Safeguarding Adults in Lambeth

Lambeth Safeguarding Adults Board

ANNUAL REPORT 2016/17

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FOREWORD FROM INDEPENDENT CHAIR, SIÂN WALKER

Welcome to the 8th Annual Report of the Lambeth Safeguarding Adults Board. In this Annual Report you will note the 3 themes for the ongoing strategic plan of the Board to 2020. I would also like to reflect on these, in looking back over the last year.

In terms of **Representation** - This has been an exciting year with continued commitment from all the partners on the Board to improving services, learning and making a difference. You will see the Partner Member achievements noted on Page 19 and I am particularly pleased that the sub groups of the Board continue to develop and move forward.

Promotion, Communication & Involvement is reflected in the work of the Board's sub groups. The Community Reference Group has become more established and ensures that as a Board we are reminded of the important issues for people who use services. This group has been instrumental in delivering a Community Event for Lambeth citizens about safeguarding issues with a focus on the Mental Capacity Act. Promoting how we ensure people are safer is key to our strategy and we have met, and will continue to meet, with 'Black Thrive' the Black Wellbing Partnership to ensure that we reflect the important issues for a substantial number of citizens in Lambeth's diverse community.

Our newly titled Performance & Quality Group is supported by some extremely committed and competent professionals who ensure that concerns or issues raised at the Board are communicated through to front line services as part of the improvement journey. This group makes a difference in improving policy and processes to ensure that making a concern known, about an adult with care and support needs who may be experiencing abuse, is much easier and importantly that changes are made where needed to ensure citizens are safer. The Group also supports the Board in reviewing some of the important issues which need to be considered, so it acts as a 2-way filter.

We launched the Mental Capacity Act Group, initially as a task and finish group; however it is now one of the Board's permanent sub-groups. This group is aiming to ensure that learning and knowledge is widened in respect of Mental Capacity legislation, so that people are better served with improved decision making to support and protect them.

I was delighted this year with the launch of our new website, which is part of the plan to improve communication to the wider public in Lambeth. The website will continue to develop in 2017/18 as we improve its content and information will continue to be placed on the website in a variety of different media.

Prevention is the most important aspect of our work and in this last year, the launch of the Multi-Agency Safeguarding Hub (MASH) made a big difference in ensuring that there was improved scrutiny of all referrals for formal safeguarding intervention. In the forthcoming year we will be looking for evidence from performance and quality data, supporting the review and continued developoment of this crucial service.

The Board continues to work closely with the Lambeth Safeguarding Children Board, importantly to ensure that we all 'Think Family' and work together on investigations and enquiries where there are links between Safeguarding Children and Safeguarding Adults Enquiries and learning.

So, continued enthusiasm for partnership work in Lambeth to safeguard and protect adults at risk has, I believe, enabled us to do much to support the ethos of 'making safeguarding personal'. I reflect on a year of hard work, passion and improvements delivered by all partners, which will continue in the years to come.

Siân Walker

Independent Chair

EXECUTIVE SUMMARY

The Lambeth Safeguarding Adult's Board's (LSAB) main objective is to help and protect adults in Lambeth who;

- have care and support needs;
- are experiencing, or at risk of, abuse or neglect; and
- As a result of those care and support needs, are unable to protect themselves from either the risk of or the experience of abuse or neglect

The Annual Report for 2016/17 sets out the work of the LSAB and its partners over the last year ending in March 2017, in achieving this objective. This is in the context of increased Safeguarding Activity in Lambeth, where the number of safeguarding concerns reported in Lambeth have been steadily rising year on year.

REVIEW OF 2016/17

Over the course of 2016/17, the LSAB has made progress in a number of areas. Our achievements include:

- Close partnership working
- Launching the Lambeth Safeguarding Adults Board website
- Raising community awareness
- Agreeing an LSAB Safeguarding Adults Policy
- Setting up the Mental Capacity Act Task and Finish Group
- Delivering Deprivation of Liberty Safeguards

LOOKING FORWARD

To continue building on these achievements, the LSAB has set out our goals for the next three years in our strategic plan for 2017 to 2020, and have broken these down in to aims for the next financial year (2017/18). Our priorities, as outlined in these plans, are **Representation**, **Promotion, Communication & Involvement**, and **Prevention**.

SAFEGUARDING ADULTS REVIEWS

There was one Safeguarding Adults Review (SAR) concluded in 2016/17, and this concerned the case of Mr D. The findings from this review are outlined within this report.

WHAT IS SAFEGUARDING ADULTS?

WHAT IS MEANT BY SAFEGUARDING ADULTS?

Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult's wellbeing is promoted.

The Care Act 2014 states that safeguarding duties apply to an adult who:

- has needs for care and support (whether or not the local authority is meeting any of those needs)
- is experiencing, or at risk of, abuse or neglect
- as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect

WHO IS AN ADULT AT RISK?

Anyone who is 18 years and older, who has care and support needs and as a result is unable to protect themselves.

The Lambeth Safeguarding Adults Board's (LSAB) policy defines 'care and support needs' in the context of adult safeguarding issues as: *"needs that arise from or are related to a physical or mental impairment or illness."*

WHAT IS ABUSE OR NEGLECT?

Abuse is mistreating or neglecting someone so that it has a negative impact on their quality of life. It is seen as the violation of an individual's human and/or civil rights by any other person or persons.

The types of abuse outlined in the Care Act 2014 include; physical, sexual, psychological, financial and material, neglect and acts of omission, discriminatory and organisational. It now also includes modern slavery, domestic violence and self-neglect.

WHERE DOES ABUSE/NEGLECT OCCUR AND WHO SHOULD REPORT IT?

Abuse can happen anywhere. It can take place in someone's home, in a hospital, in a community setting and in public.

All professionals are responsible for responding and reporting concerns about abuse however **anyone who is concerned that an adult may be experiencing abuse/neglect should report this.**

You don't need evidence to report your concerns. The safeguarding enquiry process will seek to establish the facts and ensure the person is safe.

HOW TO REPORT ADULT SAFEGUARDING CONCERNS

In an emergency – you should always call the police or emergency services on 999

THE INITIAL CONTACT SERVICE IS LAMBETH COUNCIL'S REFERRAL POINT:

Tel: 0207 926 5555

Email: adultsocialcare@lambeth.gcsx.gov.uk

LSAB Website: www.lambethsab.org.uk

IF YOU WOULD PREFER TO CONTACT SOMEONE OTHER THAN LAMBETH COUNCIL, THERE ARE CHARITIES WHICH CAN OFFER ADVICE AND SUPPORT:

- Action on Elder Abuse can be contacted on their Helpline on: 080 8808 8141 or by email at enquiries@elderabuse.org.uk

- Respond can be contacted on their Helpline on: 0808 808 0700 or by email at helpline@respond.org.uk

WHERE ELSE CAN YOU REPORT YOUR CONCERNS?

You can also report any concerns of abuse or neglect of yourself or someone else to:

- Your GP or Nurse
- A health or social care staff member in any hospital
- A voluntary or community organisation that is helping you

WHAT HAPPENS AFTER A SAFEGUARDING CONCERNS IS REPORTED?

A social worker or a professional, who knows the adult well, will first try to talk with the person to understand the situation from their perspective and to ask what they might want help with. They might also talk to other people, such as family members (unless they are the cause of the safeguarding concern), staff, GPs, friends and possibly the police.

If the police say a crime has been committed, then they may investigate what has happened.

If there is concern about an adult at immediate risk of harm, actions will be taken very quickly to protect the adult at risk of abuse or neglect and anyone else who may also be at risk.

The process is a supportive one which can often involve working with those people thought to be causing harm with the view of achieving a good outcome for everyone.

REAL CASE EXAMPLES OF WHAT THE SAFEGUARDING ADULTS PROCESS CAN ACHIEVE

*Names have been changed

It can often establish whether abuse/neglect has taken place

•Mr Jones was admitted to hospital with two serious pressure sores. The concern was that he had been neglected by his two private care workers. The safeguarding enquiry found both care workers had failed to follow protocol by not reporting the pressure sores, though they had liaised with the pharmacy. The pressure sores were not obvious and the careworkers did not fully understand the seriousness of them. Mr. Jones felt the care-workers had provided a good level of care overall and did not want action taken against them. The outcome of the investigation found there had been neglect 'by omission'. The care-workers received a warning from their employer. CQC was involved in the case and the agency agreed that they would revise the level of training they provided to all their care-workers in relation to Pressure Care.

It can help to resolve issues between family and friends

•A safeguarding concern was raised by a Housing Scheme Manager about two residents - Paul and Joseph. Joseph was taking money from Paul, smoking in his home and eating his food. The two were friends but Paul was more vulnerable due to his epilepsy. Paul considered Joseph his friend and refused for the social worker to involve the Police. However, he did agree for the social worker to meet with Joseph to discuss these issues. Joseph agreed to pay Paul back and to stop smoking in Paul's house and eating his food. The scheme manager continues to monitor this situation.

It can provide reassurance about the quality of care being provided

•Mr Grant suffered a seizure in the residential home where he was living. He was admitted to hospital where he died. There were concerns from the hospital that the care home staff had not responded appropriately during his seizure. The safeguarding enquiry found that staff had called an ambulance immediately and their records showed staff had followed the correct procedure. There had been a poor handover between Ambulance staff and Hospital staff which had led to hospital staff not having the full facts and family members being left distressed over what had really happened. The outcome of the enquiry reassured the family that the residential home staff had provided Mr Grant with the emergency care he needed.

It can reassure that abuse is not happening and identify where family members may require support

•Mrs. Pike's neighbour wrote a letter to the council disclosing that she had concerns that Mrs. Pike's son may be abusing her. He was allegedly trying to put his name on his mother's tenancy agreement and take over her bank account. A safeguarding enquiry found that due to Mrs. Pike's dementia diagnosis, she no longer had the mental capacity to make decisions about her tenancy or finances. The social worker met with the son who was able to explain that he was his mother's carer and was taking these actions as a way of supporting Mrs. Pike. The Housing Association was in agreement for him to put his name on the tenancy to help manage this. The son also provided the social worker with evidence of his Power of Attorney application which showed he was seeking to legally support his mother with her finances. The social worker was able to offer the son a Carer's Assessment and signpost him to some relevant support services.

LAMBETH SAFEGUARDING ADULTS BOARD

THE BOARD

The Lambeth Safeguarding Adults Board (LSAB) is a statutory board set up in accordance with the Care Act 2014. It's main objective is to assure itself that local safeguarding arrangements and partners act to help and protect adults in its area who have care and support needs, are experiencing or at risk of abuse or neglect, and as a result of their care and support needs are unable to protect themselves from abuse or neglect.

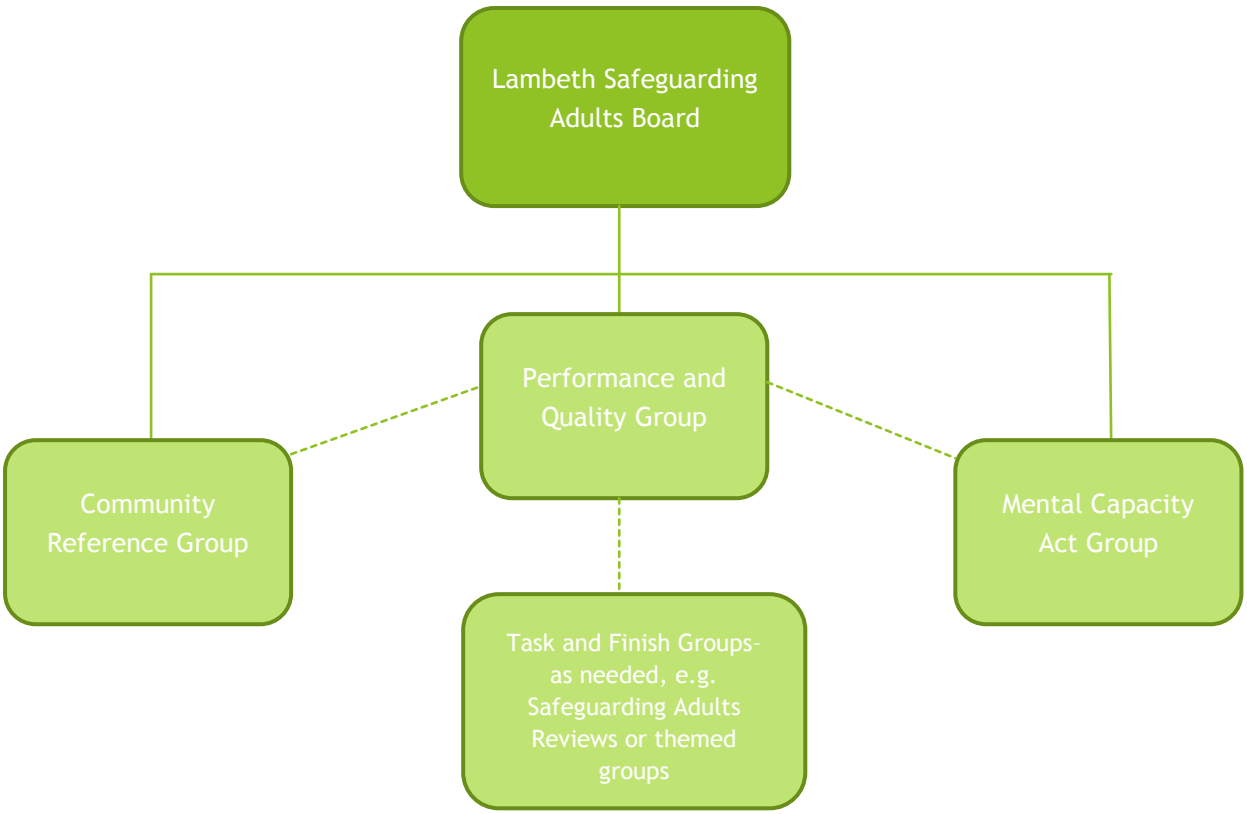
SUB-GROUPS OF THE BOARD

The LSAB has the following subgroups:

1) Performance and Quality Group (PAQ) which is responsible for managing the implementation of the work programme set by the LSAB. This subgroup was chaired by Ann Hamlet (Safeguarding lead, Kings College Hospital NHS Trust) throughout 2016/17.

2) Community Reference Group (CRG) which is chaired by Catherine Pearson (Chief Executive - Healthwatch Lambeth) and is the link between the Board and the Community.

3) The Mental Capacity Act (MCA) subgroup which is responsible for overseeing the awareness, promotion and application of the Mental Capacity Act (2005) in Lambeth. This is a new subgroup which acted as a Task and Finish group throughout 2016/17. The group is chaired by David Rowley (Safeguarding Lead Nurse - Lambeth CCG)



MEMBERSHIP OF THE BOARD

The Board is made up of senior members from a range of organisations and has an Independent Chair.

Full Board Members during 2016/17:

Name	Title	Organisation
Adela Kacsprzak	Assistant Chief Officer	National Probation Service
Aisling Duffy	Chief Executive	Certitude
Bruce Grain	Station Manager	London Fire Brigade
Cassie Newman	Head of Strategic Partnerships	London Community Rehabilitation Company
Catherine Pearson	Chief Executive	Healthwatch Lambeth
Cllr Jackie Meldrum	Cabinet Member for Social Care	LB Lambeth
Cllr Jim Dickson	Cabinet Member for Health and Wellbeing	LB Lambeth
Darren Farmer	Quality Governance and Assurance Manager	London Ambulance Service
Fiona Connolly	Director, Adult Social Care	LB Lambeth
Lucy Canning /Godfried Attafua	Service Director	South London and Maudsley, NHS Foundation Trust
Richard May / Graham Gardiner	Chief Executive	Age UK, Lambeth
Helen Charlesworth-May	Strategic Director, Adults and Health	LB Lambeth
Simon Langstone	Head of Safer Prisons and Equality	HMP Brixton
Mark Stancer	Director, Children's Social Care	LB Lambeth
Moira McGrath	Director Integrated Commissioning (Older Adults) / CCG Safeguarding Lead	LB Lambeth and Lambeth CCG
Paula Townsend	Corporate Director of Nursing	Kings College Hospital, NHS Foundation Trust
Rachel Sharpe	Director, Housing	LB Lambeth
Sarah Wilding	Director of Nursing	Guys and St Thomas' Hospital, NHS Foundation Trust (GSTT)
Sean Oxley	Detective Superintendent	Lambeth Metropolitan Police
Siân Walker	Independent Chair	

Advisory Board Members during 2016/17:

Name	Title	Organisation
Ann Hamlet	Head of Safeguarding Adults	Kings College Hospital, NHS Foundation Trust
Barbara Joyce	Welfare Specialist	Office of the Public Guardian (OPG)
Clement Guerin	Head of Quality and Safeguarding Adults Service	LB Lambeth
Janna Kay	Quality and Safeguarding Adults Manager	LB Lambeth

SAFEGUARDING ACTIVITY IN LAMBETH

NUMBER OF SAFEGUARDING CONCERNS RECEIVED IN LAMBETH

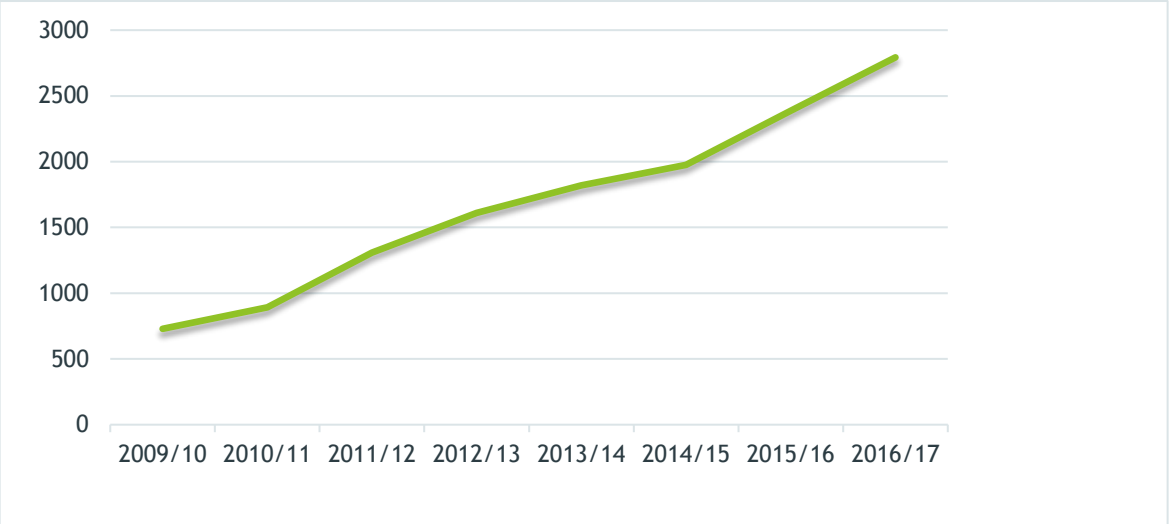


Figure 1: Number of safeguarding concerns received by Lambeth Adult Social Care and South London and Maudsley NHS Foundation Trust, 2009/10 to 2016/17

Lambeth Adult Social Care and South London and Maudsley NHS Foundation Trust are the two organisations which coordinate the responses to safeguarding adults concerns in Lambeth.

As seen in Figure 1, the number of safeguarding concerns in Lambeth has been steadily rising year on year. This is in part a result of the introduction of the Care Act in 2014 which saw a broader range of issues being classified as a safeguarding concern, such as modern slavery and self-neglect.

It is thought that, on the whole, more people are now aware of adult abuse and understand the need to report concerns to the local authority or relevant professionals.

Approximately 50% of adult safeguarding concerns received, meet the threshold for a section 42 safeguarding adults' enquiry. This highlights that there remains some confusion over what constitutes an adult safeguarding issue. The LSAB's thresholds task and finish group will be working to clarify and agree definitions around adult safeguarding thresholds with the view of improving the quality of referrals received.

LOCATION OF SAFEGUARDING CONCERNS

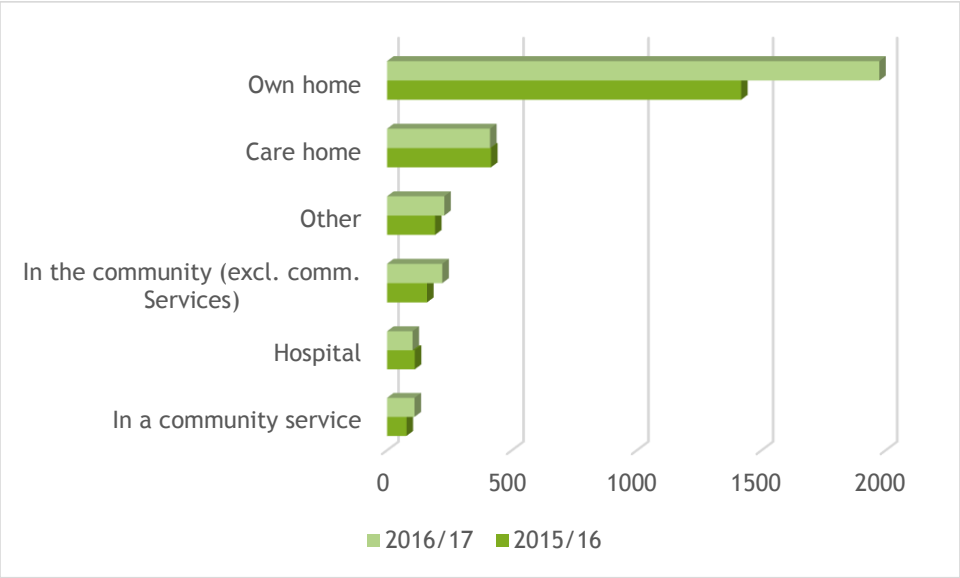


Figure 2: Location of safeguarding concerns reported in 2016/17

Figure 2 shows the location in which abuse was reported to have taken place for safeguarding concerns reported in 2016/17. As seen in previous years, the most common location of safeguarding concerns continues to be individuals' own homes (65%).

This is consistent with the national picture which has shown that the location of risk is most frequently the home of the adult at risk, or care homes. Data on abuse and neglect which takes place in a person's own home captures not only concerns about domestic abuse, but also includes concerns related to domiciliary or health care services provided within people's own homes.

57% of cases where location of risk was the person's own home related to individuals age 65 and over.

MAKING SAFEGUARDING PERSONAL

Making Safeguarding Personal (MSP) is the approach to safeguarding adults' work that aims to ensure that wherever possible, the adult is involved in the process from the start and that the adult is supported to identify what outcome they want from the process.

Lambeth is committed to ensuring MSP is standard practice and we have been working to improve this, throughout 2016/17.

Our data shows that 87% of individuals were asked about what they wanted to see happen as part of the safeguarding process, either directly or through their representative. Of this group, 90% expressed their desired outcomes.

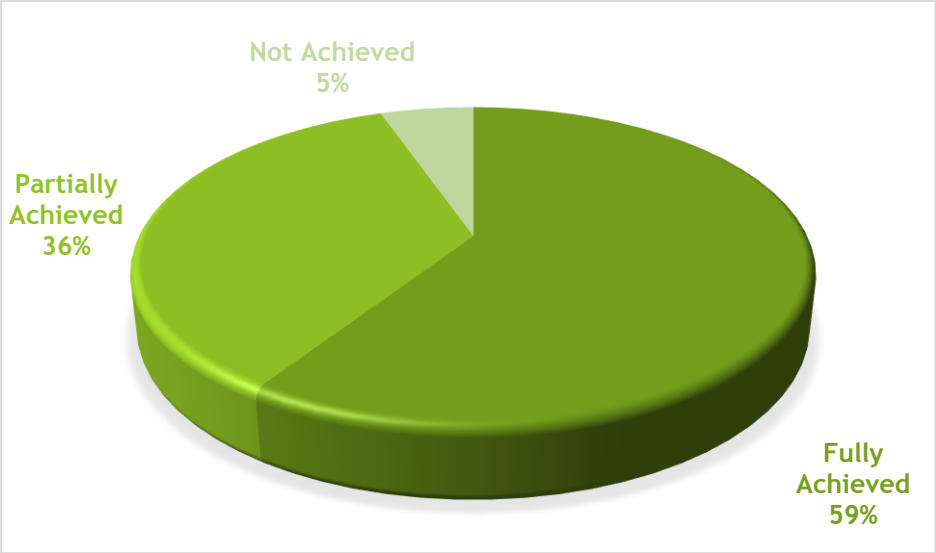


Figure 3: Outcomes for safeguarding enquiries concluded in 2016/17

Figure 4 shows whether adults' preferred outcomes were met at the end of the safeguarding enquiry. Over half of those who were asked about their preferred outcomes said that there were fully achieved or exceeded at the end of the enquiry process. 5% said that none of their desired outcomes had been achieved.

DEMOGRAPHICS

AGE

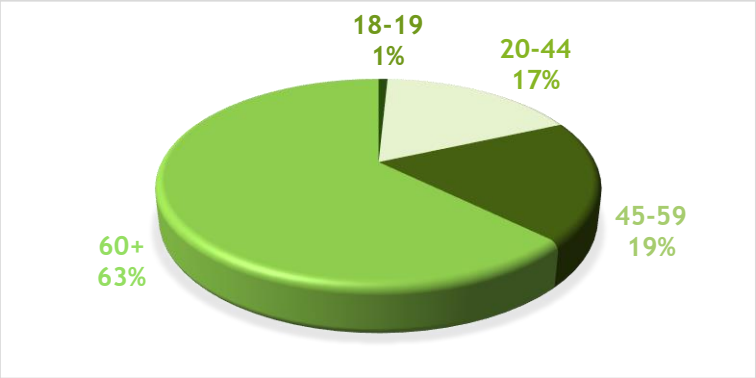


Figure 4: Number of Safeguarding Concerns received in 2016/17 broken down by age group

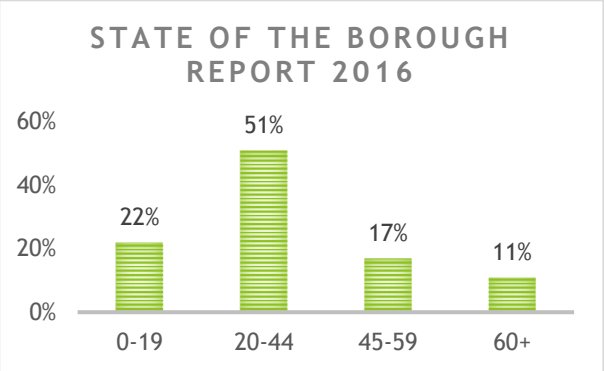


Figure 4 shows the number of concerns received in 2016/17 broken down by their age group, and highlights that the 60+ age group has the most safeguarding concerns.

When compared with the picture presented in the State of the Borough Report 2016[i], we can see that this is at odds with a relatively young, working population. However, 79% of the adult social care population (those known to social services and/or receiving support) are age 60+, therefore the safeguarding activity appropriately reflects this demographic.

GENDER

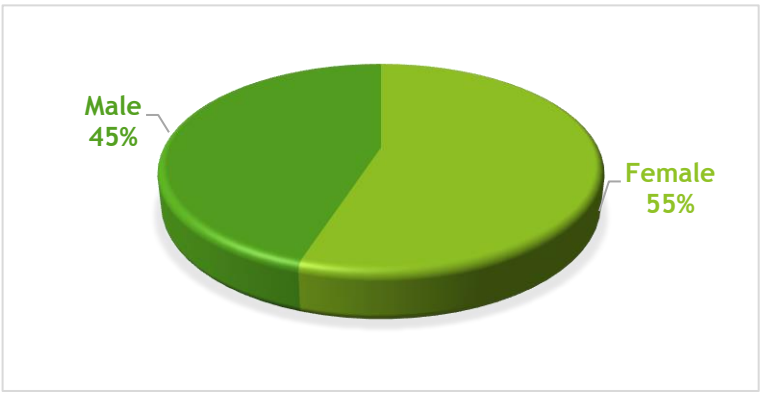


Figure 5: Number of Safeguarding Concerns received in 2016/17 broken down gender

There were more safeguarding concerns received for female individuals than male individuals in 2016/17. This is line with the national trend[ii] and also reflects the adult social care population where there is a 55%/45% split between female and male service users.

ETHNICITY

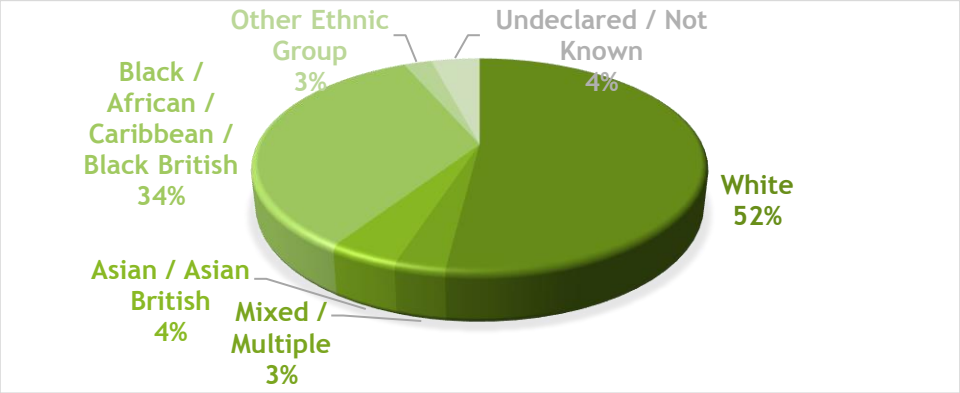


Figure 6: Number of Safeguarding Concerns received in 2016/17 broken down by ethnicity

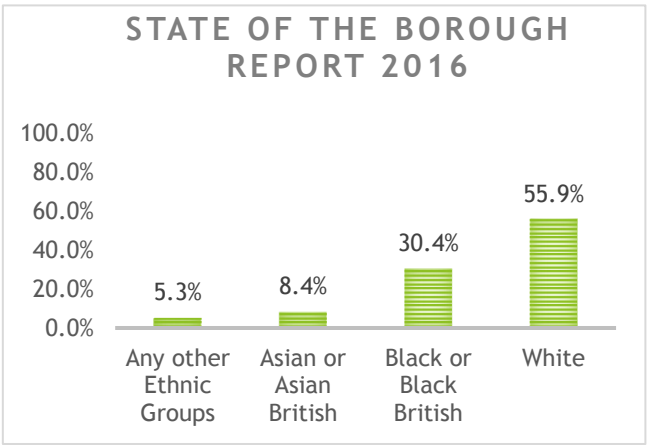


Figure 6 shows the breakdown of individual safeguarding concerns by ethnic group in 2016/17. These figures generally reflect the demography of the Lambeth population as recorded in the 2016 State of the Borough Report.

There is a higher representation of safeguarding concerns for those whose ethnicity is recorded as white when compared to the more general adult social care population where white individuals make up 49% of service users. In line with this, those whose ethnicity is stated as Black or Black British are slightly underrepresented in adult safeguarding (34%) when compared to the adult social care population (38%), but higher than the general population (30.4%).

Those whose ethnicity has been recorded as; 'Asian or Asian British' or 'Any other ethnic group' are also slightly underrepresented in the number of safeguarding referrals received when compared both to the adult social care population and the borough population as a whole. Of those safeguarding cases where ethnicity has been recorded as 'Any Other Ethnic Group', a small snapshot analysis has shown that nationalities recorded within this group include; Chinese, Turkish, Turkish Cypriot, Cypriot, Portuguese, Somalian, Lithuanian, Ecuadorian, Cuban, Colombian, Peruvian, Eritrean, Moroccan, Indian, Vietnamese, Filipino, and Chilean.

The Lambeth Safeguarding Adults Board has identified this as an area requiring attention and this is now part of the Board's strategic objectives for 2017/18.

SAFEGUARDING ADULTS REVIEWS

Section 44 of the Care Act 2014 made it a statutory duty for local Safeguarding Adults Boards to carry out a Safeguarding Adults Review (SAR) when someone with care and support needs experiences serious neglect or abuse which has led to their death or permanent harm, and there is a concern that the local authority or its partners could have done more to protect them.

Following a concern of such a case, the Lambeth Safeguarding Adults' Board (LSAB) commissioned a SAR in 2015/16 and this was concluded in 2016/17.

THE CASE OF MR D

OVERVIEW:

Mr D was a 74 year old man living in Lambeth. In May 2015, the London Ambulance Service (LAS) were called to an address where Mr D had been living with Ms E. Mr D was found to be emaciated and unkempt and was admitted to St George's Hospital where the full severity of Mr D's condition was documented. The LAS, the nurses in A&E, and nurses in the Acute Medical Unit were all so concerned about the condition of Mr D when he was first seen that they all separately raised these concerns under the Safeguarding Adults Policy & Procedures. Due to the severity of Mr D's condition, a nurse at St George's Hospital also alerted the Metropolitan Police Service. When the police visited the home of Ms E, the property was found to be in poor condition with no heating, lighting, or running water and described as 'very dirty, with dust, cobwebs, flies and a stench of faeces and urine'. Mr D passed away in hospital on the 21st May 2015.

FINDINGS:

Mr D had very limited contact with Health and Social Care services throughout his life. In the final period of his life the only agencies working with Mr D were his GP and St George's Hospital, who were working with Mr D due to a knee injury. Physicians at the hospital were so concerned about Mr D's leg that amputation was recommended on numerous occasions, but these recommendations were rejected by Mr D. Mr D also developed leg ulcers on his left leg, but preferred to dress these himself and seemed reluctant to engage with community health services. At one stage, Mr D took an overdose of morphine though it was not clear if this was a suicide attempt or an accidental overdose. No referral was made to mental health services at this time.

LEARNINGS:

In the last 6 months of his life, Mr D had no contact with his GP, hospital services, Adult Social Care or Mental Health Services. Little is known about this time in Mr D's life but it would appear that there was a serious deterioration in his health and that he spent much of this time in one room and laying on a bed.

Learnings from this SAR was therefore limited but included some of the following recommendations:

- Health Trusts to assure the Safeguarding Adults Board that there are processes in place to respond to adults presenting with serious self-harm or suicide attempts

- A referral to Adult Social Care should always be made where medical/surgical advice is refused and there are also concerns of significant self-neglect by the adult

- Health and Adult Social Care services must promote the entitlement for all adults and their carers to have an assessment under the Care Act 2014, where there is an appearance of need and specifically for people either deemed to be at risk of, or caring for, adults who self-neglect.

- Any adult safeguarding concerns in relation to a carer's ability to monitor and manage risks of self neglect for another adult, should be recorded on the carer's electronic records.

WHAT THE LAMBETH SAFEGUARDING ADULTS BOARD DID TO ACT ON THESE FINDINGS:

The LSAB created an action plan which monitored the implementation of the SARs recommendations and each member took forward the learning that came from Mr D's case, to each of their respective organisations.

The Executive Summary of the SAR for MR D can be found on the LSAB website.

REVIEW OF 2016/17

STRATEGIC PLAN 2016/17

Our strategic plan for 2016/17 aimed to address five main areas:

- Raising public awareness
- Preventing abuse and neglect in health and social care providers
- Embedding "Making Safeguarding Personal"
- Delivering the Deprivation of Liberty Safeguards (DoLS)
- Policies and Procedures

Over the course of the year, the Board and its subgroups have succeeded in:

Close Partnership Working

LSAB Members have collaborated to deliver a range of projects and initiatives to improve adult safeguarding practice. For example, health input into safeguarding enquiries and supporting front line social work practice.

Launching LSAB website

The LSAB launched a new website in conjunction with the Lambeth Children's Safeguarding Children's Board. This website provides information, guidance and details on how to report concerns.

Raising Community Awareness

The Community Reference Group (CRG) worked with partners to deliver a community event explaining the Mental Capacity Act 2005, entitled 'No Decision About Me, Without Me'. The CRG intends to build on the success of this event in planning further events during 2017/18 to raise awareness of safeguarding adults' issues.

Agreeing Safeguarding Policy

The LSAB has agreed an Adult Safeguarding Policy with all its' members. This helps to define some of Lambeth's local thresholds and sets out what should be done to both prevent and respond to a safeguarding adults concern in Lambeth.

Setting up the MCA Task & Finish Group

This group was set up in response to the House of Lords Post-Legislative Scrutiny Committee review which identified an overall poor implementation of this legislation. The group has been working on improving awareness, policy and training in this area for health and social care staff.

Deprivation of Liberty Safeguards

During 2016/17, 533 DoLS authorisation requests were granted by the Local Authority. This was achieved through the support of health and other board partners and signals an improved understanding of the application process. Many people thought to be deprived of their liberty by hospitals or care-homes, were assessed to ensure this deprivation was appropriate and in their best interest.

BOARD MEMBERS' ACHIEVEMENTS IN IMPROVING ADULT SAFEGUARDING

The London Ambulance Service have worked on raising awareness of adult safeguarding. This included holding a Trust wide month on safeguarding, hosting drop in sessions at control rooms, producing posters and promotional materials e.g. a safeguarding key ring which was placed on all service vehicles. The Trust have also produced a set of 4 short films on dementia, including a film on dealing with safeguarding concerns, and have improved responses to hoarding by introducing information sharing with the London Fire Brigade.

The role of the National Probation Service (NPS) is to protect the public, support victims and reduce reoffending. In carrying out its functions, the NPS is committed to protecting an adult's right to live in safety, free from abuse and neglect. During the last year we have delivered Adult Safeguarding Training for all staff to ensure that they are clear about their roles and responsibilities and how to raise safeguarding concerns. We have also continued to work with key partnership agencies in the borough under the Multi Agency Public Protection Arrangements to ensure that perpetrators of abuse are assessed and managed appropriately.

Healthwatch Lambeth is the local health and care charity that works to ensure that everyone's health and wellbeing needs are heard, understood and met. We do this by being a trusted source of insight into people's lived experiences of using these services. The Chief Executive Officer is a member of the Board and Chairs the Community Reference Group, which brings together the main voluntary sector providers of care and their users. The Group's aim is to ensure that as many people as possible know that safeguarding exists and how to seek help if they or someone they know is at risk.

Lambeth CCG have started to make progress in improving GP understanding around Safeguarding Adults and developing a strategy going forward. Over the past year, the CCG have developed practice around promoting human rights for continuing care patients subject to a deprivation of liberty, through enhancing our legal knowledge in this area and supporting a number of cases at the Court of Protection.

The introduction of the Multi-Agency Safeguarding Hub has made a difference to mental health services, as there is clear oversight of safeguarding concerns going through and teams also getting better direction. Adult Social Care has also succeeded in managing to respond to the significant increase in adult safeguarding referrals and to work effectively alongside Commissioning/Contracts colleagues in particular, to improve the quality of provider services.

Following a review of the safeguarding adults' service,GSTT has strengthened its safeguarding adults governance arrangements within the Trust. In response to the continued increase in safeguarding adults referrals, GSTT has invested in its central safeguarding adults team by three staff members. It has also focused on improving its training compliance to achieve the set target of 85% compliance.

South London and Maudsley NHS Foundation Trust have made achievements in the last year and this is evidenced by their recent CQC inspection which highlighted improvements in safeguarding.

The Trust have also worked on improving interface and processing.

Kings College Hospital NHS Foundation Trust have seen continued improvement in safeguarding adults training and considerable work has gone in to this particular area. The building blocks are now in place for further development.

Having colleagues from the Public Protection Desk sitting alongside the Adults Multi-Agency Safeguarding Hub has made a big difference to how Police (MPS) are able to respond to adult safeguarding concerns and in knowing where certain referrals should be sent i.e. which service would be best to respond to the person.

THE MULTI-AGENCY SAFEGUARDING HUB (MASH)

In October 2016, the Lambeth Multi-Agency Safeguarding Hub was launched bringing together a number of key partners together within a single team. The aim of the hub is to provide information sharing across all organisations involved in safeguarding – encompassing statutory, non-statutory and the third sector.

Essentially the hub analyses information that is already known within separate organisations in a coherent format to inform all safeguarding decisions for cases that have already met the section 42 threshold for Safeguarding Adults Enquiries.

All partners work together to provide the highest level of knowledge and analysis to make sure that all safeguarding activity and intervention is timely, proportionate and necessary.

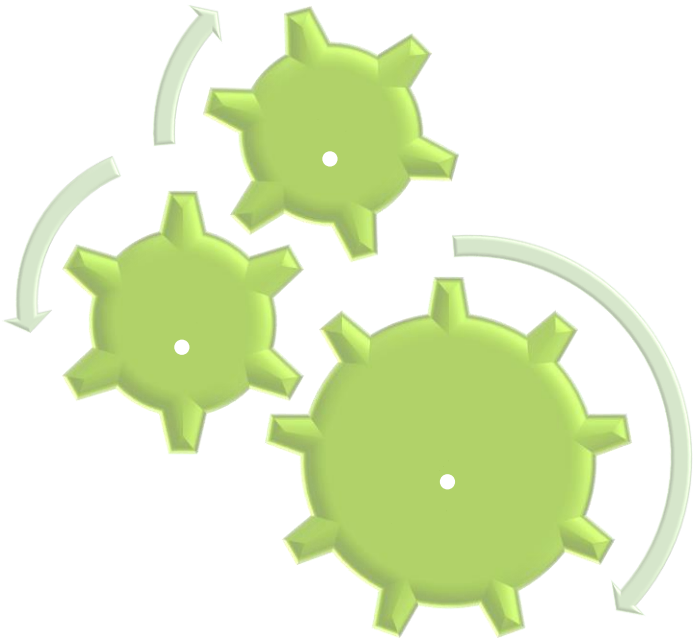
MASH focuses on three main functions:

1) Receipt and distribution of all referrals to Lambeth adult social care or adult mental health services from the Metropolitan Police, London Fire Brigade and London Ambulance Service

2) Statutory Local Authority oversight of Care Act 2014 section 42 Concerns and Enquiries undertaken by our Mental Health partner agencies

3) Information sharing between partner agencies to inform risk management and safeguarding processes

The first two functions of the MASH are in operation and it is hoped that the 3rd function will commence by August 2017.



DEPRIVATION OF LIBERTY SAFEGUARDS (DoLS)

Lambeth Safeguarding Adults Board is responsible for overseeing the use of the Mental Capacity Act 2005 (MCA), including its Deprivation of Liberty Safeguards (DoLS).

The safeguards are used to protect the rights of people who lack the ability to make certain decisions for themselves and make sure that their freedom is not inappropriately restricted. They do this by helping to make sure that decisions made on their behalf are done so in their best interests, and also by empowering them to make their own decisions wherever possible.

Following a decision by the Supreme Court in March 2014, use of DoLS increased dramatically across England and Wales, and Lambeth has been no exception. As is occurring in most Local Authorities, Lambeth is under enormous pressure to complete the assessments required for the DoLS process in a timely manner.

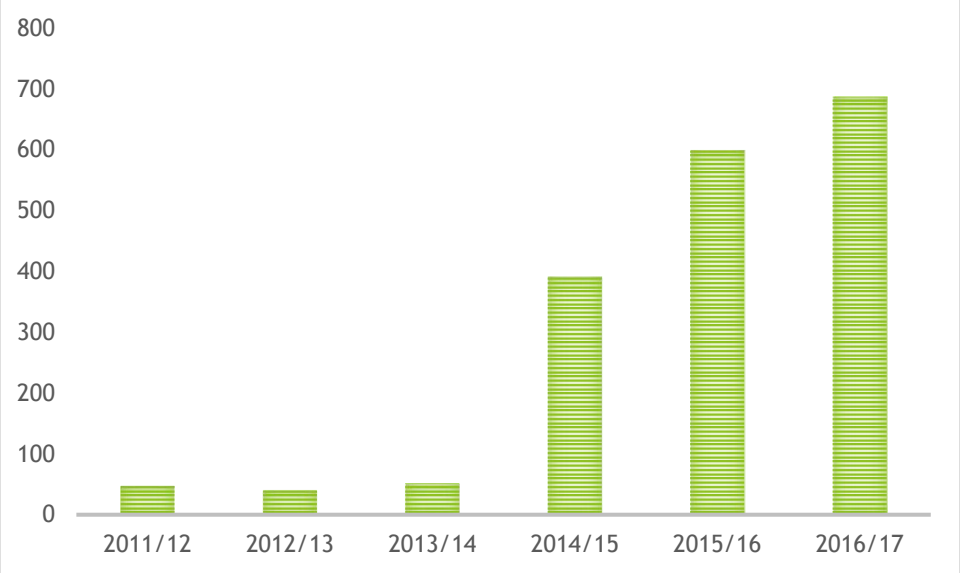


Figure 7: Number of DoLS authorisation requests received

You will note from Figure 7 that numbers increased significantly from 2014/15. 2016/17 saw a further 13% increase in the number of authorisation requests received.

The Government asked the Law Commission to review this system after concluding it was not fit for purpose. The Law Commission has recently delivered its final recommendations. The Commission believes its proposed Liberty Protection Safeguards (LPS) scheme will be less onerous than the DoLS while still offering human rights protections.

However, it will still take some years before the proposed changes are made and therefore this is likely to remain a challenging area of work.

RAISING AWARENESS OF THE MENTAL CAPACITY ACT

Mental Capacity Act 2005

The Lambeth Safeguarding Adults Board's Community Reference Group worked alongside partners in Southwark and Guys and St Thomas' NHS Foundation Trust to bring about a week of events aimed at raising awareness and understanding on the Mental Capacity Act (MCA) 2005.

In Lambeth Adult Social Care, there was a focus on providing training for all social workers on understanding and applying the Mental Capacity Act in practice.

There was an event held at Guys and St. Thomas Hospital for Health and Social Care staff that included speakers such as Baroness Finley who chairs the National Mental Capacity Act Forum. The event was a great success and someone even made an MCA cake!

There was a Community Event held at “We Are 336” in Brixton where guest speakers and partner agencies presented information to residents, service users and professionals to help explain this vital piece of legislation and its relevance to decision making.

LOOKING FORWARD

STRATEGIC PLAN 2017/18

The Lambeth Safeguarding Adults Board has agreed an overarching plan for the three years from 2017/18 to 2019/20. Our priorities, outlined in this plan, are:

Our three year plan will act as a blueprint for the Board, and clearly sets out what we want to do and how members can work together to make it happen.

Our strategic plan for 2017/18 breaks down our aims for the next year in more detail. Our full strategic plan can be found on the LSAB website.

[i] Lambeth State of the Borough 2016 Report
[ii] Safeguarding Adults, Annual Report, England 2015-16, Experimental Statistics

Safeguarding Adults in Lambeth