' assessments.
c) Improved communication, through the development of a good practice guide, for adoption by housing providers, to better meet the needs of vulnerable adults for visits to their homes for repairs and safety checks, including provision to have a trusted adult present.
d) Improved help for victims and families in relocating homes as a result of Domestic Abuse, in recognition of the negative impact staying in the same home can have on feelings of psychological safety.
e) Strengthening communication and coordination with relatives and trusted supporters by developing protocols to facilitating the sharing of information appropriately.
f) Better alert systems and support for people whose vulnerability may be indicated by repeated missed appointments, including involving carers wherever possible.
g) Improved access to advocacy services
h) Sign posting or commission a service for adults with mental health needs to provide mentoring and advocacy in order to stabilise lives, particularly to secure and sustain housing.
i) Better continuity of support when people move between boroughs.
j) Enhanced training on autism, ADHD, personality disorders, trauma and coercive control.
k) Stronger approaches to evidence gathering and investigation during safeguarding enquiries, particularly when there are complex family dynamics.
l) Better information on how carers can report quality and safeguarding concerns about providers to the CQC and commissioners.

Next Steps

Participants were informed that evidence from the workshop would be anonymised and incorporated into the Adult Safeguarding Review. A draft summary would be circulated for comment prior to publication, and the findings will contribute to recommendations considered by the Health, Adult Social Care and Community Safety Scrutiny Commission Adult Safeguarding report, due to be finalised this autumn.

Adult Safeguarding Review: Carers Survey

A survey for carers to inform Southwark's Adult Safeguarding Scrutiny Review

* Required

Introduction

1. Southwark Council's Health, Adult Social Care and Community Safety Scrutiny Commission is currently carrying out a review of adult safeguarding. The review is exploring how safeguarding services can better support adults at risk while promoting independence, dignity, choice and wellbeing. We want to hear directly from carers because carers often have unique insights into the challenges people face and the support that works best. Your experiences will help us understand what is working well, where there are gaps, and what changes might improve safeguarding support for adults and their carers. This survey is open from 14 August 2026 to the 11 September 2026.

   Your participation is voluntary. You may choose not to answer any question. Responses will be analysed and reported anonymously. Any comments included in reports will be anonymised . The information collected will be used solely to inform Southwark's Health, Adult Social Care and Community Safety Scrutiny Commission's review of Adult Safeguarding. Following completion of the review, a report will be published setting out the Commission's findings and recommendations. Information about how to access the report will be made available to participants.

   I have read the information above and consent to participate in this survey. *

   - ◯ Yes
   - ◯ No

2. Are you currently a carer? *

   - ◯ Yes
   - ◯ No
   - ◯ Former carer
   - ◯ Other

3. **Who do you care for now or in the past?** (Tick all that apply) *

- ◯ Parent
- ◯ Partner/spouse
- ◯ Child
- ◯ Sibling
- ◯ Friend
- ◯ Other

4. **How long have you been caring for someone?** *

- ◯ Less than 1 year
- ◯ 1–5 years
- ◯ 6–10 years
- ◯ More than 10 years
- ◯ Prefer not to say

5. Does the person you care for experience any of the following? (Tick all that apply) *

- ◯ Dementia
- ◯ Mental ill health
- ◯ Learning disability
- ◯ Physical disability
- ◯ Autism
- ◯ Substance misuse
- ◯ Hoarding/self-neglect
- ◯ Prefer not to say
- ◯ Other

Your experiences

6. What helps most to keep the person you care for safe while maintaining their independence and dignity?

7. Have you felt listened to and treated as a partner by professionals involved in safeguarding or care? *

- ◯ Always
- ◯ Usually
- ◯ Sometimes
- ◯ Rarely
- ◯ Never
- ◯ Prefer not to say

8. Please tell us more about your experience.

9. What has been your experience of using technology or practical measures to support safety at home?

10. Have you ever been told not to do something by a healthcare professional that you felt was necessary to keep the person you care for safe? *

- ◯ Yes
- ◯ No
- ◯ Prefer not to say

11. Please tell us more about this experience.

12. Have you supported someone experiencing hoarding or self-neglect? *

- ◯ Yes
- ◯ No
- ◯ Prefer not to say

13. If yes, what support was available and what would have helped?

14. What approaches have been most effective when supporting someone experiencing hoarding or self-neglect?

15. If you could change one thing about safeguarding services for carers and families, what would it be?

16. Is there anything else you would like the Scrutiny Commission to know?

Equalities Monitoring

The following questions are optional and will only be used in anonymised form to help us understand whether we have heard from a diverse range of carers. To make sure we are providing fair services to all of Southwark's diverse communities, it is important that we ask you a few questions about yourself. You are under no obligation to provide the information requested, but it would help us greatly if you did. The information will be used to ensure we have consulted with a broad range of carers). Your responses will be kept confidential and any information published will be made anonymous. The information will be used in a statistical format only.

17. What is your age?

- ◯ Under 16
- ◯ 16–17
- ◯ 18–24
- ◯ 25–34
- ◯ 35–44
- ◯ 45–54
- ◯ 55–64
- ◯ 65–74
- ◯ 75–84
- ◯ 85–94
- ◯ 95+
- ◯ Prefer not to say

18. Are you disabled?

- ◯ Yes
- ◯ No
- ◯ Prefer not to say

19. If you answered 'Yes' above, please tick the box(es) below which best describe your disability.

- [ ] Hearing / Vision (e.g. deaf, partially deaf or hard of hearing; blind or partial sight)
- [ ] Physical / Mobility (e.g. wheelchair user, arthritis, multiple sclerosis etc)
- [ ] Mental health (lasting more than a year, e.g. severe depression, schizophrenia etc)
- [ ] Learning disability (e.g. dyslexia, dyspraxia etc)
- [ ] Long-term illness or health condition (e.g. Cancer, HIV, Diabetes, Chronic Heart disease, Rheumatoid Arthritis, Chronic Asthma)
- [ ] Other
- [ ] Prefer not to say

20. If you wish to specify your disability, please do so here:

21. What is your ethnic background? Please pick one section below and tick one box.

Please select the option that best describes your ethnic background. You may specify further if you wish.

- [ ] White or White British – British
- [ ] White or White British – English
- [ ] White or White British – Scottish
- [ ] White or White British – Welsh
- [ ] White or White British – Northern Irish
- [ ] White or White British – Irish
- [ ] White or White British – Gypsy, Roma or Irish Traveller
- [ ] White or White British – Other European
- [ ] White or White British – Other White (please specify if you wish):
- [ ] Black or Black British – Black British
- [ ] Black or Black British – Caribbean
- [ ] Black or Black British – Nigerian
- [ ] Black or Black British – Ghanaian
- [ ] Black or Black British – Sierra Leonean
- [ ] Black or Black British – Somali
- [ ] Black or Black British – Other African
- [ ] Black or Black British – Other Black (please specify if you wish):
- [ ] Asian or Asian British – Asian British
- [ ] Asian or Asian British – Indian
- [ ] Asian or Asian British – Bengali
- [ ] Asian or Asian British – Chinese
- [ ] Asian or Asian British – Pakistani
- [ ] Asian or Asian British – Vietnamese
- [ ] Asian or Asian British – Filipino
- [ ] Asian or Asian British – Any other Asian (please specify if you wish):
- [ ] Mixed Background – White and Black Caribbean
- [ ] Mixed Background – White and Black African
- [ ] Mixed Background – White and Asian
- [ ] Mixed Background – Other mixed background (please specify if you wish):

- [ ] Other Ethnic background – Arab
- [ ] Other Ethnic background – Latin American (please specify if you wish):
- [ ] Other Ethnic background – Any other ethnic background (please specify if you wish):
- [ ] Prefer not to say

22. What is your religion or belief?

Please select the option that best describes your religion or belief. You may specify further if you wish.

- [ ] Christian
- [ ] Sikh
- [ ] Hindu
- [ ] Muslim
- [ ] Jewish
- [ ] Buddhist
- [ ] No religion
- [ ] Prefer not to say
- [ ] Other religion or belief (please specify if you wish):

23. If you wish to specify your religion or belief, please do so here:

24. What is your sex as recorded at birth?

A question about Gender Identity will follow.

- ◯ Male
- ◯ Female
- ◯ Prefer not to say
- ◯ Other

25. Is the gender you identify with the same as the sex you were recorded at birth?

- ◯ Yes
- ◯ No
- ◯ Prefer not to say

26. If no, how would you define your gender identity?

27. Please specify your gender identity if you wish:

28. Sexual Orientation: Which of the following best describes your sexual orientation?

Please select the option that best describes your sexual orientation. You may specify further if you wish.

- ◯ Heterosexual/straight
- ◯ Lesbian/Gay woman
- ◯ Gay man
- ◯ Bisexual
- ◯ Other
- ◯ Prefer not to say

29. Do you live in Southwark or does the person/s you care for live in Southwark or use Southwark Council or Southwark NHS services?

Please tick all that apply.

- ☐ I live in Southwark
- ☐ The person/s I care for lives in Southwark
- ☐ Use council or NHS services in Southwark
- ☐ Prefer not to say

30. What is the first part of your postcode?

Please provide the first section of your postcode – for example SE1 or SE5.

31. Prefer not to say

- ◯ Prefer not to say

Communication

How to stay in touch

32. Would you like to be contacted about the review findings or discuss your experiences further with the Scrutiny Commission?

If yes, please email julie.timbrell@southwark.gov.uk.

- ◯ Yes
- ◯ No

Privacy notice

Southwark Council is collecting this information on behalf of the Health, Adult Social Care and Community Safety Scrutiny Commission to inform its review of Adult Safeguarding. Responses will be analysed in aggregate and reported anonymously. We will not publish names or any information that could identify individual participants.

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DRAFT SAFEGUARDING SCRUTINY REVIEW

Health & Adult Social Care and Community Safety Scrutiny Commission

Draft: October 2026

DRAFT

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DRAFT

1 Executive Summary

The Health and Social Care Scrutiny Commission undertook this review between 2023 and 2026 to consider how adult safeguarding in Southwark can be applied consistently, confidently and effectively. The review drew on evidence from council officers, the Southwark Safeguarding Adults Board, national and local specialists, care providers, elected members, carers and people with lived experience. Its focus was safeguarding practice and system-wide learning rather than the examination of individual cases.

The review found many examples of thoughtful and person-centred practice. Officers emphasised personalisation, the presumption of capacity and an adult's right to make decisions that others may regard as unwise. Evidence from practitioners and care providers demonstrated the value of individual care planning, clinical input, professional judgement and the use of the least restrictive options. The Commission also welcomed the Safeguarding Adults Board's work to strengthen understanding of the Mental Capacity Act and develop a complex case pathway to support earlier intervention and prevention.

Building on these strengths, the central conclusion of the review is that adult safeguarding is most effective when it combines protection from harm with respect for autonomy, dignity and individual choice. Many safeguarding situations involve uncertainty rather than straightforward answers, particularly where dementia, self-neglect, fluctuating capacity, family care or assistive technology are involved. Practitioners therefore need access to reflective supervision, practical guidance and case-based learning that enable them to exercise professional judgement confidently and proportionately.

The review found that assessment should consider the person's circumstances "in the round". Short visits or initial assessments may not reveal the full extent of a person's needs, particularly where somebody with dementia is able temporarily to mask their difficulties. Families and carers can provide essential information about a person's history, routines, preferences and day-to-day risks. Their insight should be actively sought and given appropriate weight, while maintaining professional curiosity about family pressures, relationships and possible risks. Neither family care nor institutional care should be assumed to be inherently safe or unsafe.

Assistive technology can help people retain independence and remain safely at home. The review heard, however, that approaches to cameras, sensors, monitoring equipment and door security can sometimes be inconsistent or overly cautious. Decisions should instead be personalised, evidence-based and regularly reviewed, balancing safety, privacy and autonomy while drawing on the knowledge of families and carers. Clear local guidance would support practitioners to consider these options positively and ethically rather than relying on blanket prohibitions.

The Commission identified prevention and early intervention as particularly important for people whose circumstances do not meet statutory safeguarding or Care Act thresholds but who remain vulnerable. The development of Southwark's complex case pathway is a positive and important step towards recognising cumulative risk and preventing circumstances from escalating into crisis. This work should explicitly

address dementia, carer strain, self-neglect and hoarding and should provide clear routes for sustained multi-agency involvement.

Hoarding and self-neglect illustrate the value of this approach. The Southwark Hoarding Panel provides an important mechanism for multi-agency oversight, trauma-informed support and the balancing of engagement with enforcement. Evidence showed that persistent, skilled and non-judgemental engagement can achieve significant improvements, even where support is initially declined. Earlier intervention, stronger specialist advice and appropriate training for frontline housing, health and social care staff would further improve outcomes and reduce the likelihood of crisis-led action.

In relation to care homes, the Commission welcomed evidence of good practice from Agincare, including person-centred care planning, open communication, support for whistleblowing and a learning-focused response to incidents and allegations. The review would welcome greater assurance that comparable arrangements operate consistently across all care homes in the borough. Regular engagement with families, accessible and independent routes for raising concerns, professional exchange between social workers and providers, and funding decisions that properly reflect residents' levels of need would strengthen the system further.

Available safeguarding data underline the importance of looking across all settings and relationships. In 2022–23, 59.3% of recorded concerns arose in people's own homes and 14.5% in care homes. Neglect and acts of omission were the most frequently recorded category of abuse, followed by financial, psychological and physical abuse and self-neglect. The review concludes that stronger analytical capacity, consistent categorisation and improved tracking of patterns and quality concerns would support prevention, accountability and earlier intervention.

The Commission's recommendations are intended to consolidate good practice and support continuous improvement. They propose:

stronger reflective supervision and locally relevant, case-based guidance;
confident and proportionate application of the Mental Capacity Act;
positive guidance on the ethical use of assistive technology;
earlier intervention and specialist expertise for self-neglect and hoarding;
targeted training for frontline staff;
stronger partnership with families, carers and communities;
regular learning forums and professional exchange with care providers;
improved safeguarding data, intelligence and annual assurance on care homes;
accessible and, where appropriate, anonymous routes for raising concerns;
external assurance and greater consistency in safeguarding reporting across London; and
NHS-led training for care-home staff on the prevention and management of pressure sores.

Overall, the review provides a positive platform for further development. Southwark has committed practitioners, established multi-agency arrangements and important improvement work already under way. By investing in reflective practice, early intervention, family partnership, specialist support and better use of intelligence, the

council and its partners can build on these foundations and achieve safeguarding practice that is consistently proportionate, preventative, person-centred and humane.

2 Introduction

The Health and Social Care Scrutiny Commission undertook this review between 2023 and 2026 to examine how adult safeguarding can be implemented more consistently, confidently and effectively to better protect and support vulnerable adults, families, carers and staff.

Adult safeguarding is designed to protect people at risk of abuse or neglect while also upholding their rights, dignity and autonomy. Evidence presented to this scrutiny review highlighted that, in practice, safeguarding is sometimes experienced as **inconsistent**, **risk-averse** or there is **insufficient engagement** particularly in complex situations involving dementia, self-neglect (particularly hoarding), family care and the use of assistive technology.

Members heard that inconsistent application of safeguarding principles can lead to distress, disengagement for individuals and families, the worsening of situations involving self-neglect, demoralisation among paid care staff, and a loss of trust in statutory services. In some cases, overly restrictive or poorly explained safeguarding decisions were experienced as more harmful than supportive.

This review draws together evidence from national experts, frontline practitioners, third sector specialists and people with lived experience to examine how safeguarding in Southwark can be implemented **more consistently, proportionately and humanely**, in line with the Care Act 2014 and the Mental Capacity Act 2005.

Definition of Abuse and Neglect (Adults)

Under the Care Act 2014, safeguarding adults includes protecting people from **abuse and neglect**, which may take different forms and can occur in any setting, including family homes, care homes, hospitals or the community.

Type of Abuse	Definition / Examples
Physical abuse	Assault, hitting, pushing, inappropriate restraint, misuse of medication
Domestic abuse	Controlling, coercive or threatening behaviour between partners or family members
Sexual abuse	Rape, sexual assault, inappropriate touching, exposure to sexual acts
Psychological / emotional abuse	Threats, intimidation, humiliation, coercion, isolation or controlling behaviour
Financial or material abuse	Theft, fraud, coercion over money, misuse of property or benefits

Modern slavery	Human trafficking, forced labour, domestic servitude or exploitation
Discriminatory abuse	Harassment or unfair treatment based on age, sex, pregnancy & maternity, disability, race, religion, marital status, gender reassignment or sexuality
Organisational (institutional) abuse	Poor care or neglect arising from service culture, systems or practice (e.g. in care homes or hospitals)
Neglect and acts of omission	Failure to provide adequate care, food, medication, or access to services
Self-neglect	Hoarding, poor hygiene or refusal of care leading to risk of harm

These forms of abuse may present as isolated safeguarding incidents or as patterns of lower-level “quality concerns”, which, when repeated, may constitute neglect or organisational abuse.

3 Purpose of the Review

The purpose of this review is to explore how adult safeguarding can be applied more consistently, confidently and effectively in Southwark, particularly in areas where professional judgement is required and thresholds are unclear.

The review seeks to:

- Improve clarity and consistency in safeguarding decision-making
- Support practitioners to balance autonomy and protection
- Strengthen professional curiosity and multi-agency working
- Reduce unintended harms caused by a risk-averse culture
- Improve practice in situations where there is poor guidance or insufficient professional support
- Ensure safeguarding practice better reflects lived experience

The review focuses on safeguarding practice rather than individual cases.

4 Contributors to the review and evidence base

External experts and practitioners

- Hourglass - Kyra Gonzales, Community Response Officer and Independent Domestic Violence Advisor (IDVA) attended a commission meeting
- Agincare – Mercy Mautsi , care home manager, provided an interview and Agincare provided group policies on Safeguarding and their Disciplinary policy and procedure . Agincare operate four care homes in Southwark Greenhive

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

- Grant Malyn , Dementia Clinical Nurse Specialist at SLaM, provided an interview.
- Claire Webster, Practice Development Consultant, Social Care Institute for Excellence provided an interview

Council officers

Pauline O'Hare , Director of Adult Social Care, provided an officer report on Hoarding and attended a commission meeting.

Service users voice and experience

Jean Thomas – provided a letter setting out her experience (appendix one)

Councillors provided anonymised case work on hoarding

Background information

Published reports and annual interview

Social Care Institute for Excellence practice publications and articles

Southwark Adult Safeguarding Board reports 22/23 23/24 24/25 and annual interviews with the Adult Safeguarding Board Independent Chair, Anna Berry

5 Crosscutting Safeguarding Themes

The following crosscutting themes reflect systemic safeguarding issues identified across all evidence, cutting across service areas, client groups and individual diagnoses.

5.1 Balancing Autonomy and Risk

A recurring theme throughout the review was the challenge of balancing personal autonomy with the duty to protect adults from harm.

Evidence from the Social Care Institute for Excellence (SCIE) emphasised that safeguarding should not default to risk elimination or paternalism. Claire Webster Practice Development Consultant at SCI highlighted the central principle of the Mental Capacity Act - the presumption of capacity and the importance of

least-restrictive decision-making - reflecting the Act's emphasis on autonomy and human rights[1].

Elsewhere in her published writing with SCIE she has drawn attention to judge Sir James Munby's famous rhetorical question: 'What good is it making someone safer if it merely makes them miserable?[2] '

Grant Mayln, Dementia Clinical Nurse Specialist at SLaM, also emphasised keeping people safe with the least restrictive option, in the context of considering use of technology to help keep people with dementia safe in the home.

Mercy Mautsi, Care Home Manager, Agincare said that care home staff are guided by care plans, especially in cases involving personal routines. For example if a resident wishes to stay in bed all day, the home seeks to understand the reasoning and ensure other care needs are met. Decisions on turning at night are informed by the resident wishes and clinical input on skin viability – a specialized mattress may be used.

When giving evidence on Safeguarding, officers emphasised the importance of 'personalisation', a practice that focuses on individualised care, placing the person at the centre of their support to determine their own needs, choices, and maximise control. Officers also drew the commission's attention to right of adults to make unwise choices.

Safeguarding practice should therefore:

- Assume capacity unless proven otherwise
- Focus on least restrictive options
- Develop care plans that take account of personal circumstance and input of family and other professionals
- Support informed decision-making, even where risk remains.

The review heard that capacity is sometimes mistakenly treated as a reason for inaction, particularly in cases of self-neglect or domestic abuse. SCIE guidance is that while a person may have capacity, this does not remove the need for professional engagement where risks are significant, but requires a different approach based on advice, relationship-building and risk enablement rather than control[3].

The Independent Safeguarding Chair reported that a recurring lesson for the board was the need for better understanding and application of the Mental Capacity Act; the board is developing bite-sized learning materials and lunchtime learning sessions to raise awareness among staff.

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[1] The Mental Capacity Act (MCA) principles are set out here by SCIE https://www.scie.org.uk/mca/practice/care-planning/human-rights-choice-control/

[2] See H is for Happiness, Human Rights and Hayden in the A to Z of the Mental Capacity Act 24 May 2021 Webster & Skinner

[3] See above SCIE MCA briefing above

5.2 Positive but Sensitive Approach to Technology

Evidence from carers highlighted inconsistency in how assistive technology is viewed and applied. A carer described being discouraged from using door locks even where this interventions enabled a family member to remain safely at home, and after a considered risk assessment.

A SLaM Dementia Nurse described a tendency for a “black and white” approach, where technologies such as cameras, sensors or tracking devices are prohibited rather than considered as part of a personalised plan. In some cases, refusal to explore technology has led to moves into residential care — a far more restrictive and expensive outcome.

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.

The commission heard that on occasions there is a risk-averse culture which does not take realistic account of family resources or sufficiently explore other opportunities to keep people safe and manage risk. For example a member told the commission that sometimes carers are told not to let people with dementia out of their sight which is contradictory as a type of surveillance 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.

The review found that:

- Technology can enhance autonomy rather than restrict it;
- Risk should be assessed in context and over time;
- The Social Care Institute for Excellence (SCIE) has guidance on supervision including continuous restriction;
- Drawing on SCIE guidance, safeguarding should avoid default, rule-based positions and instead adopt a personalised, case-by-case approach. Decisions about restriction and safety should be proportionate, evidence-based and rooted in the principles of autonomy, least-restrictive practice and individual outcomes[4].

Where technology is used, it should be:

- Proportionate
- Time-limited and regularly reviewed
- Be considered with family input as often carers are best placed to understand risks and benefits.

5.3 Assessment “in the Round” and Professional Curiosity

[4] See SCIE MCA briefing above and https://www.scie.org.uk/evidence-topic/assistive-technology/

Multiple witnesses highlighted the importance of assessments that look beyond surface presentation. This is especially critical in dementia, where people may mask difficulties during short visits and initial assessments. There is a well documented phenomena where people with dementia can put on a ‘showtime’ for a short period and draw on social memory to appear much more high functioning than they actual are.

The SLaM Dementia Nurse emphasised the need to corroborate function with family members and carers, and to actively probe day-to-day risks rather than accepting responses at face value. Families and carers were identified as often being best placed to understand how a person manages in practice and how risks present over time, and their views were described as an essential source of safeguarding intelligence rather than supplementary information.

Hourglass warned against professional bias, including the risk of untested assumptions about safety, noting that trauma responses can differ and that family dynamics, history and power relationships are sometimes overlooked. At the same time, the review heard that professional curiosity must be applied with balance and proportionality, recognising both the protective role families often play and the importance of giving appropriate weight to family and carer judgement, particularly where they have long-standing knowledge of the individual and are providing daily care.

Evidence to the review also indicated that professional curiosity must be applied consistently across all care settings, and that it is important not to assume safety purely on the basis of context or setting. Drawing on Claire Webster’s published work for SCIE [5], the review heard that risks can arise both in family care and in regulated settings, particularly where there are closed or defensive cultures, workforce pressures or barriers to raising concerns. Evidence from safeguarding reviews highlights how neglect and harm can become embedded where warning signs are not acted upon and where staff or families feel unable to speak up.

The review therefore concludes that effective safeguarding assessment requires curiosity, corroboration and proportionality, with neither family care nor institutional care treated as inherently safe or unsafe.

5.4 Reflective Practice, Confident Safeguarding and Local Guidance

Evidence from the Social Care Institute for Excellence (SCIE), including published work by Claire Webster, highlights reflective practice as a critical enabler of confident, proportionate and humane safeguarding. Webster’s work emphasises that many safeguarding decisions sit in areas of uncertainty, particularly where autonomy, risk, family dynamics and capacity intersect, and therefore require professional

[5] https://www.scie.org.uk/safeguarding-in-care-homes-the-importance-of-open-culture/

judgement supported by reflection and learning, rather than reliance on rigid procedures or defensive decision-making [6].

The review heard that where reflective practice is limited, safeguarding can become overly risk-averse or inconsistent, with practitioners either escalating concerns prematurely or failing to intervene where action is required. This reflects wider evidence that safeguarding systems can drift into compliance-focused practice where staff feel compelled to "reduce risk" rather than work constructively with it. Claire Webster has highlighted that misuse or misunderstanding of the Mental Capacity Act can contribute to both **over-intervention and inaction**, reinforcing the importance of confidence, supervision and shared learning in applying the Act appropriately. [7]

Claire Webster's published work also emphasises that safeguarding outcomes are closely linked to organisational culture. In care settings, closed or defensive cultures — where staff feel unable to raise concerns, where practice is not openly discussed, or where learning is limited — can allow neglect and poor care to become embedded. By contrast, open, learning-focused cultures, where staff are encouraged to question, reflect and share concerns without fear of blame, are associated with stronger safeguarding practice and earlier identification of risk[8].

The review therefore heard that reflective practice should be understood not as an additional activity, but as a core safeguarding function, supporting practitioners to:

- work confidently with complexity and uncertainty
- apply the Mental Capacity Act in a proportionate and rights-based way
- challenge assumptions and professional bias
- and respond flexibly to changing circumstances over time

Claire Webster also highlighted the importance of an open and learning-focused culture, where staff are encouraged to ask difficult questions, raise uncertainties and share concerns without fear of blame. Senior leaders play a key role in modelling this culture by supporting reflective supervision, welcoming challenge and valuing professional curiosity. The review heard that regular forums, case discussions and locally relevant case studies would help staff navigate complex safeguarding decisions more consistently and with greater confidence, while maintaining a strong focus on human rights, proportionality and least-restrictive practice.

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[6] SCIE: Mental Capacity Act – practice guidance on judgement, uncertainty and decision-making https://www.scie.org.uk/mca/practice/

[7] See risk-averse and paternalistic practice linked to poor MCA understanding https://www.scie.org.uk/mca/practice/care-planning/human-rights-choice-control/

[8] Claire Webster – safeguarding in care homes / open culture https://www.scie.org.uk/safeguarding-in-care-homes-the-importance-of-open-culture

Grant Malyn, Dementia Clinical Nurse Specialist at SLaM, referred to the need for better training and ongoing professional development including input from people with lived experience, including carers and people with dementia, and highlighted that SLaM has a user forum that could be utilized to share materials and insights.

5.5 Complex Cases Below the Threshold: Prevention and Early Intervention

A key crosscutting issue identified through the review was how safeguarding operates in complex cases below statutory thresholds, where individuals may not meet Care Act eligibility or safeguarding criteria but remain at risk. Evidence showed that such cases often involve dementia, self-neglect (including hoarding), mental ill health, family strain or social isolation, with risk escalating gradually rather than presenting as a single safeguarding incident. An over-reliance on statutory thresholds can leave people known to services but not adequately protected.

The Hourglass Community Response Officer gave an example of a case where an older women's carer was her son, who had mental health problems, however she was not deemed vulnerable enough for intervention by statutory services.

The Independent Safeguarding Chair reported that there is an ongoing focus within the Safeguarding Adults Board on complex safeguarding, including the development of a complex case pathway aimed at earlier intervention and prevention for people who may not meet statutory thresholds but are nonetheless vulnerable. This work was reported to be making good progress and was welcomed by the commission as this reflects a strategic shift towards recognising cumulative risk and preventing harm before statutory safeguarding thresholds are met. Members also expressed a desire to see this work explicitly include people and families affected by dementia, given the heightened risks of neglect and domestic abuse highlighted by Hourglass. This also chimes with the Safeguarding Chair's comments, noted below that dementia and carers will receive more focus in the coming year.

Evidence to the review consistently showed that where intervention is delayed until statutory thresholds are met, situations are more likely to escalate into crisis, including hospital admission, serious self-neglect or environmental hazards. Members heard that safeguarding responses are more effective when prevention is recognised as a safeguarding function, rather than solely as a care or wellbeing issue. Early engagement, ongoing involvement and proportionate responses were identified as critical in preventing harm in below-threshold cases.

The commission also noted that frontline practitioners — such as housing officers, occupational therapists, district nurses and community health staff — are often the first to encounter early warning signs. Supporting these roles with appropriate training, access to specialist advice and clear escalation routes was identified as essential to strengthening preventative safeguarding and reducing later crisis-driven interventions.

Overall, the review concludes that improving outcomes in complex, below-threshold cases depends on:

- earlier and skilled engagement rather than waiting for crisis;

- explicitly recognising prevention as a safeguarding function, not just a care function;
- sustained multiagency involvement through pathways such as the complex case approach.

Strengthening these elements would improve safety, support autonomy and reduce pressure on acute safeguarding and care services.

Family and Community Involvement as Safeguarding Partners

A further cross-cutting theme emerging from the review was the essential role of families, carers and the wider community in effective safeguarding. This is particularly important in complex, below-threshold cases, where family and community insight may be the earliest indicator of emerging risk.

Evidence demonstrated that families and carers often hold detailed knowledge of an individual's history, routines, preferences and subtle changes in behaviour, particularly in cases involving dementia, long-term mental illness or self-neglect. When this knowledge is not actively sought or valued, risks may be underestimated and opportunities for early intervention missed.

The review also highlighted that family involvement can be complex. While families are frequently a protective factor, they may also be under significant strain, and long-standing family dynamics can themselves contribute to risk. Evidence from Hourglass and others emphasised the importance of professional curiosity, including understanding historical and current family relationships, and avoiding assumptions that family care automatically equates to safety. Effective safeguarding therefore requires a balanced approach that views families as partners, while retaining appropriate professional challenge and oversight.

Members also heard that safeguarding systems are more robust where there is wider community oversight and engagement. Hourglass noted that many safeguarding alerts arise from friends and family rather than institutions, and that reduced family presence in care settings may contribute to under-reporting.

Elected members expressed a clear desire to strengthen family and community involvement in safeguarding, including within care homes, and to improve transparency and accessibility of safeguarding processes. Members supported the development of council-facilitated forums where families, carers, providers and practitioners can share experiences, raise concerns, and build shared understanding of safeguarding principles, thresholds and rights. The review concludes that safeguarding is most effective when it is understood as a shared responsibility, underpinned by open communication, trust and collaboration between statutory services, families and communities.

6 Area of Focus: Dementia

6.1 Ensuring Good Quality, Early and Holistic Assessment

Dementia featured prominently across safeguarding evidence, with Hourglass, who work to prevent abuse of older people, reporting that often cases involve a diagnosis of dementia. Witnesses consistently stressed that **early, holistic assessment** is critical to preventing harm and unnecessary escalation.

The review heard concerns that:

- Masking can obscure risk
- Carers , family and friends have a unique perspective which ought to inform care planning
- Family pressure may remain unseen
- People below eligibility thresholds still face significant safeguarding risks.

6.2 Support Below the Threshold of Care for people with dementia and carers

Evidence highlighted the importance of services available to people and families who do not meet Care Act eligibility, including:

- Southwark Carers
- Aging Well Southwark
- Admiral Nurses
- Community and voluntary sector provision
- Housing
- Culturally appropriate homecare services

These services play a vital preventative role, yet families reported that they were often left to navigate support themselves, leading to stress and exhaustion.

A carer described feeling criticised by Social Workers rather than supported when making safety decisions for her mother with dementia, leading to anger, distress and disengagement from services. She did however find homecare provided by a culturally and ethnically appropriate service supportive, but noted this was sourced by her rather than by Social Services.

The Independent Safeguarding chair told the commission in March 2026 that emerging themes at the board include the need for deeper understanding of dementia and support for carers, with future reviews set to address these areas and inform further training and action planning, which the commission welcomed.

6.3 Professional Curiosity and Family Dynamics

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Both Hourglass and SLaM emphasised the importance of understanding family systems in safeguarding practice, particularly in cases involving dementia. Evidence showed that abuse, neglect or harm can occur even where family members are providing care, especially where care is delivered under prolonged strain or in the context of dependency.

Hourglass highlighted that older people may tolerate abuse in order to avoid losing their only source of care, and that power dynamics, historical relationships and patterns of control are often central to risk, particularly in cases of domestic abuse. These risks may be masked by outward appearances of coping or by assumptions that family care is inherently protective.

The review therefore concludes that safeguarding practice must not assume that family care is safe and must actively explore family histories, dynamics and pressures as part of assessment and decision-making. This includes recognising that carers themselves may need support, and that failure to understand these dynamics can result in missed opportunities to intervene, particularly for people with dementia who may have limited ability to disclose harm.

Maintaining professional curiosity in these circumstances is essential to ensuring that safeguarding responses are proportionate, preventative and rooted in lived experience, rather than shaped by assumptions about family roles

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7 Safeguarding in care homes

The commission approached four care homes providers in Southwark. Agincare gave an interview and provided policies on safeguarding and staff disciplinary and grievance procedure (to consider how complaints are addressed). HC-One, Mission Care, County Court were unable to attend or provide documentation.

7.1 Providing adequate funding to meet complex needs

Agincare’s evidence highlighted the complexity of safeguarding practice in care homes and the need for clearer, more consistent approaches across local authorities. The care home manager noted variation in how safeguarding alerts are raised and interpreted across different local authorities. Some quality of care issues, such as falls, pressure sores acquired before admission, dementia-related behaviours or late medication are being escalated as safeguarding concerns.

Safeguarding alerts were on occasions indicative that additional support or resources were required where residents ’needs exceeded what was originally

commissioned. The care home manager explained that increasing resident complexity, combined with constrained support packages, can unintentionally drive safeguarding activity, and alerts can signal this to Social Services.

Agincare recommended the Funding Panel give greater weight to care home managers 'assessments and use of the dependency tool. There was also a suggestion that social workers and senior managers could benefit from work experience in care homes to better understand operational realities and improve collaboration. The care manager expressed an interest in a social worker work placement to get an insight into brokerage decisions.

7.2 Balancing autonomy and risk

Balancing autonomy, risk and family involvement was a further key theme in Agincare's evidence. Care planning was described as central to safeguarding decisions, particularly where residents 'preferences—such frequent use of call bells—might present perceived risks or unmet needs. Staff seek to understand underlying needs, use clinical input and adopt least restrictive solutions wherever possible. Families 'knowledge of residents 'preferences is recorded, but homes prioritise residents 'current lived experience, recognising that needs and wishes may evolve in care settings.

7.3 Open learning culture

The discussion with the Agincare care manager underlined the importance of reflective practice, staff support and proportionate responses to allegations. Agincare described a culture that encourages whistleblowing, open communication with managers and case-by-case reflection following incidents. Where safeguarding allegations are raised against staff, temporary redeployment, investigation and training needs are considered, with dismissal reserved for cases where evidence is clear. While vexatious complaints were acknowledged, the focus remained on resident experience and outcomes. The care home manager stressed the value of learning-focused safeguarding approaches that balance fairness to staff with the duty to protect residents.

Claire Webster emphasised that an open culture is critical to effective safeguarding, noting that closed or fear-based environments, for example where staff are unable to whistleblow or feel insecure in their employment, can allow neglect and poor care to persist unchecked. In addition she has highlighted overseas staff may feel unable to raise concerns due to visa dependency and fear of losing employment[9].

Members welcomed and noted the high quality evidence from Agincare, the robust policies and procedures, and the emphasis on an open and learning culture. The

[9] https://www.scie.org.uk/safeguarding-in-care-homes-the-importance-of-open-culture/

commission would like more assurance from other care home providers that similar practices are in place.

7.4 Enabling family, friends and the community to raise concerns

Hourglass reported fewer alerts from care homes, however they said this may be because there is less family and community oversight as most alerts arise from friends and family. Members consider that more could be done to engage families and carers, including regular forums for discussion and support.In addition, anonymous reporting mechanisms (e.g. email, text, WhatsApp) would enable staff and families to raise concerns.

Members also raised concerns that complaints about care in homes can sometimes referred straight back to the home in question by council officers as ‘quality concerns’ for the home to resolve rather than being captured at Safeguarding incidences and benefiting from independent investigation.

8 Area of Focus: Hoarding and Self-neglect

Hoarding was consistently identified as a complex safeguarding issue, often requiring sustained, multiagency intervention. Evidence showed that hoarding is frequently linked with trauma, mental illness, substance abuse, or dementia and should not be dismissed as a “lifestyle choice”. It can also be a result of disability, illness or ageing.

8.1 Safeguarding Context

Hoarding is recognised under the Care Act 2014 as a form of selfneglect and may trigger safeguarding duties where an individual has care and support needs and is unable to protect themselves.

The Southwark Hoarding Panel was highlighted as an important mechanism for:

- Multiagency oversight
- Longterm, trauma-informed support
- Balancing enforcement with engagement

The majority of people supported by the panel are Southwark council housing tenants.

8.2 Early Intervention, persistence, and training.

Members expressed concern that intervention often occurs only after serious incidents such as fires, infestations or hospital admissions. The review also heard concerns about inconsistency between policy and frontline practice, particularly

where hoarding was minimised or reframed as personal choice, or where intervention was overly focused on enforcement and used punitive language.

Officers highlighted that it can take time a long time to engage service users. Councillor casework corroborated this, with a frequent a pattern of early refusal but it also demonstrated that persistent engagement by skilful practitioners did improve the residents 'situations, often significantly.

These are two examples:

Case one

A resident with significant belongings and complex physical and mental health problems came to the attention of a local councilor in 2023. The councillor was able to arrange some community help to clear pathways. In the same year district nurses and an Occupational Therapist were engaged with the resident's 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 decided the main problem was cleaning, which they considered to be a "lifestyle" issue which did not require intervention.

In 2025 a full care assessment did find eligibility for care by a social worker, and the resident now has carers to support him so the situation has improved. There remains a concern from the councillor 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 two

A resident contacted a councillor 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". The housing officer referred the case to a Complex Case Worker, who offered to visit with support of the councilor. The councillor 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. However, the Complex Case Worker appeared to have no knowledge of addiction issues or the 12 step programme so the commission feels that such frontline workers need additional training.

The commission concluded that earlier and more skilful intervention would improve outcomes and reduce pressure on health and care services. It is usually frontline workers such as housing officers, Occupational Therapists, district nurses, health and social workers who will encounter hoarding and as such investment in training and access to specialist support, such as complex case workers, would aid more timely and effective intervention. Officers advised that training was not mandatory but that extensive training opportunities were available, and agreed with the commission that more training would be beneficial .

The Safeguarding Chair reported that the focus on complex safeguarding, including the development of a complex case pathway for early intervention and prevention, targeting individuals who may not meet statutory safeguarding criteria but are at risk due to issues like hoarding or self-neglect, was making significant progress. This was welcomed by the commission.

The review heard that responses to hoarding are more effective when they:

- begin earlier
- are conducted by frontline workers with appropriate training
- are relationship based and non judgmental
- encourage engagement rather than waiting for crises.

A purely procedural or enforcement-led response was shown to be more likely to result in disengagement and worsening risk.

8.3 Key Learning

Effective safeguarding responses to hoarding require:

- Shared professional understanding
- Ongoing training of frontline health, housing and social workers
- Clear escalation pathways, including for complex cases where residents sit below the threshold of care
- Strong partnership with housing, fire services, mental health and social care.

The review highlights hoarding as a clear example of where safeguarding, prevention and mental health intersect and that early intervention by skilful practitioners, alongside multi-agency working can improve outcomes.

9 Data, intelligence and trends in safeguarding

Evidence presented to the commission highlighted the importance of robust, accessible and well-analysed safeguarding data to support effective decision-making across the system.

Safeguarding data for 2022–23 shows clear patterns in both the location of incidents and the types of abuse reported. The majority of safeguarding concerns arose in an individual's own home (59.3%), with a smaller proportion occurring in care homes (14.5%), community services and hospitals. This reflects the central role of family and informal care settings in safeguarding, while also demonstrating that risk is present across all care environments.

Data on relationships of alleged perpetrators also illustrates the complexity of safeguarding, with concerns involving family members (15.9%), people known to the individual (13.4%), as well as paid care staff, including domiciliary care workers (11.7%) and residential care staff (6.6%). This reinforces the need for safeguarding approaches that do not assume safety based on setting or role, but instead focus on relationships, power dynamics and professional curiosity.

In terms of types of abuse, the most frequently recorded categories were:

- Neglect and acts of omission (25.7%)
- Financial and material abuse (16.9%)
- Psychological or emotional abuse (15.9%)
- Physical abuse (13.4%)
- Self-neglect (10.3%)

This distribution highlights the prevalence of neglect and lower-visibility forms of abuse, which may develop over time and may not always meet safeguarding thresholds at an early stage.

The commission heard that, while headline figures are important, there remain gaps in data and analysis, including the need for:

- clearer understanding of trends across care settings
- improved data on quality concerns versus safeguarding incidents
- more detailed tracking of issues such as pressure sores and their origin[10]
- consistent categorisation and reporting across partners

Members also noted that improved data is essential to understanding whether safeguarding systems are operating effectively, identifying patterns of concern, and supporting earlier intervention in complex cases.

The commission therefore concludes that strengthening data and analytical capacity is critical to improving safeguarding practice, informing prevention and providing assurance across the system.

[10] https://www.gov.uk/government/publications/pressure-ulcers-how-to-safeguard-adults/safeguarding-adults-protocol-pressure-ulcers-and-raising-a-safeguarding-concern.

10 Recommendations

The following recommendations are intended to address the systemic issues identified in Section C, particularly around prevention, reflective practice and partnership with families and communities.

Recommendation 1 – Reflective Practice, Proportionate Risk and Partnership with Families

That the council, through the Southwark Safeguarding Adults Board (SSAB), strengthens reflective supervision and group reflection for safeguarding-related roles, particularly in complex cases involving dementia, self-neglect and fluctuating capacity.

This should include:

Reinforcing a **commonsense, proportionate approach to risk**, avoiding overly risk-averse or defensive practice

Clear support for professionals to apply the Mental Capacity Act confidently, including where adults make unwise decisions

Explicitly recognising **family carers as key partners**, giving due weight to their expertise in assessing day-to-day risks (for example, decisions about supervision, leaving someone at home, or use of equipment)

Supporting staff to evidence professional judgement rather than defaulting to restrictive or bureaucratic responses.

Recommendation 2 – Local Case-based Safeguarding Guidance

That locally relevant case studies and practice briefings are developed, drawing on Southwark experience, to support consistent decision-making in grey area safeguarding situations (for example autonomy, self-neglect, dementia, family care and fluctuating capacity).

Recommendation 3 – Confident Application of the Mental Capacity Act

That refresher training and practice support be prioritised to reinforce:

Presumption of capacity

The right to make unwise decisions

Clear and proportionate recording of best interest decisions

to address both **risk-aversion and inaction**.

Recommendation 4 – Positive, Proportionate Use of Technology in Family Homes

That clear local guidance for social workers be developed, drawing on SCIE work, on the **proportionate and ethical use of assistive technology in family homes**, including:

Use of cameras

Door locking

Sensors and monitoring devices

This guidance should support personalised, least-restrictive decision-making that balances autonomy, safety and family insight, and avoids default prohibitions.

Recommendation 5 – Earlier Intervention for Self-neglect and Hoarding

That early, skilled intervention for self-neglect (including hoarding) be strengthened through:
The complex safeguarding pathway
Improved escalation routes below Care Act thresholds
Ongoing, trauma-informed engagement rather than crisis-led responses

Recommendation 6 – Training for Frontline Non-Safeguarding Roles
That targeted safeguarding training be provided to frontline staff most likely to encounter early risk (for example housing officers, Resident Service Officers, OTs, district nurses), including training on the **psychology of hoarding**, to ensure residents are approached with compassion rather than punitive or enforcement-led responses, with clear routes to specialist advice.

Recommendation 7 – Specialist Hoarding Expertise
That the council and NHS partners explore options to **reinstate the former SLaM Specialist Hoarding post or reestablish an equivalent specialist hoarding service**, to provide expert assessment, consultation and support to frontline staff managing complex self-neglect cases.

Recommendation 8 – Strengthening Family Involvement in Care Homes
That the council works with care providers to promote **meaningful family involvement in care homes**, including:
Clear communication routes
Recognition of families as safeguarding partners
Regular family forums

Recommendation 9 – Council and NHS-Facilitated Learning Forums
That the council, working with NHS partners, facilitates regular forums bringing together care providers, families, carers, practitioners and commissioners to share learning, discuss safeguarding challenges and improve mutual understanding across the system.

Recommendation 10 – Admission and Funding Decisions in Care Homes
That funding and admissions processes give greater weight to care home managers 'professional assessments, including dependency tools, to reduce safeguarding risks arising from under-resourced placements.

Recommendation 11 – Professional Exchange Between Social Care and Care Homes
That opportunities be developed for professional exchange, including:
Social workers undertaking time-limited placements in care homes
Care home managers gaining insight into brokerage and funding processes to improve mutual understanding and collaboration.

Recommendation 12 – Data, Intelligence and Oversight
That additional funding be provided to the Safeguarding Adults Board to support **dedicated data and intelligence capacity**, including:
Improved analysis of safeguarding alerts and care home quality concerns

Better understanding of trends over time
Collection and analysis of data on **pressure sores**, including origin and setting.

Recommendation 13 – Independent Review of Safeguarding Practice
That the council commissions **SCIE to undertake an independent review of Southwark's safeguarding policies and practices**, to provide external assurance, benchmark against best practice and inform continuous improvement.

Recommendation 14 – LondonWide Consistency in Safeguarding Reporting
That the council requests London Councils to undertake work to **harmonise safeguarding reporting criteria across London boroughs**, particularly in relation to care homes, to reduce inconsistency, administrative burden and confusion for providers.

Recommendation 15 – Annual Care Homes Assurance Report
That the council produces an **annual report on care homes in the borough**, similar to the Corporate Parenting Annual Report, integrating:
Safeguarding data
Assurance on safeguarding, disciplinary and grievance policies
Evidence of open and reflective culture (e.g. learning networks, staff development)
Evidence of regular family engagement and forums

Recommendation 16 – Culture of Openness and Whistleblowing
That the council and SSAB continue to promote an open safeguarding culture, including:
Clear and accessible routes for staff, families and communities to raise concerns
Exploration of **anonymous reporting mechanisms**, including a council-supported whistleblowing service
Ongoing support for whistleblowing without fear of reprisal.

Recommendation 17 – NHS-led Training on Pressure Sore Prevention
That NHS partners undertake or commission **boroughwide training for all care home staff** on the prevention and management of pressure sores, to reduce avoidable harm and safeguarding concerns.

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11 Acknowledgements and thanks

Health and Social Care Scrutiny Commission 2023/24/25/26 members:

Councillor Suzanne Abachor (Chair)

Councillor Maria Linforth-Hall (Vice-Chair)

Councillor Naima Ali

Councillor Sam Dalton

Councillor Esme Dobson

Councillor Nick Johnson

Councillor Sunil Chopra

Councillor Sandra Rhule

Julie Timbrell, Project Manager and report author on behalf of the commission.

The Commission would like to thank all the contributors to the report, listed in section C , and Cllr Esme Dobson who championed the review.

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1.

Appendix one: Carer experience letter, Jean Jones

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

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Agenda Item 9

Item No. 9.	Classification: Open	Date: 21 October 2026	Meeting Name: Health, Adult Social Care and Community Safety Scrutiny Commission
Report title:		Health, Adult Social Care and Community Safety Scrutiny Commission Work Programme 2026 - 27	
Ward(s) or groups affected:		N/a	
From:		Julie Timbrell, Project Manager, scrutiny.	

RECOMMENDATIONS

1. That the Health, Adult Social Care and Community Safety Scrutiny Commission note the work programme as attached as Appendix 1.

2. That the Health, Adult Social Care and Community Safety 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, Adult Social Care and Community Safety Scrutiny Commission is considering in 2026 - 27.

6. The work programme is a standing item on the Health, Adult Social Care and Community Safety 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, Adult Social Care and Community Safety Scrutiny Commission agenda and minutes	Southwark Council Website	Julie Timbrell Project Manager
Link: https://moderngov.southwark.gov.uk/ieListMeetings.aspx?CommitteeId=518		

APPENDICES

No.	Title
Appendix 1	Work Programme 2025-26

AUDIT TRAIL

Lead Officer	Everton Roberts, Head of Scrutiny
Report Author	Julie Timbrell, Project Manager, Scrutiny.
Version	Final
Dated	19 October 2026
Key Decision?	No

CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER		
Officer Title	**Comments Sought**	**Comments Included**
Assistant Chief Executive – Governance and Assurance	No	No
Strategic Director of Resources	No	No
Cabinet Member	No	No
Date final report sent to Scrutiny Team		19 October 2026

Health, Adult Social Care and Community Safety Scrutiny Commission Workplan 26 - 27

Review

Complex needs and street based Anti Social Behaviour (ASB).

Topics

1. Community Safety Partnership – overview of strategy and scrutiny of annual plan with co-chairs of CSP and partners
2. Neighbourhood health service – integrated neighbourhood teams (INTs)
3. Two wheeled enabled phone theft and robberies
4. Sexual health services with reference to the new Sexual and Reproductive Health Strategy 2025-2030
5. CQC report on Adult Social Care and response to recommendations around Safeguarding in particular
6. Women's reproductive health services
7. Transition arrangements between CAMHS/Adolescent mental health Services and adult services

Briefings

Wheelchair charging in King's College Hospital

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Follow up on previous years

1. Parking for disabled people
2. Peckham Rye Station toilet provision following Network Rail announcement re investment in disabled toilets being delayed
3. Care charges scrutiny review – with particular reference to £10 pw disregard and implementation, DRE (Disability Related Expenditure) , and Inclusion London report due in the autumn
4. Asylum Road care home delivery – quarterly updates
5. Complete the Safeguarding scrutiny review , rolled over from last administrative year, and conduct engagement work with residents over the summer

Interviews with Executive members and partners - tbc

Chair/ Co Chairs of Community Safety Partnership

Strategic Director of the Environment

Police Borough Commander

Fire Borough Commander

Independent Chair of the Safeguarding Adult Board

Deputy Executive Member for Adult Services

Portfolio

- adult social care – including adult safeguarding; home care; nursing and care homes; occupational therapy, aids and adaptations; and commissioning extra care, sheltered and supported housing
- adult mental health
- older people – including ensuring Southwark is an age friendly borough

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- adults with disabilities – including social care support; increasing the voice and influence of people with disabilities and their families in local decision making
- carers – support for people who are providing unpaid care for adult family members or friends with a disability or health condition, including respite care

Executive Member for Education and Care

Portfolio

- adult services – working closely with the Deputy Executive Member who holds this portfolio in its entirety.

Executive Member for Community Safety and Engagement

Portfolio

- reducing crime and antisocial behaviour – including community wardens, anti-social behaviour team, noise service, CCTV, public spaces protection orders, preventing hate crime, tackling modern day slavery
- violence reduction – working to end misogyny and violence against women and girls, youth violence and the criminal exploitation of young people
- domestic abuse – support for people who have experienced domestic abuse, Women's Safety Centre and safe spaces
- improving policing – promoting equitable policing and strengthening community relations with the police
- licensing – premises serving alcohol or late-night refreshments and gambling
- environmental health – including trading standards, food safety and environmental protection
- landlord licensing – increasing protections for private renters licencing and advice services for private sector renters
- youth offending services

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- enforcement – taking assertive action to tackle fly tipping, graffiti and litter across our borough

Deputy Leader and Executive Member for Planning, Infrastructure and Wellbeing

Portfolio

- public health – including reducing health inequalities; Community Health Ambassadors; vaccinations, immunisation and screening; health visiting, school nursing and childhood obesity; sexual health, contraception and HIV; and smoking, drug and alcohol services

- health and wellbeing partnerships – overseeing key stakeholder relationships such as Health & Wellbeing Board and the South East London Integrated Care Partnership, Partnership Southwark and SC1

- improving health services – working with the NHS, general practice (GPs), local hospitals, community health services and pharmacists

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Meeting plan

Health and Care Scrutiny Commission meeting type / number	Date	Items
1	Thursday 23 July	• Health and Community Safety Powers • Southwark Partnership • Healthwatch: a. Annual Report 2025–26 b. Housing, health and hope: Experiences of living in and moving on from asylum accommodation • Asylum Road Care Home delivery update – to note • Workplan
2	21 October	1. CQC report on Southwark Council Adult Social Care 2. Sexual Health 3. Safeguarding scrutiny review report – engagement . 4. Asylum Road Care Home delivery update . 5. Work programme
3	Monday 30 November (date to be moved)	1. Community Safety Partnership attendance with focus on Anti- Social Behaviour and Complex needs 2. NHS / ICS response to the cancer prevention and early diagnosis scrutiny review report .

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4	Tuesday 26 January	Womens Reproductive Health (tbc)
5	Monday 1 March	1. Cabinet member interviews tbc 2. Transition arrangements between CAMHS/Adolescent mental health Services and adult services

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Health, Adult Social Care and Community Safety Scrutiny Commission

MUNICIPAL YEAR 2026-27

AGENDA DISTRIBUTION LIST (OPEN)

NOTE: Original held by Scrutiny Team;

all amendments/queries to Julie.Timbrell@southwark.gov.uk

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