



**Merton Safeguarding Adults Board (MSAB)**



**Annual Report 2016-2017**

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## **MESSAGE FROM THE CHAIR**

I am very pleased to introduce the Annual Report for the Merton Safeguarding Adults Board 2016/17. I am in my first year as Merton SAB's first Independent Chair and I am very grateful to all partners for their welcome to me in this role, and for their ongoing support. The Annual Report reflects the partner's commitment and enthusiasm for taking forward shared vision and actions over the past year, to develop the work of the Board and to respond to the relatively new demands of statutory status.

This Report shows what the Board aimed to achieve on behalf of the residents of Merton during 2016/17, both as a partnership and through the work of its participating partners. It illustrates an increasingly ambitious agenda and what the Board has been able to achieve, as well as those areas for action that we still need to address. The Report provides a picture of who is safeguarded in Merton, in what circumstance and why. This helps us to know what we should be focusing on for the future. The Operational Sub Group which was originally established to implement some improvements identified in the 3 Year Strategy has been reformed to ensure that the challenges of our duties are met, including undertaking, and learning from, Safeguarding Adults Reviews. We are also enhancing our performance management and quality assurance data to underpin and inform our priorities more effectively.

Additionally, progress is being made in terms of ensuring that the work of the Board is accountable to local people and I am looking forward to working with partners to find new ways of hearing from and engaging with local individuals and community groups, so that our work is directly informed by learning from people's experience of local services.

I am very aware of the pressures on partners in terms of resources and capacity so would like to thank all those who have engaged in the work of the Board, for their time and effort. In particular, I would like to thank Gemma Blunt, Merton Council's Safeguarding Manager for her organisational support, which makes an enormous contribution towards helping the Board deliver its aims and objectives. There is a great deal that we need and want to do to reduce the risks of abuse and neglect in our community and to support people who are most vulnerable to these risks. I am confident that the Board's partners have the vision and dedication to achieve our shared aims and I look forward to continuing to chair the partnership in the next year to progress our work.



Teresa Bell

## **INTRODUCTION**

This annual report is produced on behalf of the Merton Safeguarding Adults Board (MSAB).

This report outlines the progress made during the year April 2016 – March 2017 and how local and national developments have influenced this. This report will also describe our actions for April 2016-March 2017 and continued efforts to ensure the board is strengthened in line with our statutory footing since the Care Act 2014 was introduced.

## **WHO WE ARE**

The Safeguarding Adults Board's membership is as follows:

- Independent Chair
- Director of Community & Housing London Borough of Merton
- Director of Quality Merton and Wandsworth CCG
- Borough Commander, London Fire Brigade
- Borough Commander, Metropolitan Police
- Safeguarding Lead, London Ambulance Service
- Safeguarding Adults and DOLS Team Manager, London Borough of Merton
- Head of Access and Assessment LBM
- Safeguarding Lead, St George's NHS Trust
- Safeguarding Lead, CLCH
- Associate Director of Social Work S.W. London and St Georges Mental Health NHS Trust
- Health Watch
- London Probation Service
- Circle Anglia Housing (now known as Clarion)

The Board meets quarterly, four times a year.

MSAB has 3 core duties in line with the Care Act 2014 guidance:

- it must publish a strategic plan for each financial year that sets how it will meet its main objective and what the members will do to achieve this. The plan must be developed with local community involvement, and the SAB must consult the local Healthwatch organisation. The plan should be evidence based and make use of all available evidence and intelligence from partners to form and develop its plan
- it must publish an annual report detailing what the SAB has done during the year to achieve its main objective and implement its strategic plan, and what each member has done to implement the strategy as well as detailing the findings of any safeguarding adults reviews and subsequent action
- it must conduct any safeguarding adults review in accordance with Section 44 of the Act.

This work is underpinned by the six safeguarding adult principles:

<b>Empowerment</b>	Adults are encouraged to make their own decisions and are provided with support and information.	I am consulted about the outcomes I want from the safeguarding process and these directly inform what happens
<b>Prevention</b>	Strategies are developed to prevent abuse and neglect that promotes resilience and self-determination.	I am provided with easily understood information about what abuse is, how to recognise the signs and what I can do to seek help
<b>Proportionate</b>	A proportionate and least intrusive response is made balanced with the level of risk.	I am confident that the professionals will work in my interest and only get involved as much as needed
<b>Protection</b>	Adults are offered ways to protect themselves, and there is a co-ordinated response to adult safeguarding.	I am provided with help and support to report abuse. I am supported to take part in the safeguarding process to the extent to which I want and to which I am able
<b>Partnerships</b>	Local solutions through services working together within their communities.	I am confident that information will be appropriately shared in a way that takes into account its personal and sensitive nature. I am confident that agencies will work together to find the most effective responses for my own situation
<b>Accountable</b>	Accountability and transparency in delivering a safeguarding response.	I am clear about the roles and responsibilities of all those involved in the solution to the problem

## **OBJECTIVES AND THREE YEAR STRATEGY UPDATE**

The main objective of a MSAB is to assure itself those local safeguarding arrangements and partners act to help and protect adults in its area, as directed within the Care Act 2014 guidance.

As a local multi-agency Board, comprising senior representatives, the Board will carry out the following key functions in order to meet our main objective:

- Strategic leadership and oversight of adult Safeguarding arrangements in the London Borough of Merton discharged through all statutory and non statutory partners.
- Monitoring continued compliance with the Care Act 2014.
- Oversight of the effective implementation of the Pan London Safeguarding Adults Policy and Procedures at local level.
- Support and guide communities and organisations to ensure that the circumstances in which neglect and abuse occur in the London Borough of Merton are actively identified and prevented, thereby promoting the welfare and interests of adults at risk.
- Raise awareness, knowledge and understanding of abuse and neglect in order that communities and organisations know how to respond in an effective, coherent and timely way when safeguarding issues arise.
- Ensure that adult's at risk that use services that fall within the remit of the Board are safe and their care and treatment is appropriate to their needs.
- Ensure that each partner organisation has systems in place that evidence that they discharge their functions in ways that safeguard adults at risk.
- Work together as a Board to learn and share lessons learnt from national and local experience and research and to promote best practice by ensuring that such learning is acted upon.

- Develop systems to audit and evaluate the impact and quality of safeguarding work to aid continuous improvement of interagency practice, including lessons learned from practice.
- Develop and maintain a strong and evolving network of stakeholders including adult's at risk, their carers and advocates.
- Undertake Safeguarding Adults Reviews when it is confirmed or there is strong evidence to suggest that an adult at risk has died, been significantly harmed or put at risk as a result of abuse or neglect.

Making Safeguarding Personal is the intrinsic link which is integrated through our objectives. Whilst we may undertake specific work linked to strengthening the Making Safeguarding Personal agenda in Merton, this agenda is significant and relevant in all of the objectives and underpins the board functions and how we apply them.



## **Safeguarding Board Achievements**

The board have successfully achieved the following actions during this year:

### 1. Leadership and Governance

- 1.1. Set up an Operational Subgroup of the SAB to meet bi-monthly to ensure that the Delivery Plan is delivered (Chair - Member of the MSAB; Core Membership - safeguarding leads from 3 statutory partners). The operational subgroup to ensure that: delivery plan is actioned, monitored and reviewed.

*The first sub group will begin in June 2017, membership is established.*

- 1.2. Task and Finish groups to be set up by the MSAB or Operational Subgroup to achieve the objectives of the delivery plan.

*This action is in place and the board held a Hoarding task and finish group to update the Hoarding protocol into 2017.*

- 1.3. Appoint an Independent Chair for MSAB and agree a MSAB Budget for the Chair and MSAB support.

*We are pleased to have Teresa Bell as our independent chair of the MSAB. Budget considerations have begun and will continue to be discussed and explored into the following year 2017/2018.*

- 1.4. Review the membership of MSAB, including identifying advocacy and service user voices on the MSAB.

*We have yet to have an advocacy representative on the board but we continue to explore how we can ensure service user voice and welcome hearing about the South West London and St George's Trust Making Safeguarding Personal Group.*

### 2. Performance Management and Quality Assurance

- 2.1 Agree and establish a performance framework (both performance information and analysis) including reporting on: the 'conversion rates' from safeguarding concerns to enquiries, by referral source and category; trends in types of abuse; outcomes identified by service users and achieved through s.42 enquiries; impact of safeguarding activity; safeguarding activity reporting from all MSAB partners; provider quality and safeguarding concerns (from the multi-agency quality monitoring meetings); repeat adult safeguarding referrals and activity.

*A task and finish group has been set up to look at this action in more detail and will be carried forward into the next year.*

- 2.2 Develop and deliver quality assurance tools e.g. quality audits of case files.

*This work will be carried out by the operational sub group and will be included in their annual work plan once fully operational.*

2.3 Review 2015/6 Merton data in order to benchmark performance, both regionally and nationally, to inform future priorities

*This work has begun and includes involvement in the work by the London Safeguarding Board that will produce a London wide data set which can accurately benchmark safeguarding data with other boroughs. The NHS Digital data collection cannot accurately do this at present as it does not account for how each local authority logs a safeguarding concern or enquiry.*

2.4 Identify where issues raised through safeguarding concerns could be resolved without s.42 enquiries, and appropriate information and advice provided as safeguarding early intervention and prevention activity.

*This action will be taken forward to the following year.*

### 3. Safeguarding Adult Reviews

3.1 Develop and adopt a Safeguarding Adults Review(SAR) protocol so that the partnership can learn and improve safety and wellbeing of Merton residents.

*This has been completed and signed off with the board.*

3.2 Set up a process to manage and deliver the SAR protocol so that staff understand the criteria for a SAR, and how cases can be escalated for consideration by the Operational Sub group.

*This will be in place through the operational sub group.*

3.3 Ensure partner agencies contribute to the SAR processes.

*Partners contribute to the process through the operational sub group.*

### 4. Workforce Strategy

4.1. Co-ordinate adult safeguarding training and development plans across all partners – share plans and review to ensure a consistent approach to competency expectations (use Bournemouth model/ NHS intercollegiate safeguarding competency model?)

*This action will progress through the operational sub group into the next year.*

4.2. Prioritise legal literacy training across priority staff groups in LA, MHT and CHT (undertaking and managing enquiries?)

*LBM will renew their ASC training offer to council staff involving safeguarding and legal update courses. Opportunity for partners to access these courses will be discussed and explored into the next year with the development of a safeguarding board training offer.*

4.3 Review MCA training to ensure consistent approach across all agencies and use of Toolkit

*This will be carried forward to the next year and included within the training discussions.*

4.4 Consider how to assess that training has had the desired impact in terms of improving staff effectiveness (e.g. via multi agency case file audit?)

*This will be the work of the operational sub going forward into the next year.*

## 5. MSAB Strategy 2017-20

5.1. Independent Chair to lead a review of current strategy and the process for developing a new strategy.

*This will be completed in the Autumn of 2017*

5.2. Consultation is undertaken during 2016/17 and this informs the priorities of the draft strategy for 2017-20.

*The safeguarding and mental capacity learning forum will be utilised to ensure consultation with staff regarding the new strategy is completed.*

## **NATIONAL AND LOCAL PROGRESS**

The Care Act 2014 came into practice on 1<sup>st</sup> April 2015. The Board is compliant with the requirements of the Care Act by:

- Establishing the board on a statutory basis
- Involving key partners as board members
- Ensuring requirements under schedule 2 of the Care Act 2014 are followed and in place.

The Multi Agency Pan London Safeguarding Adults at Risk policy and procedures were published in November 2016 and have been adopted by the Board entirely with a local operational protocol being revised which details specific arrangements to Merton.

Board Partners completed the self audit – Safeguarding Adults at risk audit tool developed by ADASS in relation to their own organisation. This assisted with giving assurance to the board as well as formulating action plans to meet requirements as set out in the audit.

### MSAB Away Day

The board held a planning away day in May 2016, facilitated by Adi Cooper OBE. This was to assist the board with reviewing the 3 year strategy 2014-17 and revising the board actions to ensure they remained relevant.

The notes of the away day were circulated to members and copy of the notes can be requested from the Safeguarding Adults Board Administrator.

The success of this away day ensured that the MSAB were in a position to recruit an independent board chair, develop our SAR Policy and put plans in place to establish an operational sub group which can drive forward the actions from the away day in line with the 3 year strategy.

## **TRAINING:**

Total number of staff attending safeguarding training this year is 341. The breakdown of course and participant follows:

- Raising a concern

85 staff attended this course, 55 participants were LBM staff and 30 were staff from partner agencies.

- Undertaking an enquiry

64 LBM staff attended this course.

- Managers

26 staff attended this course, 4 were managers from partner agencies.

- Basic Awareness

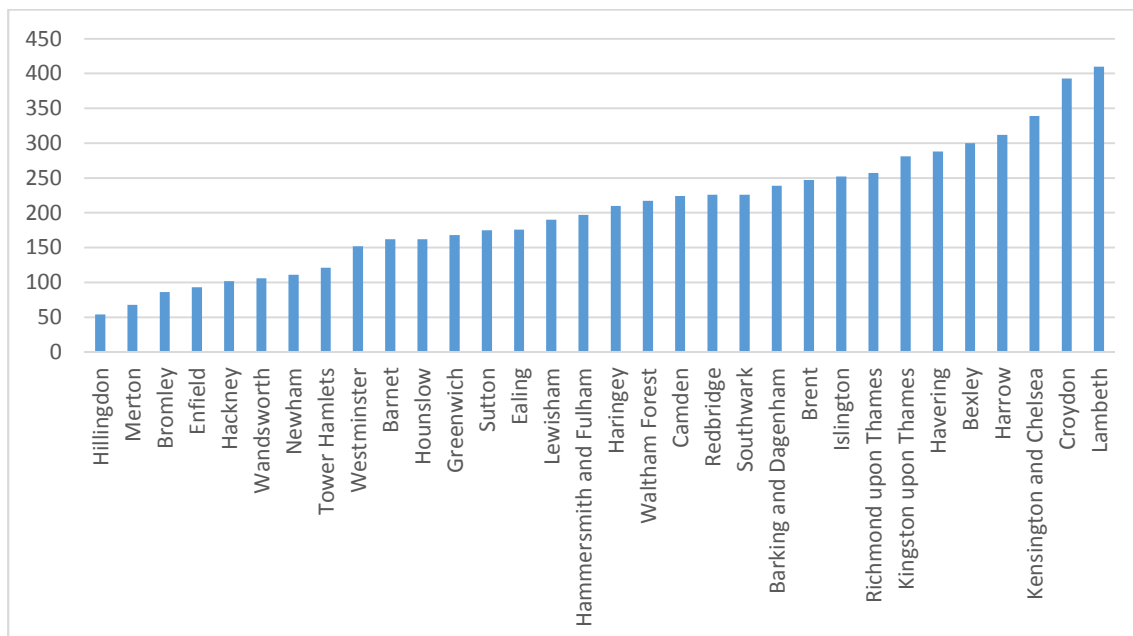
166 staff attended this course, 69 staff were from partner agencies.

## **SAFEGUARDING ADULTS DATA:**

London Context:

There is an existing common data set, the [Safeguarding Adults Collection \(SAC\)](#) (previously known as the [Safeguarding Adults Return \(SAR\)](#)) collected by [NHS Digital](#) (previously known as the [Health and Social Care Information Centre](#)). Despite amendments to the definitions of this data set over the years it has yet to result in reliable data, and NHS Digital still classify the data set as 'Experimental'.

The problem with the SAC can be seen by looking at [the data collected by NHS Digital for the number of s42 enquiries per 100,000 of population in London local authority areas in 2015/16](#) (Diagram 1). The average in London is 205, but there is a very wide spread between areas from 54 in Hillingdon to 410 in Lambeth.



**Diagram 1: s42 Care Act Enquiries per 100,000 population 2015/16** (source: NHS Digital)

While there will necessarily be variations in activity levels between areas, it would be unlikely that these would account for such a wide spread. More likely, some of this spread will be due to differences in ways of working, differences in data collection processes, or some combination of the two. The London Safeguarding Adults Network has put a proposal forward to the London Safeguarding Adult's board to develop a common data set for use by local SABs that will give better information about issues such as levels of activity, nature of the issues, timeliness of adult safeguarding enquires, user experience, and impact of the work. This data set will have definitions of the data items that will help reduce the variation due to differences in practice and systems.

## London Borough of Merton

Subject to NHS Digital Validation, the SAC data return for the year 2016/2017 is displayed below.

**Diagram 2: Safeguarding activity in London Borough of Merton**

Table SG1f	
Counts of Safeguarding Activity	Count
Total Number of Safeguarding Concerns	589
Total Number of Section 42 Safeguarding Enquiries	104
Total Number of Other Safeguarding Enquiries	14

This table demonstrates that 18% of safeguarding concerns reported to LBM, went on to sec.42 safeguarding enquires. This may appear to be low but what it can suggest is that the borough receives high number of safeguarding concerns and once screened, are either not a safeguarding concern by definition of the Care Act 2014 or are managed at the first stage and not appropriate to proceed further into enquiries. The total number of safeguarding concerns is similar to previous years, for example 2015/2016 at total of 557 were reported, there was an increase this year of 32 concerns.

**Diagram 3: Reported categories of abuse**

Table SG2a Counts of Enquiries by Type and Source of Risk	Concluded Section 42 Enquiries			Other Concluded Enquiries			Total Section 42	Total Other
	SOURCE OF RISK			SOURCE OF RISK				
	Service Provider	Other - Known to Individual	Other - Unknown to Individual	Service Provider	Other - Known to Individual	Other - Unknown to Individual		
Physical Abuse	8	8	7				23	0
Sexual Abuse	0	0	4				4	0
Psychological Abuse	5	6	3				14	0
Financial or Material Abuse	3	14	2				19	0
Discriminatory Abuse	1	0	1				2	0
Organisational Abuse	5	1	5				11	0
Neglect and Acts of Omission	17	11	12				40	0
Domestic Abuse							0	0
Sexual Exploitation							0	0
Modern Slavery							0	0
Self-Neglect							0	0

This table demonstrates the reported categories of abuse. The SAC does not require mandatory reporting of the categories in grey, LBM do collect this and will be in reportable data form when Mosiac system is functioning.

Neglect is the highest reported category of abuse, followed by physical abuse then financial abuse. This has been the categories reported consistently in previous years and offer no new themes or patterns in LBM.

**Diagram 4: Reported categories by location of abuse**

Table SG2b	Concluded Section 42 Enquiries			Other Concluded Enquiries				
Counts of Enquiries by Location and Source of Risk	SOURCE OF RISK			SOURCE OF RISK				
	Service Provider	Other - Known to Individual	Other - Unknown to Individual	Service Provider	Other - Known to Individual	Other - Unknown to Individual	Total Section 42	Total Other
Own Home	9	21	9				39	0
In the community (excluding community services)	1	2	1				4	0
In a community service	1	0	4				5	0
Care Home - Nursing	0	0	0				0	0
Care Home - Residential	17	8	10				35	0
Hospital - Acute	0	0	0				0	0
Hospital - Mental Health	0	0	0				0	0
Hospital - Community	0	0	0				0	0
Other	0	2	3				5	0

This table shows that abuse or the risk of abuse is likely to within a residential care home or persons own home. Again, this is consistent to previous years and offers no new themes in relation to activity in the borough.

**Diagram 5: Mental Capacity status for individual subject to s.42 enquiries**

Table SG3a							
Mental Capacity Table for Concluded Section 42 Safeguarding Enquiries	Age Group						
For each enquiry, was the adult at risk lacking capacity to make decisions related to the safeguarding enquiry?	18-64	65-74	75-84	85-94	95+	Not Known	Total
Yes, they lacked capacity	11	3	6	8	2	0	30
No, they did not lack capacity	11	4	2	5	1	0	23
Don't know	2	1	2	0	1	0	6
Not recorded	14	1	5	7	2	0	29
Of the enquiries recorded as Yes in row 1 of this table, in how many of these cases was support provided by an advocate, family or friend?	9	2	6	6	0	0	23

This table demonstrates that the mental capacity of an individual in relation to partaking in safeguarding enquires is either that they lacked capacity or is not recorded. These findings do not appear to offer a clear picture to *how* mental capacity is assessed to whether a person consents to a safeguarding enquiry. This may be something the board may want to consider in relation to multi agency audits, mental capacity set as a theme.

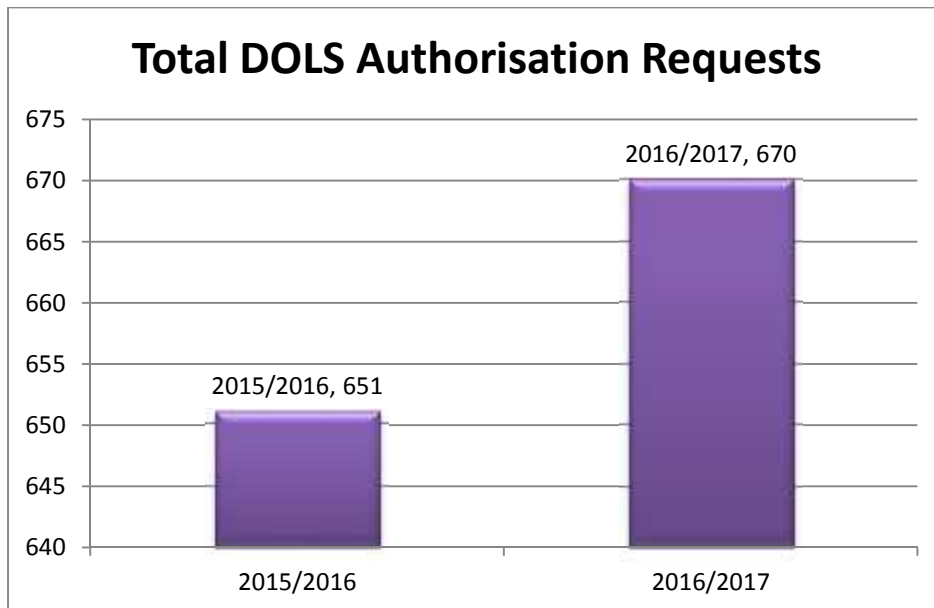
## **Safeguarding Adults Reviews (SAR)**

There has been no SAR's this year, however the MSAB will be holding the action plan following the DHR for Mrs A. The DHR report can be found online [www.merton.gov.uk/domesticviolence](http://www.merton.gov.uk/domesticviolence)



<b>Yearly Summary</b>		<b>Apr-16</b>	<b>May-16</b>	<b>Jun-16</b>	<b>Jul-16</b>	<b>Aug-16</b>	<b>Sep-16</b>	<b>Oct-16</b>	<b>Nov-16</b>	<b>Dec-16</b>	<b>Jan-17</b>	<b>Feb-17</b>	<b>Mar-17 (Year total)</b>
<b>Safe (REF)</b>	Number of safeguarding referrals (concerns) started in the year (YTD)	70	129	181	222	262	322	368	417	458	505	538	589
<b>Safe (REF)</b>	Number of safeguarding referrals (concerns) started in the year, which are still open	4	8	11	18	22	36	47	57	61	51	43	40
<b>Safe (REF)</b>	Number of safeguarding referrals (concerns) started in the year and are closed as an alert (concern) only. (YTD)	51	86	127	152	174	210	238	267	290	359	364	406
<b>Safe (IN)</b>	Number of safeguarding investigation closed as alert only	3	5	11	11	13	16	20	22	24	23	24	26
<b>Safe (IN)</b>	Number of safeguarding investigation cases - closed (YTD)	5	13	29	30	33	33	42	46	55	61	67	88
<b>Safe (IN)</b>	Number of safeguarding investigation cases - open	34	36	43	47	54	63	76	85	78	89	88	53

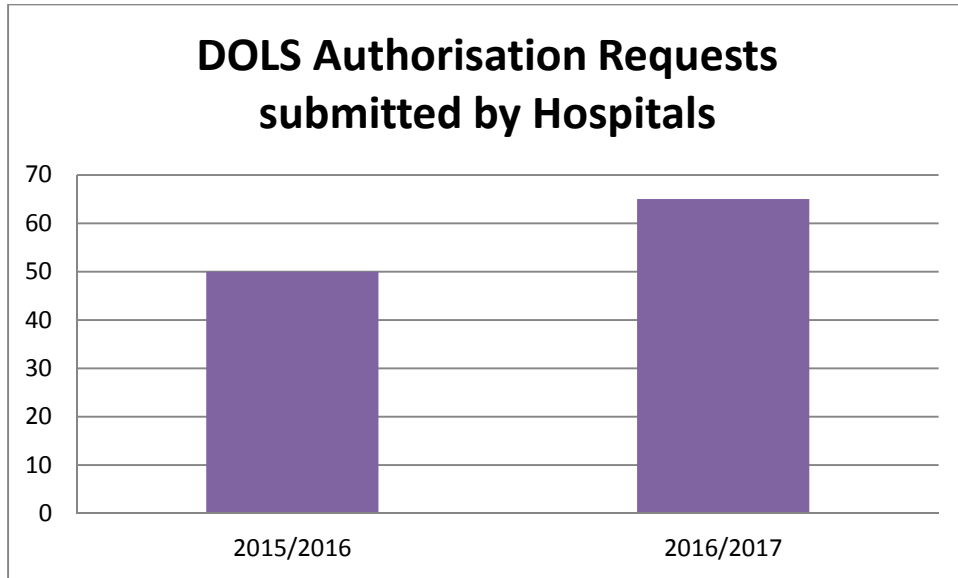
## DEPRIVATION OF LIBERTY SAFEGUARDS (DOLS) DATA



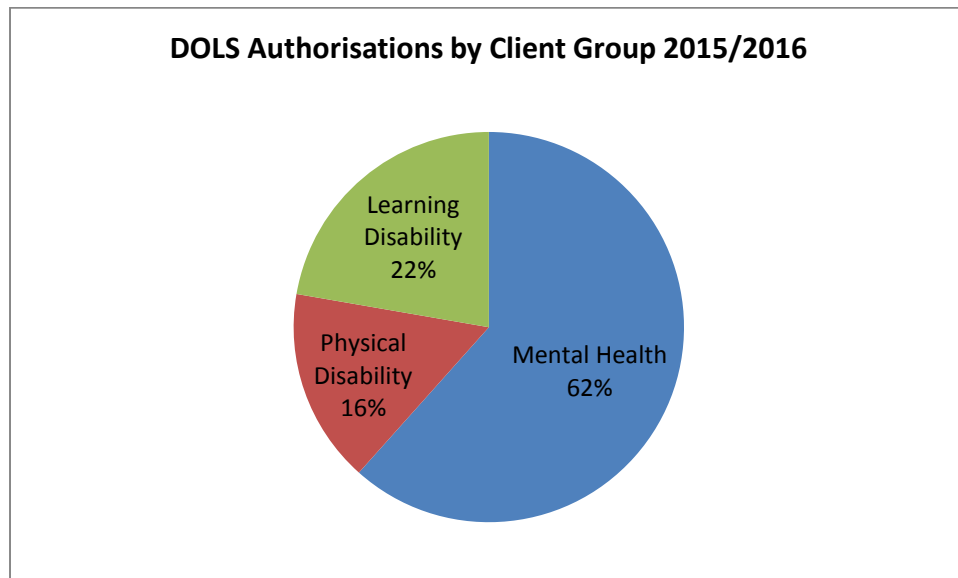
This graph shows that number of DOLS requests received is increasing every year, although this was a slight increase by 19 authorisation requests. This may show that applications are rising but not significantly which may indicate applications are at a steady pace with no indication or further significant increases.

In 15/16 there were 516 DOLs completed – there was no allocation list at that time and, the rest were either abandoned, duplicated, or DOLS criteria not met (i.e not authorised)

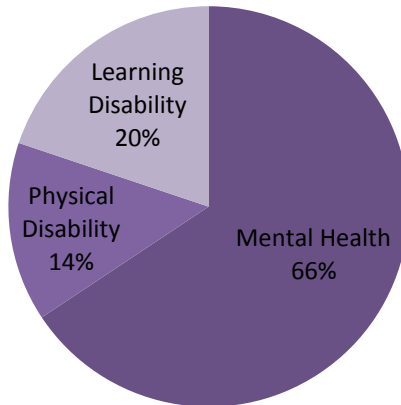
In 16/17 there were 289 DOLs completed with 199 on the allocation list, the reason for creation of the allocation list was due to a change in the safeguarding team and availability of full time assessors. LBM have also ceased using independent BIA's unless there is a valid reason to (e.g conflict of interest), therefore ASC staff that are BIA's complete approx. 2 BIA assessments a month as part of their caseload of work.



For both care home and hospital, the number of authorisation requests has increased slightly for Care and Nursing Homes. The above shows that Hospital authorisation requests have increased further this year. This could be due to hospital staff becoming more aware of DOLS and increased numbers of adults admitted that meet the criteria.



### DOLS Authorisations by Client Group 2016/2017



Mental Health continues to be the highest reported client group of people subject to a DOLS authorisation request. This includes Dementia and other cognitive conditions. This is consistent with national figures and is expected due to nature of DOLS process.

**PARTNER CONTRIBUTIONS**

Partners have contributed via the Safeguarding Adults at Risk Audit Tool. A summary of each agency is compiled below:

	A1	A2	A3	A4	A5	B1	B2	B3	C1
LBM									
CCG									
Police					No RAG rating given		N/A		
LFB					N/A				
LAS									
Clarion (MPH)									
London Probation									
SWLSTG									
MSCB									
St Georges Hospital									
CLCH									

	C2	C3	C4	D1	D2	D3	D4	D5	E1
LBM									
CCG									
Police									
LFB									
LAS									
Clarion (MPH)									
London Probation									
SWLSTG									
MSCB									
St Georges Hospital									
CLCH									

	E2	F1	F2	F3	Examples of Red and Amber actions:
LBM					<p>Examples of Red and Amber actions:</p> <ul style="list-style-type: none"> <li>➤ St Georges: Ensure patient representative on Trust Safeguarding Committees.</li> <li>➤ LFB: Safeguarding Training will be rolled out to all personnel within a target period of 18 months.</li> <li>➤ CCG: To work with NHSE and other Designated Leads to ensure we are compliant with the MCA/DOLS Process</li> </ul> <p>Examples of good practice:</p> <ul style="list-style-type: none"> <li>➤ SWLSTG: Making Safeguarding Personal Group; a co-production project which helps to shape safeguarding practice</li> <li>➤ Police: CMARAC examples showing evidence of good outcomes for Merton residents as a result of being taken through the CMARAC process.</li> <li>➤ CLCH: Safeguarding/MCA and DOLS surgeries held monthly in trust in-bedded rehabilitation unit.</li> </ul>
CCG					
Police					
LFB	N/A		N/A	N/A	
LAS					
Clarion (MPH)					
London Probation					
SWLSTG					
MSCB					
St Georges Hospital					
CLCH					

## Safeguarding Board Actions 2017/2018

The following tasks are planned for the next year:

- New 2017/2020 strategy to be finalised at the 2017 MSAB away day.
- Safeguarding Board operational group and work plan to be established.
- Launch of the revised Hoarding Protocol Autumn 2017.
- Common data set from all board members to be proposed and agreed.