Lambeth Safeguarding Adult Partnership Board

Annual Report

January 2014 – April 2014

- **This report covers a three month period only. This is to allow for all future reports to be in line with the Care Act 2014 which requires an April-April annual cycle.**

Board Membership during this period:

Name	Title	Name	Title
Ann Baxter	Independent Chair	Graham Norton	Ambulance Operations Manager London Ambulance Service
George Marshman	Delivery Director, Adult Social Care LB Lambeth	Hayley Marle	Inspection Manager CQC
Aisling Duffy	Chief Executive Certitude	Helen Charlesworth-May	Strategic Director Commissioning London Borough of Lambeth
Moira McGrath	Director Integrated Commissioning (Older Adults) / CCG Safeguarding Lead NHS Lambeth and LB Lambeth	Andrew Wyatt	Interim Delivery Director of Children's Social Care LB Lambeth
Maria Millwood	Commissioning Director LB Lambeth	Lenny Kinnear	Chief Executive Age UK Lambeth
Ann Corbett	Assistant Director, Community Safety LB Lambeth	Lucy Canning	Service Director, Psychosis Clinical Academic Group South London and Maudsley NHS Foundation Trust
Ann Hamlet	Head of Safeguarding Adults Kings Collge Hospital NHS Foundation Trust	Mala Karasu	Safeguarding Adults Trust Lead Guys & St Thomas' NHS Foundation Trust
Ash Soni	Clinical Network Lead NHS Lambeth CCG	Mandy Green	LBL Housing
Bruce Grain	Station Manager Fire Service	Martin Huxley	Detective Superintendent, London Lambeth Metropolitan Police
Jane Gregory	Safeguarding Adult Policy and Development Coordinator, LB Lambeth	Cllr Jane Pickard	Councillor LB Lambeth
Catherine Pearson	Chief Executive Healthwatch Lambeth	Martin Ryan	Borough Crown Prosecutor Lambeth Crown Prosecution Service
Barbara Joyce	Office of Public Guardian	Melodie-Ann Dalrymple	Senior Probation Officer - London Probation Trust (Observer)
Clement Guerin	Head of Service Safeguarding Adults LB Lambeth	Melanie Brooks	Assistant Director, Adult Social Care, LB Lambeth
Cllr Shirley Cosgrave	Cabinet Member for Social Care LB Lambeth	Paula Townsend	Deputy Director of Nursing Kings College Hospital NHS Foundation Trust
Cllr Jim Dickson	Cabinet Member for Health & Wellbeing LB Lambeth		

What the Board has done to implement its strategy:

Over this period, the Board has demonstrated progress in implementing its strategy in the following ways:

- **Outcomes for, and experiences of, people who use services**

  - The Board has put in place expectations about reporting requirements that will give it assurance about outcomes
  - There has been progress in the work with Hidden Voices, who have established both practitioner and service user forums with a focus on developing ways of measuring user outcomes.

- **Leadership, strategy and commissioning**

  - The Board's reporting requirements include assurance indicators from commissioners
  - The reporting requirements put in place involve assurance to the Board from partners

- **Service Delivery, performance and resource management**

  - The Board has revised its reporting arrangements and has also agreed to produce a themed report at each quarter, which will allow for scrutiny in particular areas such as; Crime and Community Safety, Health, Social Care and Housing.

Serious Case Reviews (SCRs) updates and feedback:

No Serious Case Reviews (SCRs) were closed over this period however there is an on-going SCR regarding 'Client B'. The Performance Advisory and Delivery Committee (PADeC) took the action plan for this forward and a task a finish group was set up with the first meeting taking place on the 30/04/2014. The group has continued to meet to progress the agreed actions. Some recommendations, for which arrangements are in place, will require quality assurance. Practice will be audited this year to ensure that changes have had an impact. The Board suggested that the recommendations be grouped by theme to facilitate the Board's overview of progress. This was done and the eight main themes covered in the recommendations cover the following issues:

1) Sharing of information, risk management, routes for escalation and *case- coordination*
2) Training needs of GP's, district nurses, Community Learning Disability Team, day centre staff and medical specialists focused on *clinical care*
3) Management of the diagnosis and *management of chronic conditions* in people with profound and multiple disabilities with parents and family members, including managing transition from children's to adult services
4) Using the *Mental Capacity Act 2005 in complex cases*
5) *Commissioning* of health care services on behalf of people with intellectual disabilities from both mainstream and specialist clinical teams
6) Management of a coherent and robust *infrastructure* for case management, safeguarding and the supervision of staff
7) Implications for *housing agencies*
8) Lessons with *implications for pan-London and national bodies*

There was no confirmed date for the inquest at this time however the Coroner asked for and was given a copy of the interim report. SCR recommendations for NHS England the OPG were held until the inquest had taken place. The Executive Summary of this SCR will be published in the next Board Annual report in the Summer of 2015.

The Care Act 2014

This is a significant piece of legislation which consolidates the current policies and social care laws. The adult safeguarding elements of this will be enacted in April 2015. This legislation puts adults safeguarding on a statutory footing for the first time and creates duties for local authorities undertaking adult safeguarding work. It further creates a duty for partner agencies to cooperate. Local authorities will not be able to delegate the decision to undertake an enquiry, but may delegate the undertaking of the inquiry to another agency. Case reviews will be replaced by 'safeguarding' reviews which are now statutory and which Safeguarding Adults Boards must arrange.

The Guidance was released in October 2014 and contributions to this were made by the LSAPB.

Summary of Safeguarding Adults Statistics (2013-14)

- A total of 1,820 referrals were recorded. This represents an increase of 11% compared to last year.
- In comparison to last year there was a 1% increase in the number of referrals that led to an investigation. Half of referrals (53%) were for adults with a physical disability. There was a significant increase in the number of referrals for the mental health client group (60%)
- In total of 1,242 referrals were concluded in the year. This reflects a 28% increase compared to 2012-13. 36% of cases were either Substantiated or Partially Substantiated, 33% were not substantiated and for 26% of cases, a conclusion could not be determined
- The most common type of alleged abuse is neglect and acts of omission (33%) this is a change from the previous reporting year, where Physical abuse (28%) was the most common type of abuse cited in 2012-13.

Summary of Homicide Review

Lambeth's domestic homicide review panel examined agency responses and support given to Ms Z, a visitor to Lambeth and England, prior to the point of her death on or between 29.12.2012 and 06.01.2013. She was killed by Mr L who she had met during a previous visit to London in the summer of 2012. He pleaded guilty to manslaughter on 18.11.13.

Conclusions

- The review found that it is difficult to conclude that Ms Z death could have been avoided. Her time in the country and with Mr L was very short and it is extremely unlikely she knew the extent of his domestic violence history or the severity of his mental illness.
- There appears to be a clear (at least circumstantial) link between Mr L's mental health and his propensity to violence. If Mr L's mental health had been better and more assertively managed in the 2 years before Ms Z's death it is reasonable to assume that the risks he posed when unwell would have been less. Mr L's mental health needed assertive care management but in the last 2 years at least, he did not receive it.
- If the Police officers who attended on the 18th & 28th Dec had had full information on the extent of Mr L's DV history and some of the mental health concerns, they may have intervened more assertively, however without the power to disclose that knowledge to Ms Z, it is unlikely to have altered the course of events

Recommendations

The DHR made 10 recommendations to: The London Probation Trust, SLaM, Housing Needs Service, Single Homelessness Project, The Metropolitan Police Service, Refuge, and the Safer Lambeth Partnership.
The recommendations included:

- *Improving protocol for management when patients are discharged from prison and for managing Community Order "Mental Health Requirements".*
- *To carry out an audit on clinical staff to establish the understanding of the extent, impact and risk of Domestic Violence and addresses the findings accordingly.*
- *To work together to ensure mandatory training in teams is completed and up to date*
- *Improving risk assessment and escalation of concerns for complex patient with a history of violence, drug and alcohol use and psychosis*