

LAMBETH SAFEGUARDING ADULTS BOARD

General agenda section

Phoenix House

14:00

4 October 2016

Attendees:

Siân Walker (SW) – *Chair*

Catherine Pearson (CP)

Sean Oxley (SO)

Adela Kacsprzak (AK)

Independent Chair

Chief Executive, Lambeth Healthwatch

Detective Superintendent, Metropolitan Police Service

Assistant Chief Officer, National Probation Service

Moira McGrath (MM)

Director of Integrated Commissioning (Older Adults) / CCG Safeguarding Lead,
LB Lambeth and Lambeth Clinical Commissioning Group

Rachel Sharpe (RS-H)

Director of Housing, LB Lambeth

Sarah Wilding (SW)

Joint Clinical Director Gastrointestinal Medicine and Surgery (GMS) & Clinical
Director Adult Safeguarding, Guys & St Thomas' NHS Foundation Trust

Aisling Duffy (AD)

Chief Executive, Certitude

Phillip Powell (PP)

Stakeholder Engagement Manager, LAS NHS Trust

Richard Sparkes (RS-ASC)

General operations Manager, Adult Social Care, LB Lambeth

Helen Charlesworth-May (HC)

Strategic Director, Children, Adults and Health, LB Lambeth

In attendance:

Janna Kay (JK)

Quality and Safeguarding Adults Manager, LB Lambeth

Clement Guerin (CG)

Head of Quality and Safeguarding Adults, LB Lambeth

Ann Hamlet (AH)

Head of Safeguarding Adults, Kings College Hospital NHS Trust

Ceri Gordon (*minute-taker*)

Adult Safeguarding Support Officer, LB Lambeth

Apologies:

Cllr Jackie Meldrum (Cllr JM)

Cabinet Lead, Adult Social Care, LB Lambeth

Paula Townsend (PT)

Deputy Director of Nursing, Kings College Hospital NHS Foundation Trust

Barbara Joyce (BJ)

Welfare Specialist, Office of Public Guardian

Lucy Canning (LC)

Service Director, Psychosis Clinical Academic Group, SLaM

Fiona Connolly (FC)

Service Director, Adult Social Care, LB Lambeth

Cllr Jim Dickson (Cllr JD)

Cabinet Member for Health & Wellbeing, LB Lambeth

5.	Minutes and matters arising from meeting held 5 July 2016, and update on actions
	<p>The board agreed that the minutes were an accurate record.</p> <p><u>Actions from minutes and matters arising:</u></p> <p><u>Action 1</u> – It has been noted as per the new constitution, that CP is now vice-chair of board. CP has attended a meeting on behalf of SW, and each will hold regular meetings together.</p> <p><u>Action 2</u> – SW has written a letter to the Government Digital Service.</p> <p><u>Actions 3 to 5</u> – Noted that this is on today’s agenda.</p> <p><u>Action 6</u> – The Annual Report has been amended and shared with the board</p> <p><u>Action 7</u> – The constitution has been circulated amongst board members.</p> <p>There were further additional matters not recorded within the actions of the last board:</p> <ul style="list-style-type: none">- The contact details for referrals to LFB for adults at risk who require a fire check be undertaken were shared amongst board members by JK.- In respect of the OPG case study and issues around triggers; this is still to be actioned with the intention to share the information on the LSAB website.

6.	Chair’s Report
	<p>SW referred to the circulated report which provides an update since the last board in July 2016. SW has undertaken telephone discussions with board members and there was general agreement around issues that people raised. There was a strong commitment by members to ensure consistent attendance at the board, improved partnership work, and ensuring wider corporate understanding across all constituent organisations of safeguarding issues,.</p> <p>Amongst organisations there was a commitment to MSP and evidencing this with improved transparency; that care models continue to hold adult safeguarding at their heart in a constantly changing structural environment.</p> <p>Going forward there is a plan to review these discussions before the development day scheduled for 23 February 2017, and for the Development Day to influence the board’s strategic plans for the next three years. An update will be given in January 2017 with the strategic plan in mind.</p>

<p>7.</p>	<p>Audit of safeguarding concerns that did not lead to enquiries: <i>response by Adult Social Care</i></p>
	<p>RS-ASC: This was a helpful internal audit by the quality assurance team, analysing cases where it was decided not to proceed to a safeguarding enquiry following a safeguarding concern being raised. This involved consideration of how adult social care were managing in the application of new threshold seen in the Care Act, whether decision making was in line with this, and how processes and recording systems were supporting this.</p> <p>Key themes that came out of the audit:</p> <ul style="list-style-type: none"> • There is a lot of initial analysis undertaken during the enquiry process, but this is not always formalising statutory decision making processes. • The importance of systems and processes which assist proper decision making. • Threshold should have been met in a number of cases when the case did not proceed to enquiry stage – this work had been done through the concern process. • Some work was singular, missing the wider context and support requirements that is important to an individual and which might have become apparent from fuller enquiry, for example assistance in accessing housing <p>RS-ASC drew attention to the action plan seen in Appendix A of provided report.</p> <ol style="list-style-type: none"> 1. Ongoing work looking at simplifying processes and decision making; there are currently a number of key steps to go through, including recording, analysing and capturing learning. Due to the demands of day to day practice, this is creating a disincentive to go through the process. There is now new draft practice guidance to be shared with the team, and work with the development team around Mosaic (electronic social care recording system) in order to simplify the process so that it is possible to complete an enquiry within one piece of work. There would also be the intention to run workshops looking at learnings and being clear about evidencing, and that statutory requirements are being met. 2. Proportionality; the system is not encouraging proportional safeguarding work, and the new system will allow much more proportion. 3. Timeliness; It was found that there was a lot of input in first part of activity which tails off in to finished outcome and capturing if intervention has made difference for someone in terms of MSP 4. The Multi-Agency Safeguarding Hub (MASH) is now operational for SLaM and the Hub, and is now screening Merlins and concerns from LAS and LFB. This should provide better consistency for risk screening. It has been operational for one month, so now at stage where need to take stock. There are more assurances for practitioners on grounds for decision making, for the Safeguarding Adults Manager; Managing risk and proportionality. <p>The board discussed the idea of proportionality and prescriptive thresholds. There was a question around how changes will encourage people to think differently and engender a sense of</p>

	<p>responsibility and authority, being less risk averse and more thoughtful about the individual. This also linked to how as an organisation we will hold that risk.</p> <p>Discussed managing thresholds for entry in to the system and how this enabled professionals and individuals to manage appropriate risks, and not over-intervene in people’s lives – adult safeguarding is about human rights and enabling people to live the life they choose to live.</p> <p>Discussed the need to look at services for children in transition to adulthood and the importance of not creating a dependency culture with children and their families about what they can expect when they are adults.</p> <p>Members agreed that the action plan drawn up is good as it talks about auditing and getting a sense of what happens with the refined system.</p> <p>Learning can be shared to develop a joint professional approach.</p> <p>CG: proportionality – will be able to give much better support where a bigger response is needed – rather than a means for doing less.</p> <p>AH – need to be clear about getting it right for the person – not about more or less. HC: Reliant on good professional judgement – work forces need to feel confident to make judgements. To describe in a way that is understandable.</p> <p>AD: could practice guidance be shared more broadly, working with providers? Strong guidance to support the culture amongst frontline workers [to be seen in agenda item 11].</p> <p>SW: It is essential that people work as part of a network of professionals understanding and holding the risks of supporting people to lead independent lives so that frontline staff can support people to manage risk and which will enable staff to be less risk averse as appropriate</p> <p>CG – good practice can be shared via the LSAB website, and has been shared with research and practice and London board.</p>
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8.	Performance Report
	<p>CG presented a summary of the key features of the performance report:</p> <ul style="list-style-type: none"> • Data is indicating that the number of safeguarding concerns being raised is going up. • A comparison of the number of concerns reported by SLaM with last year’s figures shows that whilst the number of referrals from SLaM was previously not reflecting practice due to recording issues, changes in processes have seen positive changes which have been seen in the data.

- There has been an increase in activity, and there is indication that ASC are struggling to keep up with this.
- Self-neglect accounts for 13% of concerns received, however due to the nature of working with self-neglect and the relationship based work it involves, these cases do not fit with the safeguarding enquiry model, and take a long time to see to conclusion.
- Graph depicting timeliness (Table B1 within performance report) indicates that ASC are struggling in this area and that timeliness performance is moving away from target. It is hoped that MASH will help to extract out self-neglect cases, in addition to creating a shift in process. The impact of this may be seen by the April 2017 board.
- When considering MSP, data shows that ASC are consistently struggling to make a positive impact in ensuring that service users continue to see the people they want to see. This is linked in to wider issues in people's lives, such as loneliness or having a relationship with a perpetrator disrupted. This data is gathered via questions that are available in every case, however there is a practice issue as to whether the questions are asked in every case. These questions should also have been built in to SLaM forms.
- Service user's feedback on the effectiveness of the Safeguarding process shows that there are positive results, despite the method problems with the questions asked.

The P&Q subgroup have been working on simplifying data to create a more reliable data set. This will include:

- A smaller set of data
- A new format for assurance reports from partners, which are shorter and more focused.
- Three themed sessions a year and one business session which will consider the annual report and strategic plan, with a more overarching multi-agency approach in view of statutory requirements and measuring the boards performance.

Ofsted report of LCSB noted that there was too much data and that this did not allow for strategic response, and that data needed to be more targeted. The simplified data that P&Q have been working on will help towards addressing this within the LSAB. The new format proposed for assurance reports includes quantitative data, where ASC can help with producing numbers and comparisons, in addition to more qualitative information which will help to give more narrative and context to the trends/activity occurring.

Action: Performance Report presentation with the new data templates to be sent out to LSAB members for comment

SO queried where the majority of safeguarding concerns originated from and whether this linked to police Merlins. CG clarified that ASC currently receive less numbers than CSC, however the gap is beginning to narrow. It was noted that not all Merlins which are received lead to a safeguarding process being started.

	<p>In regards to developing the strategy plan during the planned business session, SW noted that board members would be asked to bring something to the January board, prior to further discussion at the February Development Day. The proposed plan would then be brought to the April 2017 board meeting before being signed off at the July board. The plan would also be presented to P&Q subgroup as an early draft.</p> <p>There was further discussion about how the work of the CRG would feed in to the process, with reference made to Cheshire East’s open invitation to their service user group to attend the board if they choose. This enables the group to develop as well as being more open and more transparent. Anyone who has been through safeguarding process are invited to join the service user group.</p> <p>Action: SW and CP to discuss ideas which will enable the CRG to feed in to the board’s plans.</p>
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<p>9.</p>	<p>Crime and Community Safety themed report</p>
	<p>The partners contributing to this themed report cover many boroughs, and so a large proportion of the information provided is not specific to Lambeth. The data provided is broad, and though interesting, does not hone in on if the adults involved have care and support needs, and how this is broken down and fits in to the Care Act 2014.</p> <p>During discussion at P&Q subgroup, it was decided that going forward people presenting to the board will come to P&Q first so that there is an opportunity to give more focus within reports.</p> <p>In summary;</p> <ul style="list-style-type: none"> • We are getting a better sense of how Police Merlins are processed and what we could be doing differently. The new MASH will support this. <p>SW is in discussion with the chair of the Health & Wellbeing board about those reports which come to HWB and may not necessarily be within the remit of the LSAB – one example of this is the Learning Disability Mortality (LeDER) Review, which SW is discussing with the Lambeth Council Scrutiny Chairs in the next week, where she will recommend that the governance sits with the HWB and the work to oversee the review be delegated to the LSAB</p> <p>Update from MPS, SO:</p> <p>Training is being rolled out for frontline emergency services in dealing with mental health situations –this is interactive and involves role play, providing a supportive and open environment to think about experiences. There is a perception that the police do not deal with mental health issues particularly well, and this is held particularly within the Black community in Lambeth. This comprehensive training is a positive step towards trying to address this, and the MPS have invited those that have been critical of MPS’s responses to mental health to observe the training that officers are doing, thereby building a connection.</p>

	<p>CLlr Jacquie Dyer met with SW, as part of chair’s focus on doing more to reach out to communities to encourage them to understand what the board does. Particular concerns were expressed about mental health issues and perceptions of communities and police officers. This can be improved through working together in partnership.</p> <p>Action: MM to pass on details of the next Lambeth Black Wellbeing Partnership to SW</p> <p>RS-H noted that LFB have a specialism around identifying mental health through looking at hoarding and are often first port of call and referring in to other services, but that this did not feature in their report. CG noted that as the self-neglect is being taken out of adult safeguarding in Lambeth, this would no longer be relevant.</p> <p>Recommendations agreed by board.</p> <p>Action: SW to write a letter thanking Ann Corbett (who has now left the council) for her work on this report and her support for the board.</p>
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10.	NHS Improvement Audit Tool: Summary from all Health partners
	<p>During 2015, LSAB Health partners undertook a performance audit of their safeguarding work for NHS England. Each Health partner (SLaM, GSTT and Kings) spoke to the report presented at the LSAB which summarised the highlights that emerged for each of their audits undertaken.</p> <p>Partners also pointed out that the Prevent agenda in NHS is dealt with under safeguarding whilst the Local Authority and the remit of this board does not.</p>

11.	LSAB Policy and guidance
	<p>Some elements of the London Policy and Procedure run contrary to the Care Act 2014, and so the LSAB policy and guidance aims to highlight these differences with the view of agreeing a local position on these. It is the board’s responsibility, not that of individual organisations, to hold the residual risks however each partner has also been advised to discuss the Policy with their own legal advisors. Legal advice has been sought from Lambeth Council who are in agreement with the proposals made in this report.</p> <p>Key points within the policy:</p>

- The Care Act refers to care and support needs, but does not defined what this means, and the policy looks to define this in section 3.1 of the policy using the Care and Support Regulations 2014.
- Section 3.2 refers to enquiries where the individual is considered at risk of abuse or neglect and the decision making process that goes alongside this. The recommendation is that if at any point in the period between the concern being raised and the decision being made the individual was at risk, the presumption should be that there will be a safeguarding enquiry.
- Section 4 looks at the Care and Support statutory guidance, and where different policies are to be adopted in place of the statutory guidance.
 - There had been no consultation on self-neglect as an issue prior to the guidance being published. DH issued new statutory guidance in March 2016 which gave more flexibility as to whether self-neglect cases would be considered as a safeguarding issue. Within Lambeth, self-neglect cases will generally not be considered safeguarding, unless there is another presenting safeguarding issue or if the person holding the Safeguarding Adults Manager role thinks it is the best way to deal with the case.
- Section 5.1 gives clarification on the London Policy and Procedure on how to approach concerns with Carers, noting that it is not appropriate for safeguarding enquiries to be undertaken and that concerns might for instance be dealt with in a Carer Assessment instead, unless the Carer has their own care and support needs.
- There was a robust discussion around the idea of consent at P&Q subgroup, and the relationship between the assessment and duties of the local authority. The London Policy & Procedure suggests that you should always ask consent before undertaking an enquiry, however as highlighted in section 5.3, the LSAB policy highlights that there are times where safeguarding enquiries have to happen, but how they happen can be decided with the person. Section 5.4 goes on to clarify that the Local Authority can delegate safeguarding activity but not decision making.
- Section 5.5 refers to expected timescales, and explains that Lambeth has different approach to timeliness which helps align the use of the timescales with principles of good practice. Lambeth will adopt the timescales described in Section 4.3.11 of the Care Act guidance however we acknowledge that professional judgement must be applied case-by-case and so the timescales may not necessarily be met for any particular case.
- Section 5.6 highlights the incorrect definition of organisational abuse used within the London Policy and Procedures.

A guidance document on “Producing an adult safeguarding policy and procedure” has been drawn up to provide advice and support for organisations which can be used as a checklist against what is in place already. This will be on the LSAB website and will be sent out to all provider organisations and those stakeholders represented on the Board.

The board expressed thanks to CG, JK, AH and P&Q for the work done on this. The documents produced are detailed, clear and protect people on frontline by providing clear direction.

	The LSAB policy and guidance was approved by the board.
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12.	Making Safeguarding Personal evaluation: <i>ASC’s response to the RiPFA recommendations</i>
	A clear update has been provided and request made that the board note the key points included in the cover report.

13.	Self-neglect & Hoarding update
	<p>The multi-agency protocol is being worked on with SLaM with a view to joining up pathways and providing clarity around what will be within safeguarding process and what will not. The guidance adopts assessments used by fire services.</p> <p>Action: ASC will share drafted guidance and protocol in line with the policy discussed with staff and make available to partners on LSAB website.</p>

14.	Best Interest Assessors:
	<p>This relates to the proposal that each organisation consider how they might support with Best Interest Assessments’ (as part of the DoLS authorisation process) demands on the local authority. [Not applicable to LFB, MPS, or LAS].</p> <p>Board members provided the following update:</p> <ul style="list-style-type: none"> • SW, GSTT – paper is being presented to the assurance board with recommendation to support and train BIAs within the safeguarding team. Currently seeking funding and can provide further update via email. • JN, SLaM – Issue has not yet gone to SLaM’s board, however it is being looked at widely – there are currently 20% vacancies leading to some difficulty in releasing people to do the work. Will update via email. • AH, KCH– PT will formally respond, however vacancy factors also in play. There is no capacity or funding. • AD, Certitude – currently looking at how Certitude can ensure they support the training of BIAs.

	<ul style="list-style-type: none"> • MM, CCG – MM advised that KCH and SLaM would be able to look at taking this out through contractual routes; corporate ownership in context of partnership, ramifications for organisations. To be discussed outside of board meeting with KCH and SLaM. MM – this has not yet been actively recorded as a risk –but there is a significant system risk. It could imminently have legal implications and therefore does pose a partnership risk. <p>CG noted that the Court of Protection is challenging ASC case by case and asking for witness statements. SW advised in turn that the Development Day can be used to look at the risks we share as a partnership board so that this can be fed back to organisation members – using language of risk management.</p> <p>Action: BIAs to be a rolling agenda item until there is evidence that progress is being driven forward.</p>
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15.	Report from Performance and Quality Sub-group on Strategic Plan
	<ul style="list-style-type: none"> • AH noted the support of JK, who together with CG has done a lot of background work for the group • Extended membership has had a positive impact. • SW: communication events and initiatives – an aim to communicate better to the general public about what safeguarding is, what it means, how to make an alert. JK has done a lot of work to get website up and running, making it accessible and developing new content such as podcasts. • SW: Regarding commissioning providers, there is still more to do and a need to focus in on this in last 6 months of this year. • AH noted that there is softer intelligence that doesn't come to P&Q – David Rowley will be looking at where he gathers information to help in recognising a missing link. • MM: receiving assurance as commissioners – operates very differently to social care – taking high level assurance to feedback – extracting key lessons coming out of the process • AH: It is evident where work has been completed and actioned.

16.	Any other business
	<ul style="list-style-type: none"> • MCA task and finish group; an awareness event – led by Mala Karasu, GSTT – has been scheduled for 16/11/16 and is aimed at professionals. Community events are also being organised in Southwark (17/11/16) and Lambeth (18/11/16). The Lambeth event will take place at We Are 336 Brixton and there are plans for various speakers and stalls.

	<ul style="list-style-type: none"> • In reference to the revised template for reporting, SW reiterated the need to be able to review reports 2 to 4 weeks prior to the board, so that any necessary amendments can be made prior to papers being circulated. • It was noted that Action on Elder Abuse have an online petition calling for elder abuse to be made a criminal offence. The petition will be referenced on the LSAB website and the link can be sent out to board members. The petition is accompanied by briefing paper and 100 page report, to be disseminated within organisations. Adult abuse is not always felt as important when considered alongside child abuse and board members need to do all that they can to raise issue. • Action: SW to thank Maria Millwood for her work on the board. • Action: Date for Development Day to be circulated amongst board members.
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General	
1. Accompanying presentation to the Performance Report to be sent out with minutes along with the new data templates, for comment, following board	CG
2. SW and CP to discuss ideas which will enable the CRG to feed in to the board's plans.	SW & CP
3. MM to pass on details of the next Lambeth Black Wellbeing Partnership to SW	MM
4. SW to write a letter thanking Ann Corbett (who has now left the council) for her work on the board.	SW
5. Guidance document on "Producing an adult safeguarding policy and procedure" to be shared on LSAB website and sent out to provider organisations and stakeholders represented on the board.	JK/CG
6. ASC will share drafted guidance and protocol in line with the policy discussed with staff and make available to partners on LSAB website.	JK
7. BIAs to be rolling agenda item until there is evidence that progress is being driven forward.	CG
8. SW to write a letter thanking Maria Millwood for her work on the board.	SW
9. Date for Development Day to be circulated amongst board members.	CG