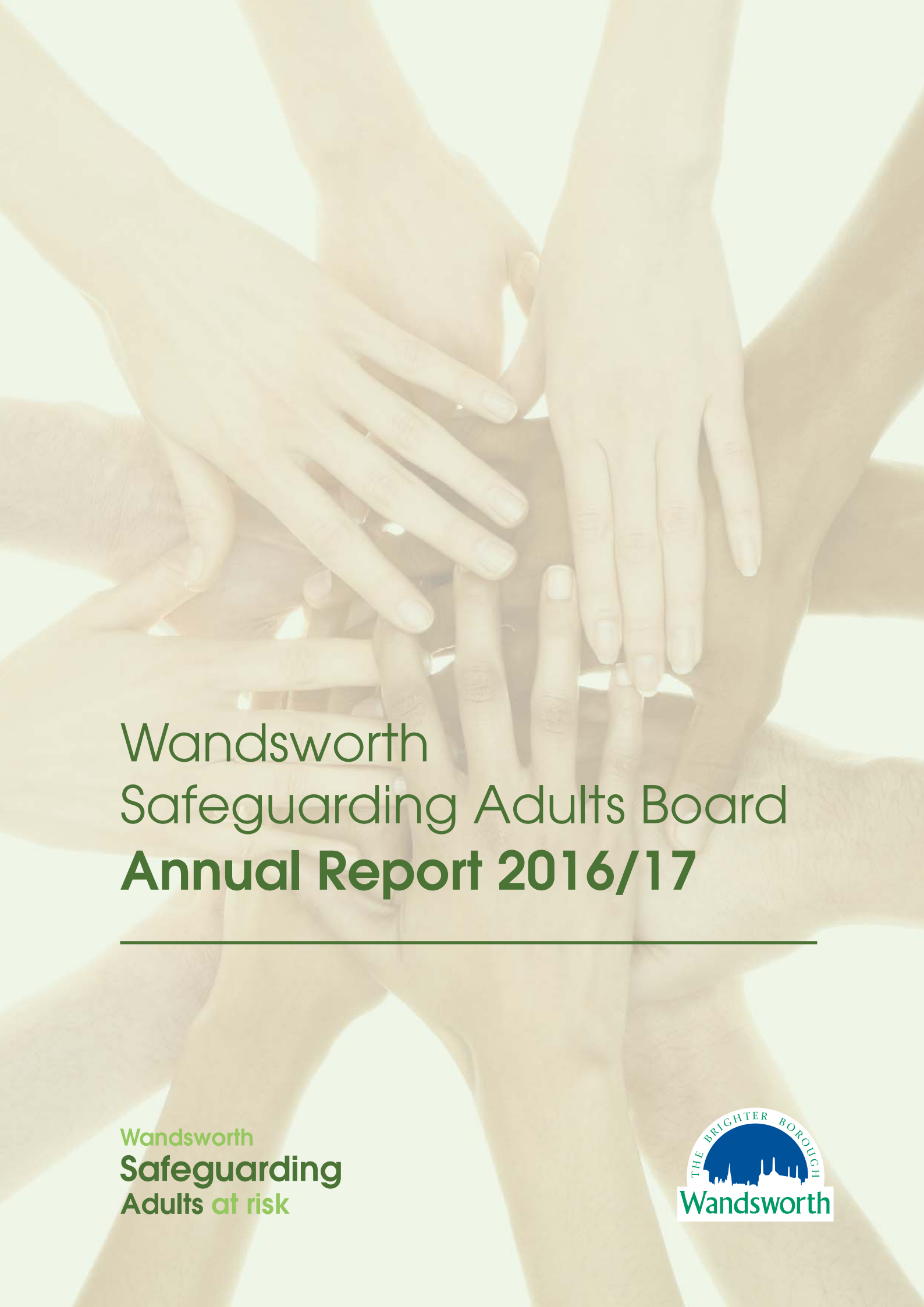


Wandsworth Safeguarding Adults Board **Annual Report 2016/17**

Wandsworth
Safeguarding
Adults at risk

THE BRIGHTER BOROUGH
Wandsworth


THE BRIGHTER BOROUGH
Wandsworth


Wandsworth CCG


Alzheimer's Society


Care Quality Commission


METROPOLITAN POLICE
Working together for a safer London


NHS
England


St George's University Hospitals
NHS Foundation Trust
NHS


South West London and St George's
Mental Health NHS Trust
NHS


London Ambulance Service
NHS Trust
NHS


LFB
LONDON FIRE BRIGADE


Wandsworth Carers' Centre
carerstrust
a Network Partner


your healthcare


London Probation Trust


National Probation Service


London
Community Rehabilitation Company
PROBATION


Wandsworth
age UK

Contents

Foreword from the Independent Chair

I am pleased to present the Annual Report of the Wandsworth Safeguarding Adults Board (the Board) for 2016/17. The Board is required to report on progress over the last year and look forward and plan our priorities for the future year. This annual report will seek to demonstrate how we have made a difference to safeguarding vulnerable adults in Wandsworth during the last year.

This has been an interesting year with many significant changes within partner agencies including the new joint arrangements across Wandsworth and Richmond for Adult Services and other shared services across the council, plans for the CCGs and Metropolitan police to bring together a number of boroughs to work more closely together. Working together has never been so important, as we continue to test and hold partner agencies to account for making a positive and real difference to people's lives. The profile of adult safeguarding continues to improve and engagement in and contribution to this area of work by all agencies is increasing. This has happened alongside the continued challenge of reducing capacity and resources within all agencies.

We have met many of the objectives we set as a Board. There are clear examples of improvements which will be detailed in this report. There is stronger Board oversight with a clear vision and business plan, with proportionate and personalised enquiries and a better trained workforce training. However, we recognise there is still more to do.

Finally I would like to acknowledge that championing adults at risk requires a culture, across all agencies, where staff are open to challenge and new ideas. That ethos has again been tested this year. I am privileged to work with partners who are open and willing to analyse their performance to ensure it improves outcomes for vulnerable adults. I would like to thank members of the Board for their work during this period and particularly all the frontline practitioners and managers in Wandsworth for their dedicated work in safeguarding vulnerable adults. We will continue to seek out what we can do better, to support the community we serve and work together with adults at risk and the local community.

Nicky Pace
WSAB Independent Chair

1 Wandsworth Safeguarding Adults Board

What does the Board do?

Wandsworth Safeguarding Adults Board (SAB) is a long established partnership of agencies who together work to promote people's right to live in safety, free from abuse and neglect. Its purpose is to ensure that organisations work together to both prevent abuse and neglect, and respond in a way that promotes each person's wellbeing, should they have experienced abuse or neglect.

The Board leads the strategic oversight of adult safeguarding arrangements in Wandsworth for adults with care and support needs who may be experiencing or at risk of abuse or neglect. The Board does this by:

- Making sure that local arrangements are in place and that the safeguarding work of its members is effective.
- Improving the way local agencies and services work together to respond when abuse or neglect have occurred and to prevent abuse and neglect from happening.
- Making sure that people are placed at the centre of enquiries when abuse or neglect has occurred
- Ensuring continuous learning and improvement of our shared practice.
- Setting out our vision, aims and objectives in strategic & business plans and ensuring that we deliver on these.

The Six Safeguarding Principles

The work of the Board is guided by the six principles that underpin all adult safeguarding work. These are:

- **Empowerment**: Adults are encouraged to make their own decisions and are provided with support and information.
- **Protection**: Adults are offered ways to protect themselves, and there is a co-ordinated response to adult safeguarding.
- **Prevention**: Strategies are developed to prevent abuse and neglect that promotes resilience and self-determination.
- **Proportionate**: A proportionate and least intrusive response is made, which is balanced with the level of risk.
- **Partnerships**: Local solutions through services working together within their communities.
- **Accountability**: Accountability and transparency in delivering a safeguarding response.

1 Wandsworth Safeguarding Adults Board

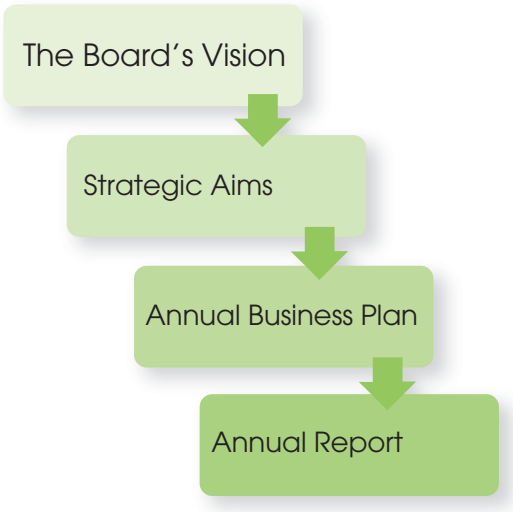
The Board's Governance Framework

The governance framework of the Board includes the definition of a **Vision** which defines the outcomes it wants to achieve for the residents of Wandsworth.

The **Strategic Aims** and 2 year objectives define how the Board plan to achive its Vision and provides direction and continuity to each year's Business Plan.

The **Annual Business Plan** provides a detailed plan of specific key actions, and target timescales required to achieve the Board's Vision.

The **Annual Report** reflects on the previous year's activity and reports progress towards the Business Plan.



Vision and Principles

The Board's Vision is underpinned by the statutory obligations set out in the Care Act 2014:

"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 including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action. This must recognise that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear or unrealistic about their personal circumstances".

The vision is that all Wandsworth residents live an independent life free from abuse and neglect where:

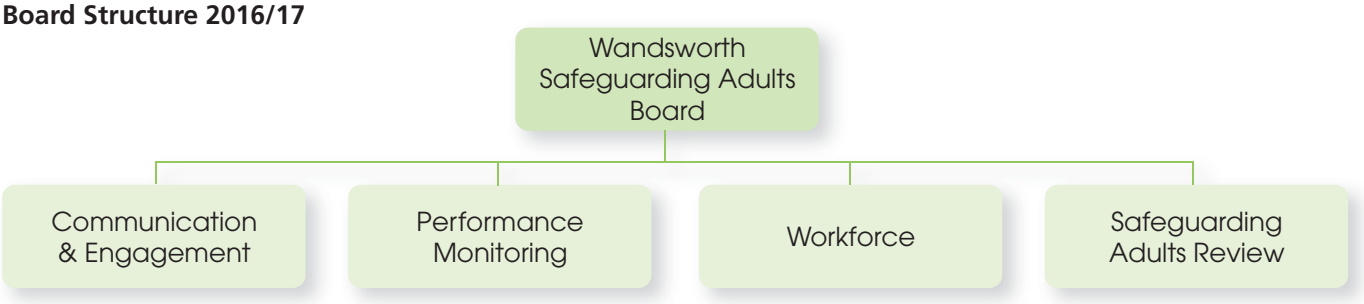
- Abuse, neglect and exploitation are not tolerated.
- Everyone works together to prevent abuse.
- Services respond effectively when abuse or neglect is suspected or happens.
- People who experience abuse or neglect are supported in the way they wish to be supported and enable them to recover and regain trust in those around them.
- Partners share information and intelligence to reduce or remove risk.
- We learn from safeguarding enquires and reviews and use this to inform our practice and preventative strategies.

1 Wandsworth Safeguarding Adults Board

Board Structure

The Board meets quarterly and undertakes its work through its four subgroups.

Board Structure 2016/17



- The **Safeguarding Adults Review Subgroup** was developed this year to provide a measured and proportionate response to the Section 42 of the Care Act 2014 requirement to review adult deaths, or serious harm where abuse or neglect may have occurred. It is Chaired by the Assistant Director of Adult Social Services (Commissioning and Quality Standards) Richmond and Wandsworth Councils and attended by senior officers designated by the three statutory partners.

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- The **Communication and Engagement Subgroup** raises public awareness of safeguarding and how to act on concerns about abuse and neglect. It is chaired by a senior officer representing Adult Social Services and is attended by representatives from the statutory and non statutory partner agencies, including providers of services.

- The **Performance Monitoring Subgroup** helps the Board and its members to evidence how its work is making a difference in preventing abuse and neglect of local people. The group has met intermittently during 2016/17 and has recently been revived with a clearer remit. It will be chaired by a representative from St George's Hosptial NHS Trust and all stautory agencies will be represented on the group.

- The **Workforce Subgroup** plans and arranges robust multi-agency safeguarding training which underpins good practice across the partnership. The group is chaired by an adult social care representive.

1 Wandsworth Safeguarding Adults Board

Board Members

The Board is led by an independent chair and has a core membership of 21 organisations. This is a list of the agencies represented on the Board. Members are of sufficient seniority within their organisation to be able to make decisions and commit resources on their behalf. There is an expectation that representatives will attend all four meetings each year.

- **Richmond and Wandsworth Council Adult Social Care**
- **Wandsworth and Merton CCG**
- **Wandsworth and Merton Metropolitan Police**
- **Richmond and Wandsworth housing**
- **Richmond and Wandsworth Public Health**
- **Wandsworth Council members**
- **South West London and St George's Mental Health Trust**
- **London Fire Brigade – Wandsworth**
- **London Ambulance service**
- **National Probation Service – London**
- **St George's Hospital NHS Trust**
- **Wandsworth Prison**
- **Health Watch Wandsworth**
- **Wandsworth DWP**
- **Wandsworth Housing associations**
- **Age UK Wandsworth**
- **Alzheimer's society**
- **Advocacy services**
- **Care UK**
- **Carers centre**
- **CQC**

2 What we set out to do in 2016/17

The Board adopted five strategic objectives for 2016/17

OBJECTIVE 1

Governance and Accountability

To establish and maintain an effective multiagency partnership to carry out the statutory duties of the Safeguarding Adults Board as defined in the Care Act.

OBJECTIVE 2

Partnership

To work collaboratively in partnership to prevent abuse and neglect where possible and to respond to situations where it does occurs in a proportionate and appropriate way.

OBJECTIVE 3

Workforce and Local Providers

To seek assurance that there is a skilled and effective workforce across the partnership.

OBJECTIVE 4

Awareness, Engagement and Participation

To develop a safeguarding culture which promotes adults at risk as being central to and fully involved in safeguarding arrangements, plans, process and any intervention.

OBJECTIVE 5

Practice and Performance

To seek assurance that adult safeguarding practice is continuously improving and enhancing the quality of life of adults in the area.

3 What we achieved in 2016/17

OBJECTIVE 1

To establish and maintain an effective multiagency partnership to carry out the statutory duties of the Safeguarding Adults Board as defined in the Care Act

To achieve this:

- We met regularly throughout the year and attendance at all meetings was good.
- We held an away day to review our activity and update our strategic objectives and business plan.
- We extended our board to include a representative from Wandsworth Prison.
- We held a successful peer challenge and support event to obtain assurance on the quality of services and awareness of adult safeguarding issues across the partnership. 13 Partners responded to the self-assessment and have identified development areas for the coming year.

OBJECTIVE 2

To work collaboratively in partnership to prevent abuse and neglect where possible and to respond to situations where it does occurs in a proportionate and appropriate way

To achieve this:

- We updated referral routes between the Local Authority and Metropolitan Police Service to improve interagency communication.
- We continued to improve risk management to prevent abuse and respond to self-neglect through the regular meetings of the Community Multiagency Risk Assessment Panel (CMARAP).
- Regular monthly workshops were delivered within the local authority to enhance skills in coordinating multi-agency risk management, with very positive evaluation.
- We maintained a Provider Risk Panel involving the Local Authority, Health and the Care Quality Commission, which reports on a quarterly basis to the Board. This panel has provided a holistic overview of safeguarding incidents, complaints and in care and nursing homes, hospitals and domiciliary care agencies. The panel maintains a provider risk action plan which is discussed regularly at the Local Authority Care Governance Board.
- Prevention of abuse and neglect of people experiencing dementia in care and nursing homes has been enhanced by the development of an innovative, experiential and sustained, training offer on life stories and person-centred care.
- We received reports and updates from the local authority on the level of applications for authorisation of the Deprivation of Liberty Safeguards (DoLS) and of the compliance of local providers with these statutory requirements.

3 What we achieved in 2016/17

OBJECTIVE 3

To seek assurance that there is a skilled and effective workforce across the partnership

To achieve this:

- We agreed a training plan across the partnership, which focused on joint training opportunities.
- All partners have strategies in place to ensure training and refresher training of staff on all aspects of adult safeguarding relevant to their roles. This year we have also focused on self-neglect, modern slavery, domestic abuse, human trafficking and radicalisation as key development areas where awareness and expertise will need to be developed. Of the total number of referrals only a small number related to the new categories of adult abuse. The highest incidence relates to domestic abuse with an increase of 2% to 5% compared to the previous year. The other new categories between them accounted for no more than 1%of the total of all referrals. No cases of trafficking or modern slavery were reported. The Board have identified 6 staff members from across the partnership who will roll out awareness training on modern slavery and human trafficking.
- The SAB and its partners have adopted the updated London Multiagency Procedures and have developed a full range of complementary policy, local procedures and guidance around effective risk management

OBJECTIVE 4

To develop a safeguarding culture which promotes adults at risk as being central to and fully involved in safeguarding arrangements, plans, process and any intervention

To achieve this:

- We have continued to raise public awareness and understanding of adult safeguarding through print material.
- We monitor the level of Safeguarding Enquiries for Black, Asian and Minority Ethnic (BAME) residents to ensure equality. During the current year 27% of cases involved BAME groups which is two percentage points lower than in 2015/16. The BAME population in Wandsworth is 29% according to the 2011 Census data. This reflects a positive trend which will be a foundation for further work to improve community awareness and engagement
- We have regular community representation at the Board to ensure the active participation of the wider community in shaping the local safeguarding adults response.

3 What we achieved in 2016/17

OBJECTIVE 5

To seek assurance that adult safeguarding practice is continuously improving and enhancing the quality of life of adults in the area.

To achieve this:

- The Board received a variety of performance reports during its quarterly meetings for discussion and as a means of assurance that safeguarding practice is enhancing the safety and wellbeing of adults at risk. Going forward the SAB is developing an improved multi-agency data dashboard in 2017 to measure activity and successful outcomes for adults at risk.
- We have ensured that we have embedded Making Safeguarding Personal in adult safeguarding practice through ensuing that people who are involved in the enquiry are able to define their own outcomes and to determine the extent to which the safeguarding processed helped them to achieve it. Almost 93% of people reported that their outcomes had been fully or partially met.
- The Board has maintained a commitment to a proportionate and personalised approach and more safeguarding concerns are effectively responded to at an early stage
- The Local Authority coordinated a range of audits to look at multi-agency enquiries and to provide assurance that practice is proportionate, personalised, robust, timely and leading to outcomes of improved safety and wellbeing. A commissioned external audit of practice in May 2016 covered these principles and outcomes, incorporating the views of service users and families and of partner agencies, and concluded that practice was of a good or adequate standard in almost all cases reviewed.
- The SAR policy has been reviewed and revised and can be found on the website. The SAR Protocol 2017 ensures that the relevant person, representative, family or friends are able to give their view and be involved as much as possible in any SAR undertaken.

4 Measuring Safeguarding Progress

Safeguarding Concerns

The introduction of the Care Act from 1 April 2015 introduced some significant changes in terminology and safeguarding requirements. For the purposes of this report, we are comparing Concerns and Enquiries in 2016/17 and 2015/16 to Alerts and Referrals in the previous years. Although a different definition, it allows some comparison to previous performance.

A Safeguarding Concern occurs when any safeguarding issue is first raised with Adult Social Care. After a Concern is received it is reviewed, considered and risk assessed. It will either be resolved at this stage or dealt with through another route if not considered to be a safeguarding matter, or it will advance to the next stage of the safeguarding process for fuller investigation and formal intervention. This is called a Section 42 Enquiry.

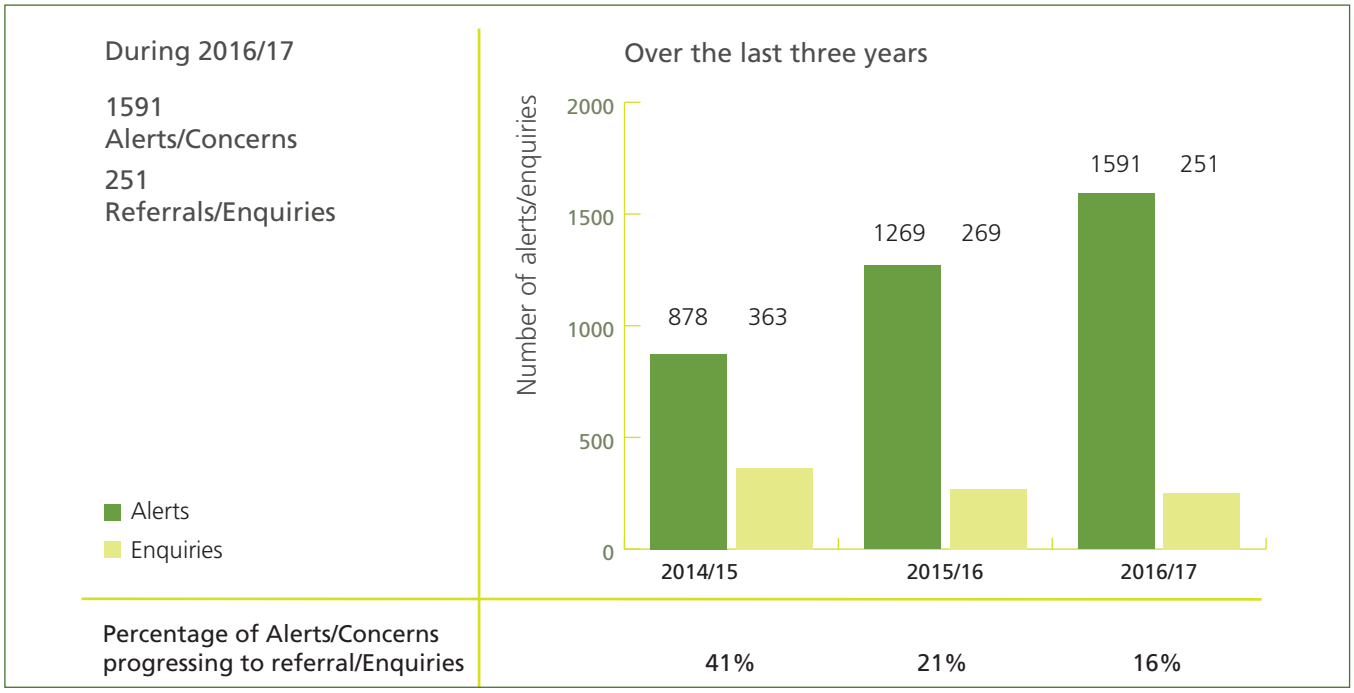
In the 2016/17 financial year:

- **1591 Safeguarding Concerns were raised,**
- **251 Enquiries commenced.**

As can be seen in Chart 1, the level of referrals have been steadily increasing over the past 3 years and there was a 25% increase in the number of safeguarding Concerns raised when compared to the previous financial year. The increasing level of referrals is positive as it reflects a growing awareness of abuse and neglect in the borough.

Enquiries have reduced by 7% in the same period due in part of an emphasis on proportionality and in part to a reporting anomaly. Consequently, 2016/17 saw the lowest proportion of Concerns progressed to Enquiry, with 16% compared to 21% in 2015/16 and 41% in 2014/15.

CHART 1: Number of referrals and percentage of enquiries



4 Measuring Safeguarding Progress

Type of alleged abuse and comparison with previous years

The three most common types of alleged abuse are:

- **Neglect - 81 incidents**
- **Physical abuse - 61 Incidents**
- **Financial abuse - 44 incidents**

Incidents of neglect usually relate to care which is provided in a care home or in the person's own home by a regulated provider. This is in part accounted for by the relativity large proportion (24%) of providers in the area rated as "Requires Improvement" by the Care Quality Commission (CQC). There is ongoing work through the Local Authority's Quality Assurance processes to work with providers to improve the quality of their services.

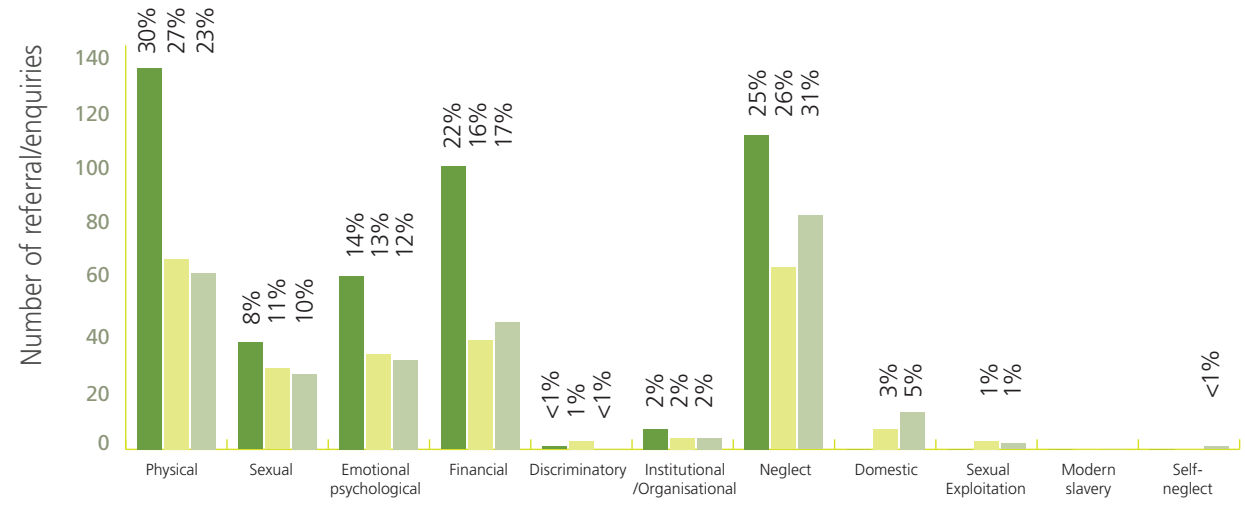
These are followed by:

- **Emotional/psychosocial - 31**
- **Sexual abuse - 25**
- **Domestic abuse - 13**
- **Institutional - 4**
- **Self-neglect - 1**

There were no cases define as discriminatory abuse and no cases of modern slavery.

The low level of self-neglect reported is a concern which may be as a result of people using the non-statutory route of CMARAP to support people who self-neglect.

CHART 2: Nature of abuse for safeguarding Referrals/Enquiries



	Physical	Sexual	Emotional psychological	Financial	Discriminatory	Institutional /Organisational	Neglect	Domestic	Sexual Exploitation	Modern slavery	Self-neglect
2014/15	132	37	60	98	1	7	109	-	-	-	-
2015/16	66	28	33	38	3	4	63	7	3	-	-
2016/17	61	26	31	44	0	4	81	13	2	0	1

4 Measuring Safeguarding Progress

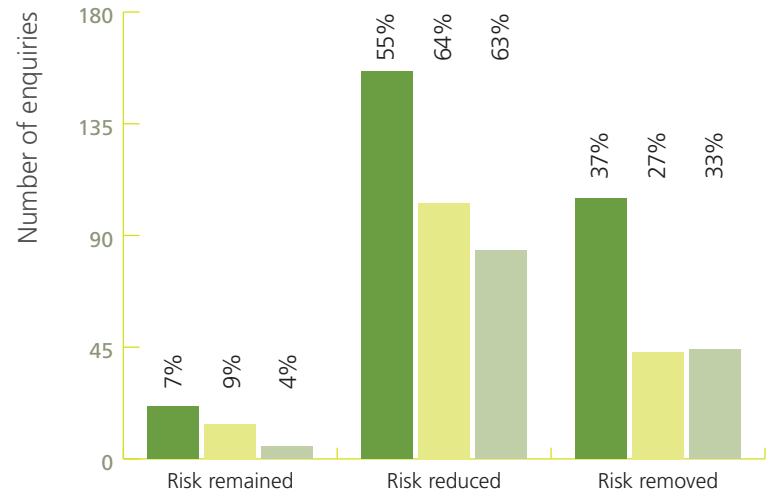
Outcomes for adults

Overall there were 133 enquiries undertaken in 2016/17. The risk was removed in 33% of these cases and reduced in 63% of cases, whilst for 4% of cases the risk remained. In circumstances of risk remaining, these cases were reviewed to ensure that effective and proportionate safeguarding responses and monitoring were in place.

Cases where the risk remains tend to involve people with decision specific mental capacity exercising their right to take risks.

Cases where risk was removed increased by 6 percentage points compared last year, which is a positive trend.

CHART 3: Result of safeguarding actions by service user group



	Risk remained	Risk reduced	Risk removed
2014/15	21	156	105
2015/16	14	103	43
2016/17	5	84	44

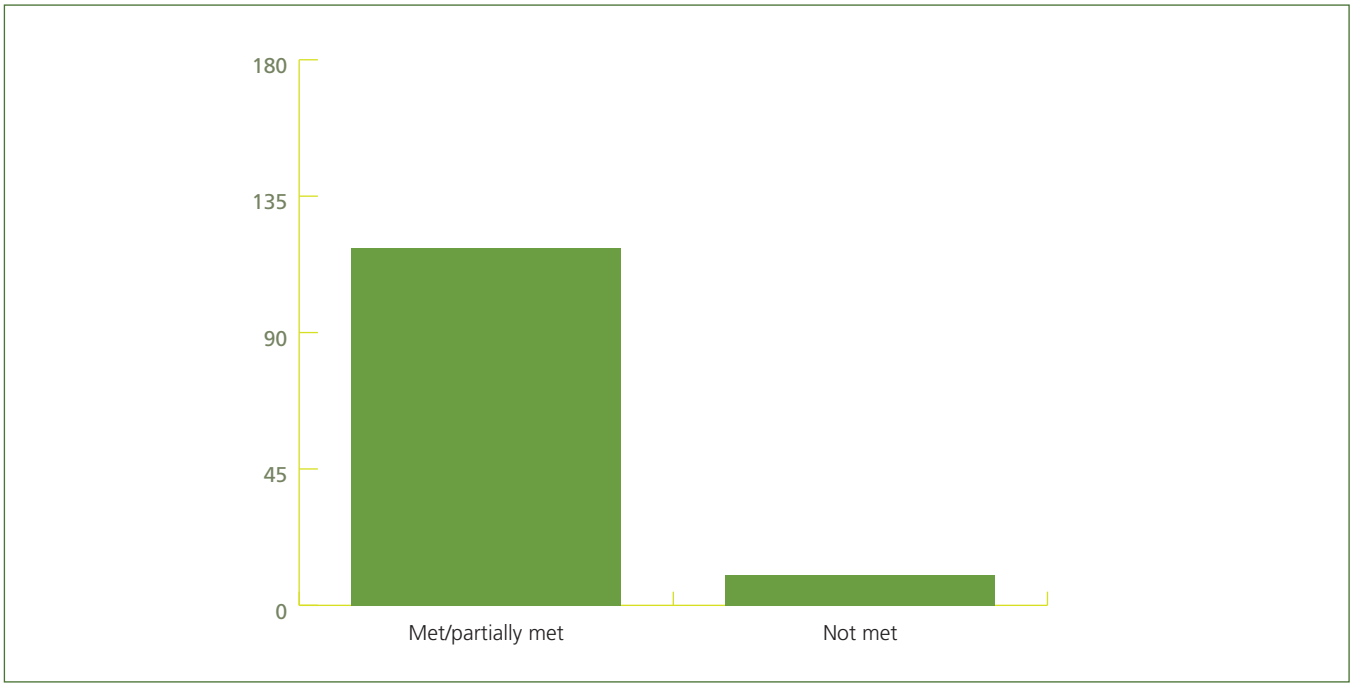
4 Measuring Safeguarding Progress

Personal outcomes achieved

Gaining both qualitative and quantitative understanding of outcomes for the person remains central to our work. We have streamlined our process to further embrace a Making Safeguarding Personal approach to safeguarding.

Chart 4 shows that nearly 93% of the adults at risk (117 people) felt they achieved the outcomes they wanted, which is a positive reflection on personalised practice. 9 people felt their outcome was not met. Outcome may not be met due to the complexity of needs and of the interpersonal relationships in the situation. In some instances they are not met as they are not realistically achievable through adult safeguarding. In all cases every attempt it made to meet the person's outcomes.

CHART 4: Personal outcome



97% of **Personal Outcomes** **fully** or **partially** met

There were 34 cases where the outcome was not recorded, this will include cases where people refused to engage in the safeguarding process as well as those not articulating an outcome or not asked at the outset of the process.

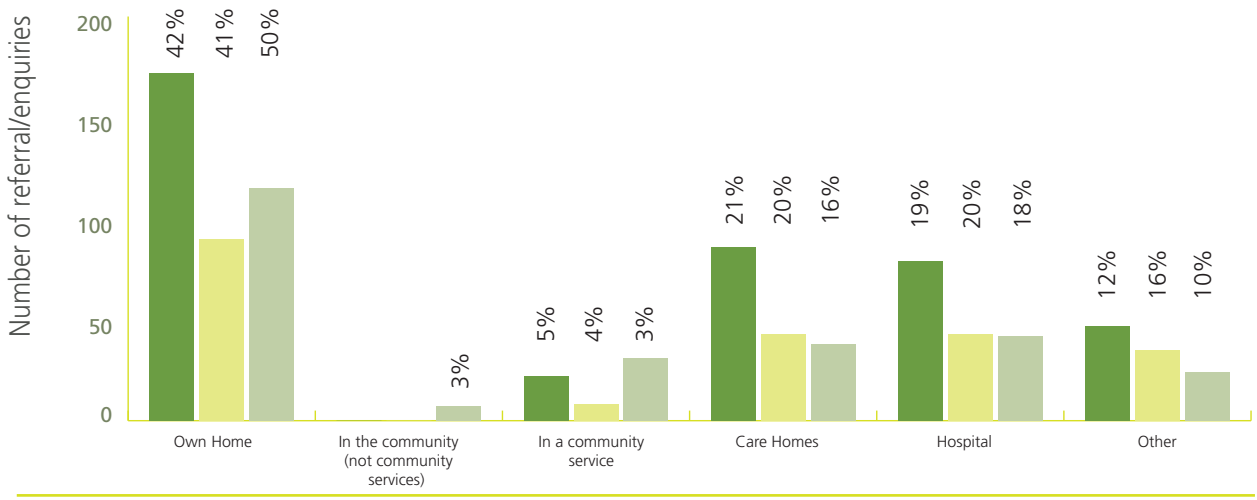
4 Measuring Safeguarding Progress

Locations of alleged abuse

As with previous years, adults at risk are more likely to be abused in their own homes (Chart 4). There were a total of 115 incidents when the alleged abuse was in the person's home, compared to 38 in Care homes and 42 in hospitals.

Compared to last year, the number of incidents in people own homes has increased while the number of incidents in care homes has reduced. The numbers in hospital are broadly similar to last year. This is reflecting the increasing proportion of people care for in their own homes.

CHART 5: Location of alerts/concerns - comparison to previous years



	Own Home	In the community (not community services)	In a community service	Care Homes	Hospital	Other
2014/15	172	-	22	86	79	47
2015/16	90	-	8	43	43	35
2016/17	115	7	6	38	42	24

50% own home
18% hospital
16% care home

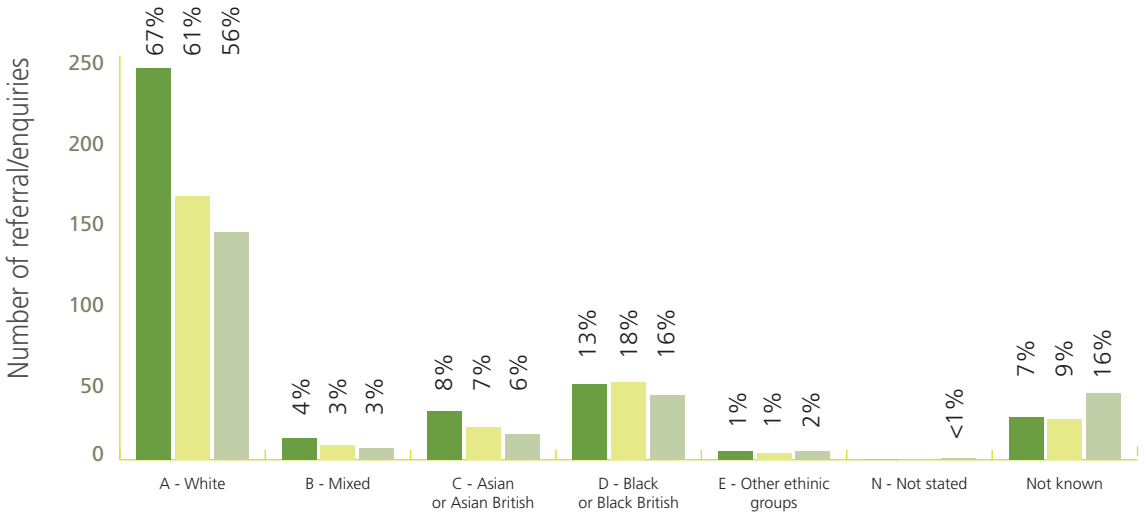
4 Measuring Safeguarding Progress

Safeguarding Enquiries by Ethnicity

There were a total of 110 safeguarding enquiries involving people who identified themselves as Black, Asian and Minority Ethnic (BAME). This is 27% of all enquiries and broadly aligned to the borough's demography which is 29% BAME. In 2015/16, 29% of all safeguarding enquiries involved BAME service users.

27% of **Enquiries** for **BAME** people

CHART 6: Ethnicity of people with safeguarding referral/enquiries



	A - White	B - Mixed	C - Asian or Asian British	D - Black or Black British	E - Other ethinic groups	N - Not stated	Not known
2014/15	242	13	3 0	47	5	0	26
2015/16	163	9	20	48	4	0	25
2016/17	141	7	16	40	5	1	41

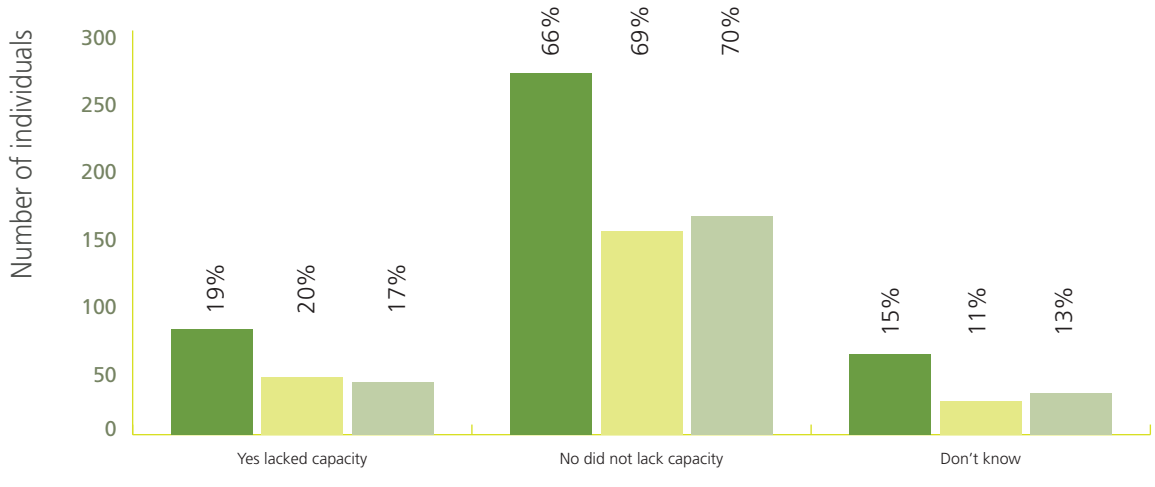
4 Measuring Safeguarding Progress

Mental Capacity

Where a safeguarding enquiry was undertaken, 162 people (70%) had capacity to engage in the enquiry and 39 people (17%) lacked capacity. In 31 cases (13%) capacity was not recorded. This is relatively similar to last year's picture.

17% of people who were **Safeguarded** lacked capacity

CHART 7: Mental Capacity of Result of safeguarding actions by service user group



	Yes lacked capacity	No did not lack capacity	Don't know
2014/15	78	268	60
2015/16	43	151	25
2016/17	39	162	31

Where people lack capacity there is a requirement to involve advocates to support people and to ensure their voice and wishes are taken into account in the enquiry.

Of the 39 people reported to lack capacity 37 (95%) had access to support via a family member or an advocate.

5 The Deprivation of Liberty Safeguards

The Deprivation of Liberty Safeguards (DoLS) place a range of statutory duties on local authorities as 'Supervisory Bodies' in the context of Schedule A1 of the Mental Capacity Act 2005 (MCA) to authorise deprivations of liberty. Since the 'Cheshire West' Supreme Court judgement in March 2014, the number or requests for DoLS authorisations has increased significantly nationally and this is mirrored in Wandsworth.

Table 1 below shows that a total of 1020 DoLS applications were received, which is a 68% increase compared to last year.

Practice has also been influenced by case law which ruled that the administration of covert medication is an interference with Article 8 of the Human Rights Act and as such must only be undertaken with the proper authorisation in place. This coupled with the National Institution for Healthcare and Excellence (NICE) Guidance stating that medication should not be administered covertly until after a best interest meeting has been held, unless in urgent circumstances, has placed a clear duty on care homes to ensure that there is a management plan in place and that the care home (as managing authority) keeps the situation under review. This has led to a number of shorter authorisations being granted with an overall increase in the number of authorisations a person may have throughout the year.

TABLE 1: DoLS Applications

Activity	2016-17	2015-16	Change from 2015-16
Total completed applications	740	540	36%
Number of incomplete applications	280	70	312%
TOTAL	**1020**	**610**	**68%**

The number of incomplete applications has significantly increases this year from 70 to 280. Similarly the number of applications not signed off has increased from 40 to 160. This corresponds to the significant demand in activity and delay in allocating, completing and signing off authorisations.

To address this the following has been put in place:

- Increasing the number of signatories across the local authority.
- Recruiting Best Interest Assessors across the local authority.
- Increased use of equivalent assessment to improve efficiency and reduce people experiencing unnecessary multiple reassessments.
- Administration has been shared with a view to improving efficiency of allocation an sharing of good practice.

5 The Deprivation of Liberty Safeguards

There has been a significant increase in the number of withdrawn applications. This is largely due to a single provider requesting a large number of applications which were considered not to have met the DoLS requirements, due to their misunderstanding of DoLS.

There has been a decrease in the number of authorisations not granted by 10%. This is due to providers being clearer on what constitutes a deprivation of liberty.

TABLE 2: DoLS Applications by status

Applications by Status:	2016-17	2015-16	Change from 2015-16
Not Granted:	65	70	-10%
Granted:	675	470	43%
Withdrawn:	120	30	307%
Not Yet Signed Off:	160	40	326%
No authorisations active at year end	550	390	42%

CASE STUDY CASE STUDY CASE STUDY CASE STUDY CASE STUDY CASE STUDY

Deprivation of Liberty safeguards in Practice - Ruby

Ruby is an 87 year old woman with dementia, who has lived in a care home for 3 months and the home manager requested a standard DoLS authorisation. During his assessment, the Mental Health Assessor (MHA) identified that Ruby was prescribed a number of medicines which had a sedative effect and suggested the care home request a review of the current medication, as there was no evidence that the medication had been reviewed for some time prior to Ruby being admitted into the home.

When the Best Interest Assessor (BIA) was undertaking her assessment, she noticed that Ruby was quite sleepy. The BIA had a discussion with Peter, Ruby's son, who commented that Ruby had been increasingly drowsy in her own home and experienced a number of falls.

The BIA spoke to the home manager and stressed the importance of the medication review to ensure that the dosage was correct. Upon reviewing the care plan, the assessor set a condition for the managing authority to carry out a Mental Capacity Assessment to see if Ruby had capacity to consent to taking her medication and if not that a Best Interest Assessment involving Peter, the prescribing clinician and pharmacist should be undertaken for the administration of medication.

The outcome of this was that Ruby's sedative medication dosage was reduced, resulting in her being more alert during the day and enjoying the daily activities the home had to offer and there was a recorded reduction in the number of falls Ruby experienced.

6 How our Partners are making a difference

NHS Wandsworth Clinical Commissioning Group

Achievements and Challenges 2016/17

NHS Wandsworth Clinical Commissioning Group (WCCG) remains a key member of the Safeguarding Adult Board, Quality Control Panel; Policy and Procedures Group; Vulnerable Adults Risk Management Meeting (VARMM) and Community Multi Agency Risk Assessment Panel (CMARAP) and has also been given the task to continue chairing of the Training and Development Group, which resulted in the development of Multi Agency Safeguarding Training Strategy. The Care Quality Commission input has resulted in more robust working arrangements with key partners and providing further assurance to the Board with regards to how the CCG maintains its statutory responsibilities around safeguarding adults as outlined in the Care Act.

The CCG continues to seek assurance within care homes by undertaking regular monitoring visits, and has undertaken joint visits with the Local Authority to address any safeguarding concerns. A full review of safeguarding polices has been completed in all care homes and changes recommended to ensure compliance with the statutory responsibilities in the Care Act. The Continuing Health Care team continues to provide expert support to care homes and recently provided Tissue Viability training in care homes, in response to concerns raised by CQC as part of providing assurance to the Quality Control Panel. The team also have offered assurance in all instances where there are quality or safeguarding concerns in a care home by reviewing all patients in that home.

The WCCG participates in Safeguarding enquires, Safeguarding Adult Reviews, Domestic Homicides Reviews and Channel (counter terrorism) panel and provides health input in complex health related safeguarding concerns and those that involve health providers. The WCCG continues to monitor and seek assurance on issues relating to safeguarding adults through various Clinical Quality Review Groups (CQRG), where any safeguarding concerns are addressed in detail and action plans formulated and implemented to address these.

The WCCG maintains up to date policies and procedures relating to safeguarding, which are developed in line with London Multi Agency Adult Safeguarding Policy and Procedures, to reflect current statutory and national guidance around safeguarding adults.

Wandsworth CCG contributed to the NHS England (London Region) development of the Mental Capacity Act and Deprivation of Liberty Safeguards Assurance Tools, which resulted in the development of 3 tools for CCGs and Providers. The tools are due to be implemented in 2017, as a way of gaining assurance for the CCG that the Mental Capacity Act legislation implemented by Providers is being monitored by the CCG. Wandsworth CCG was able to submit a good example case study, which was later published on the SCIE website as a resource to implement Mental Capacity Act.

The CCG continues to work with neighbouring CCGs as part of the South West London Peer Supervision Group, which ensures that supervision arrangements remain in place for the safeguarding leads.

6 How our Partners are making a difference

Staff training

The WCCG continues to provide training in Safeguarding Adults, through online programmes, and compliance with this is monitored through the Safeguarding Subcommittee and Board Performance Reports.

The CCG continues to support Providers with safeguarding adults and PREVENT (counter-terrorism awareness) training and has recently been involved in assisting one of the providers to secure funding from NHS England for Prevent Training. This will be implemented during 2017.

Priorities 2017/18

1. Review governance and committee structures for safeguarding across the 2 CCGs and ensure assurance is provided to each governing body relating to their area, and that all safeguarding key professionals are in place to demonstrate the CCG's commitment to safeguarding adults at strategic and governance level.
2. Develop a work plan to identify and monitor the integration of the safeguarding arrangements across the two CCGs, including alignment of the safeguarding policies and procedures.
3. Review the North West London Assurance Framework to agree preferred model for implementation across SW London. The governance for this would be through the Safeguarding Sub Committees and Clinical Quality Committees.
4. Monitor current on-going concerns involving 2 mental health hospitals, 1 NHS and 1 private, and work in conjunction with NHS England and other CCGs if required.
5. Ensure that WCCG staff and commissioned services complete safeguarding training, Mental Capacity and Deprivation of Liberty Safeguards, Domestic Violence to include: Female Genital Mutilation and Honour-based Violence, Forced Marriage, and other types of abuse, such as Sexual exploitation, Modern Slavery, and Human Trafficking, and ensure that there are systems and processes to reflect statutory requirements.
6. Ensure that WCCG staff and provider services meet the statutory requirements around 'Prevent' training and the Mental Health team are meeting their requirement around Prevent and Mental health and representation at Channel. (Channel is a programme which focuses on providing support at an early stage to people who are identified as being vulnerable to being drawn into terrorism. The programme uses a multi-agency approach to protect vulnerable people.)
7. Support GP member practices and safeguarding GP Leads to complete Safeguarding Adults training, Mental Capacity Act Training, Prevent and Domestic Violence, and to assist in ensuring that they have systems and processes that reflect the statutory requirements around safeguarding adults.
8. To implement the NHS England Mental Capacity ad Deprivation of Liberty Safeguards Assurance Tools for the CCG and Providers.
9. WCCG will continue to work with in partnership with other agencies to strengthen and promote safeguarding activities within the Borough and to provide assurance to the Board.
10. WCCG to continue with their strategic and governance oversight of safeguarding activities to ensure that the six principles as outlined in the Care Act are reflected in all safeguarding activities to have better outcomes for people at risk of abuse and neglect.

6 How our Partners are making a difference

Metropolitan Police - Wandsworth

Achievements and Challenges 2016/17

Since January 2015 the police teams involved in 'safeguarding' have been aligned under the management of one Detective Chief Inspector. This was a first for London and is seen as good practice for effective safeguarding work. This supports a more holistic approach towards safeguarding adults and children and enables improved communication and governance internally between teams, which leads to better partnership working.

There is a protocol in place for the referral to police of crime allegations and safeguarding adults' issues. This has been reviewed and updated to ensure it is fit for purpose.

The Safeguarding Adults' Board has introduced the Safeguarding Adults Review Panel (SAR) of which police are a core member and are committed to attending, supporting and providing meaningful input to improve outcomes for adults.
Resourcing continues to be a challenge. Police are represented on both the adult and children safeguarding boards and providing regular attendance at additional sub-groups is challenging, but something we are committed to.

Staff training

During 2015/16 safeguarding has been a priority for the police. Working together with both the local authority safeguarding adults and children's trainers a safeguarding package was created and delivered to all front line officers during their professional development days.
Officers from the Wandsworth Community Safety Unit (CSU) have attended the MPS domestic abuse and hate crime training course, equipping them to conduct investigations and provide victim support.

Priorities 2017/18

Police have a responsibility to safeguard all and work with both safeguarding adults and children boards. 'Safeguarding' is both an MPS and local Wandsworth priority.

All staff (of all ranks) will work towards the Wandsworth safeguarding objective;
'Safeguarding, the protection of vulnerable people, and the management of dangerous people is everyone's priority and responsibility. Vulnerability comes in many forms and is not always obvious.'

Our objective is;

- **To be proactive in identifying vulnerability**
- **Take responsibility, assess and take positive action to keep people safe**
- **Fully report and refer both internally and to relevant partner agencies**

6 How our Partners are making a difference

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How Metropolitan Police are making a difference

This example of multi-agency working refers to the case of a violent male who was repeatedly assaulting his pregnant, vulnerable partner. She would refuse to support a prosecution and calls were often made to police by concerned members of the public. The perpetrator was also frighteninging his disabled mother and would attend her address demanding money to fund his drug habit. During these visits, often when high on drugs he would subject her to threats of violence.

This case was heard at Multi-agency Risk Assessment Conference (MARAC) and also at Community Multi-Agency Risk Assessment Panel (CMARAP). Adult Social Services, Children's Social Services, Probation Service and the Police worked together to effectively safeguard the mother, partner and the unborn child. Police gathered independent evidence and pursued a victimless prosecution for the assaults committed against his partner therefore negating the need for her to give evidence. Probation enforced strong licence conditions, which he subsequently breached within hours of his release. Police expedited his arrest and had him back in custody the same day following a licence revocation. In the interim police secured a conviction against him for assault perpetrated on his partner - this resulted in a further prison sentence.

The adult safeguarding team worked with the mother and assisted her in obtaining a non-molestation order, and supported police by convincing her to allow a panic alarm to be installed should he attend their home. Following the birth of the baby the partner was placed in a mother and baby unit which was able to offer her support and guidance.

This multi-agency working ensured the on-going safety of not only his partner but also his mother and new-born child.

6 How our Partners are making a difference

Richmond & Wandsworth Local Authority - Adult Social Services

Achievements and Challenges 2016/17

Richmond and Wandsworth Adult Social Services Department has consolidated and improved on the safeguarding adult's practice. A significant development during the reporting year has been the creation of a Shared Staffing Arrangement in October 2016. As a result a joint Safeguarding Adults Team has been established across the two boroughs, providing support to the Safeguarding Adults Boards and to managers and practitioners.

There has been a continued focus on embedding the requirements of the Care Act 2014, with an emphasis on Making Safeguarding Personal through coordinating outcome-focused, personalised and proportionate enquiries, in response to an increasing number of safeguarding concerns. This has included improved guidance, updated training and staff briefings and both external and internal practice audits. An externally commissioned audit in Wandsworth during June 2016 found that 87% of enquiries were good or adequate and that safe outcomes, personalisation and proportionality were evidenced.

For the majority of people risk has been reduced or removed and their desired outcomes have been fully or partly met, and they have felt safer as a result of the safeguarding enquiry. Robust risk management arrangements are in place, mainly covering self-neglect, and these have led to significant reductions in risk through effective multi-agency risk management.

A joint Adult Social Services and Health Provider Risk Panel has improved intelligence on standards of care and contributed to Provider Concerns Enquiries, resulting in significantly improved quality of care. This is reinforced by preventative person centred care training which has been a newly introduced provision to care and nursing homes.

Staff training

Richmond and Wandsworth Department of Adult Social Services has continued to provide a comprehensive training programme to Social Care practitioners and managers to ensure that the workforce is skilled in completing safeguarding adult's enquiries that are outcome focused, personalised and proportionate. The programme is built on previous year's provision, further aligning training between the two boroughs for consistency of practice, and updating content in accordance with the Care Act and learning from regular practice audits.

The key components are Safeguarding Adults Enquiry Officer training and Safeguarding Adults Manager (SAM) training. On completing this mandatory training, managers and practitioners have received advanced training through modules on domestic situations, decision making and Mental Capacity Act.

Continued over

6 How our Partners are making a difference

Regular best practice forums have also continued this year, providing an opportunity for operational staff and safeguarding managers to share ideas, information and best practice guidance regarding safeguarding practice, creating opportunities for reflection, professional development and develop learning for evidence based decision making skills.

Training was also provided to social work practitioners and managers on a range of topics including Domestic Abuse and MARAC; Hoarding and Self Neglect; signs and symptoms of abuse, think family, risk assessment, recording, Achieving Best Evidence, Mental Capacity Act Assessments, Deprivation of Liberty Safeguards and PREVENT (Counter Terrorism).

Priorities for 2017/18

There are a number of key areas in which we intend to further enhance service standards.

1. Prevention of abuse through person centred care and basic awareness training in provider settings, increased community outreach work and safeguarding conferences across the two boroughs.
2. Safeguarding adults enquiries which are personalised and proportionate and which lead to improved safety and wellbeing; including improved involvement of service users and representatives in influencing and shaping safeguarding practice; providing clear and updated guidance to staff, alongside reflective supervision and performance review.
3. Reinforce completion of Mental Capacity Assessments and access to advocacy when necessary.
4. Further improvement in safeguarding enquiry responses to self-neglect and hoarding which lead to reduced risk.
5. Further improvement in collaboration with Health, Commissioning and Contract Monitoring partners in sharing intelligence on quality standards and safeguarding concerns, conducting provider concerns enquiries and ensuring that the safeguarding clause in provider contracts is robust.
6. Further improvement in learning from Safeguarding Adults Reviews to enhance practice, particularly in collaborating with partners.
7. Improved partnership by building on current delegated enquiry arrangements, particularly with the Clinical Commissioning Group and the Police.
8. A skilled workforce through up to date formal training, workshops and SAM forums; with further prioritisation of self-neglect and hoarding, domestic abuse and modern slavery.
9. Further externally commissioned and internal peer auditing of practice and ensuring that learning is applied through guidance and training.
10. Robust recording of protected characteristics and assurance of equality in accessing safeguarding support.

6 How our Partners are making a difference

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Sameera and Asif (not real names)

Sameera at the point of referral was a 76 year old woman who had moved to the UK with her husband and her son, Asif, 8 years previously. Her husband died shortly after arrival. Both Sameera and her son experience mental ill health and had been sectioned twice under the Mental Health Act in recent years. They became homeless and for some years have lived rough, occupying a bench day and night outside a local library. Sameera and Asif have refused all offers of accommodation as they only wish to return to their previous home, which is not available. Homeless Outreach Teams and the Police have tried to engage and encourage them to move into accommodation and to seek medical help when required, without success. They have not cooperated with Mental Health assessments but are considered to be aware of the risks and they are in receipt of benefits.

The Community Multi-agency Risk Assessment Panel (CMARAP) has provided an effective coordination and monitoring of the situation for more than 1.5 years, raising the level of intervention and offering support during cold weather spells. This has included a wide range of agencies informally monitoring, alongside formal monitoring and attempts to engage with the couple via Social Services and regular visits by a Primary Health Care Homeless and Refugee Team. Links have also been made with a local Imam and Mosque.

6 How our Partners are making a difference

Richmond & Wandsworth Local Authority – Housing

Achievements and Challenges 2016/17

During 2016/17, 32 safeguarding adult alerts were made by staff in the Housing Service. This is similar to the 30 made in 2015/16 which highlights staff being aware of their safeguarding responsibilities. The Policy and Performance Officer with responsibility for safeguarding adults has continued to meet with colleagues in adult social services to review and monitor safeguarding adult alerts which remains an effective way to monitor cases.

A safeguarding adults and children article was published in the summer edition of Homelife to raise awareness of safeguarding issues amongst Council residents which is delivered to 33,000 Wandsworth households living in council tenanted or leasehold accommodation.

The Safeguarding Adults procedure was reviewed in the year to ensure that it reflects local and best practice as well as Safeguarding Adults and Children posters being displayed in all public areas in offices as well as on each floor for staff members.

The safeguarding adults staff awareness audit was undertaken in September 2016 which will be analysed and fed back to the safeguarding adults board. There were 39 responses to the survey request. The safeguarding self-assessment audit for adults was undertaken in April and May 2016 and a short presentation on its findings provided feedback to the Board.

The Community Multi Agency Risk Assessment Panel (CMARAP) and other multi agency groups has helped to strengthen and develop joint working and has led to good outcomes for individuals. Safeguarding is reflected in operational policies and procedures and is a part of the culture of the Department. Attendance and participation in the Board and related subgroups and meetings continues.

The housing service is focussed on the need to prevent abuse and neglect for vulnerable tenants and residents. This is through the Stay Put Stay Safe Scheme, Tenancy Support services, Housing Options, Estate Managers and Sheltered Housing officers. The protocol in place between services also ensures that checks are undertaken with Adults and Childrens Social Services where legal (e.g. seeking possession) action is being considered against council tenants.

In line with other London boroughs, the Housing Service has continued to experience high homelessness demand. The main homelessness reason is eviction from the Private Rented Sector and this has led to increased use of temporary accommodation (TA).

6 How our Partners are making a difference

As at 31st March 2017 there were 1,571 households in TA compared to 1,307 last year, and of this total 1,309 were households with children or pregnant women. There have also been challenges for the service in the year around vulnerable adults who fail to engage with the housing service, fall into arrears, face enforcement action due to antisocial behaviour (ASB) or fail to maintain their tenancy conditions. This could be in situations where, for example, a tenant does not allow access or there are hoarding issues that pose a fire risk to themselves and others which is a particular challenge for the Housing Service. The service has addressed this through the implementation and promotion of risk management protocols, including the Vulnerable Adults Risk Management Meeting (VARMM) and Community Multi-agency Risk Assessment Panel (CMARAP) processes, as well as implementing actions that manage and reduce the risk. The service has worked well with other agencies to achieve good outcomes for vulnerable high risk adults. Examples of positive outcomes include: providing suitable alternative accommodation, clearing hazardous properties, increasing engagement with hard to reach individuals and helping tenants to access benefits.

Amidst a challenging year for the Housing Service, following the implementation of the Shared Staffing Service (SSA) arrangements, officers have maintained an effective joint-working relationship which will also be a key priority for 2017/18.

Staff training

The Housing Service continues to ensure that staff have a good knowledge of safeguarding. The safeguarding training course is mandatory both for new starters and existing staff.
In 2016/17 a list of officers that had not attended safeguarding training in the last 3 years was created and will be updated with future attendance. The Housing Service liaised with colleagues in the Learning and Development team so that it received reports of attendees to enable the monitoring of safeguarding training. The Department is committed to ensuring that there is complete coverage for appropriate safeguarding training which will be delivered through e-learning or classroom based training.
50 frontline officers were identified who had not completed safeguarding training or refresher training in the last three years and were sent a request to complete relevant safeguarding or refresher training. An additional 204 members of staff last received training in 2014 and will be required to complete refresher training in 2017.

Continued over

6 How our Partners are making a difference

Priorities for 2017/18

1 Training
- Ensuring all staff, both existing and new, are registered and can access TPD safeguarding training;
- Revise and develop Training Plan;
- Monitoring and increasing uptake of e-learning TPD courses;
- Ensure all SSA staff access and receive appropriate safeguarding training;
- Deliver in-house classroom based refresher training, particularly for those with limited access to computers.

2 Ensure the Joint Working Protocol between the Housing Service, Rent Collection Service, Adult Social Services and Community Mental Health Teams are completed and published;

3 Ensure (e.g. through alerts, training, learning) that Housing Services continue to make appropriate safeguarding referrals, understand when these should be made, and see clearly what actions are taken as a result;

4 Ensure that close contact and effective joint working are maintained as the SSA becomes fully integrated across Wandsworth and Richmond; and

5 Publish the Hoarding procedure for frontline staff to tackle and reduce high risk hoarding through a multi-agency approach.

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How we make a difference - Multi-agency Risk Panels

The organisation has improved the outcome of an under-occupying council tenant with suicidal ideation, significant rent arrears and who was at risk of eviction. The tenant also had addiction, mental health and self neglect issues which included hoarding and lack of access to heating and hot water. The tenant did not engage with the Council and did not keep in contact with family members.

Through intensive multi-agency work including social services, housing, rent collection, legal, police, fire brigade, mental health team and the benefits team through the Vulnerable Adults Risk Management Meetings (VARMMs) and Community Multi Agency Risk Assessment Panel (CMARAP) processes, the tenant slowly began to engage, which led to cleaning the property, reconnection to heating and hot water, claiming correct benefits, engagement with family members, moving to an appropriate sized property and a significant reduction in rent arrears which also meant the eviction proceedings were halted.

6 How our Partners are making a difference

St George's Hospital NHS Trust

Achievements and Challenges 2016/17

We have revised our safeguarding guidance and our training in line with the Care Act and the Multi-agency London Procedures, including references to self-neglect and the impact that this can have on patient's health and well-being. In our community division there is evidence of closer multi-agency working, particularly in respect of high risk cases. There is the on-going challenge of screening increased numbers of safeguarding referrals due to the widened scope of safeguarding. Additional training has been provided to senior staff within the organisation to assist with this process along with a revised flowchart and screening questions

Training

All new staff are required to complete adult safeguarding awareness training at induction. In addition all staff must complete refresher training every 3 years. Currently we have a compliance rate of 90% against a target of 85%

Priorities 2017/18

1 To roll out additional level 2 and level 3 training once the revised NHS England training framework is produced
2 To improve our understanding and compliance with the Mental Capacity Act (MCA)
3 To provide further resources to staff on both safeguarding adults and the MCA utilising our Intranet and our St Georges App.

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How we make a difference - Carol

Carol had a number of admissions to St Georges, often on the back of self-neglect and deterioration on her mental health. She lived with her husband who was her main carer. Admissions followed a similar pattern where her health would improve and she would be discharged home back into the same situation. The case was discussed extensively with the named social worker and her mental health team. Admission to a mental health unit was not deemed to be beneficial and the case was escalated to and discussed at Community multi-agency Rick Assessment Panel (CMARAP). A plan was put in place with the support of various agencies to support Carol and her husband at home. Once the agreed plan was in place Carol did not have another admission for another nine months which indicates a significant improvement in her well-being.

6 How our Partners are making a difference

South West London and St George's Mental Health Trust

Achievements and Challenges 2016/17

The Trust has been rated as 'Good' following the focussed re-inspection by the Care Quality Commission (CQC) in September. This is one of only four mental health Trusts in the whole of London to be rated 'Good' by the CQC. This has only been made possible by the hard work and dedication of all our staff providing high quality services for our patients.
The new Director of Nursing and Quality has established a monthly Executive Safeguarding Meeting that will provide comprehensive executive oversight of all safeguarding activities. Both Clinical Commissioning Groups and local authority representatives will be welcome to attend the 'open' quarterly meetings.

Training

Safeguarding adults is included in Trust induction for all staff.
Level 1 training is available through e-learning and face to face session.
The E-Learning for Health package for safeguarding adult's level 1 is up to date with latest policy and is now available on in-house Learning System with 93% compliance.
A monthly classroom based session has been provided throughout the year. It focusses on applying policy to practice and is focussed on case studies and practice examples.

Priorities 2017/18

1. From April 2017 the Trust will be moving into a new service line management (SLM) structure to improve the quality of care our patients receive.
2. Making Safeguarding Personal - Review Safeguarding Adults policy and embed the Making Safeguarding Personal Group recommendations in to practice and its workforce development plans.
3. Promote Recovery College educational sessions for service users on: 'How To Keep Yourself Safe'.

6 How our Partners are making a difference

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How we make a difference – Making Safeguarding Personal Group

A co-production project was started in June 2015 that involved MH service users from two boroughs and Trust representatives – it named itself the Making Safeguarding Personal Group (MSP Group). The MSP Group started by looking at ADASS and Local Government guidance on MSP.

How did it work?

This Trust has a long established set of systems and structures for listening to, and engaging, the people who use our services. We want to hear what they have to say about our services. And we do this at every level of service: from the frontline in our in-patient and community services and up to the most senior level on the Quality and Safety Assurance Committee (QSAC).

The MSP group was focussed on co-production. And that was the key to the success of the group. It was the group that owned the project. The rust was a member of that group. It was not the lead, it was not undertaking consultation, this was not a reference group. It was co-production. That is what underpinned the whole project.

It involved a group of people talking about a difficult subject: their own very personal, and distressing accounts of being abused and neglected. Some of the accounts dated back 30 years, some were very recent. Some required formal referral to local authority and the police. Some may have initially appeared trivial, but revealed hurtful failures to show respect and up hold dignity.

The MSP Group wanted to learn from those experiences and try to prevent anyone having to go through the same thing again.

The MSP Group recommendations:

Safeguarding should not just be a professional process, it needs a culture change. Recommendations cover what actions services should take when the service itself is alleged to have been abusive and how safeguarding should be embedded in to professional practice. It is important that existing statutory guidance is followed. And it is essential that service users are at the forefront of service developments and are represented at highest organisational levels. There is also need to increase awareness of safeguarding amongst the service user population, and for service users to know how to safeguard themselves.

Continued over

6 How our Partners are making a difference

Mental health services should:

- **Learn from what happened**
- **Promote 'Zero Tolerance' everywhere**
- **Promote social justice**
- **Uphold rights**
- **Uphold dignity**
- **Show respect**
- **Challenge discrimination**

MSP is about the person's experience of feeling abused, it is not about meeting a 'threshold'.

The MSP Group has:

- **Presented the report to the Trust Board.**
- **Had their report was included in the Trust annual report**
- **Been invited to be a member of Safeguarding Adults Board sub-group**
- **Been invited to be member of Trust Executive Safeguarding Meeting**
- **Co-produced a Recovery College educational session for service users, entitled: 'How To Keep Yourself Safe'.**
- **Held a Learning Event – opened by the local MP, with Trust staff, CCG and local authority attending.**

6 How our Partners are making a difference

Alzheimer's Society Wandsworth

Achievements and Challenges 2016/17

In 2016 the organisation introduced the safeguarding competency framework. The framework sets out the minimum competency for staff and volunteers in relation to their role. It allows staff and volunteers to demonstrate that they are competent in safeguarding by providing evidence of skills, knowledge and understanding of safeguarding within their role. The competency framework has different levels that apply throughout the organisation from volunteers through to Trustees. Line managers are required to support and assess each individual against the competencies. This highlighted individuals learning needs and development opportunities which, along with the regional training team, have strengthened the existing training opportunities internally to ensure staff have the tools to manage safeguarding effectively.

The training we provided:

The Alzheimer's Society has a culture where safeguarding adults is treated as a priority for both staff and volunteers. All staff must complete online data protection, safeguarding and Prevent E-learning modules, attend safeguarding workshops and attend local safeguarding training. Safeguarding is a standing item on monthly staff meetings and also discussed in 6 weekly supervisions.

In 2016/17 the Society introduced a system of Safeguarding Competency Framework.

During 2016/17 a Volunteer Matrix was introduced whereby each volunteer was assessed against a list of training undertaken / policies read. An individual report was then produced for each volunteer detailing the specific training requirements for particular roles and notifying the line managers of any training that still needed to be undertaken. Volunteers must also complete the mandatory data protection, safeguarding and Prevent e-learning modules before having any contact with service users. All volunteers have a one to one discussion with their line managers about safeguarding and how to recognise the signs of abuse, the different types of abuse and how to report it. All volunteers working with clients on a one to one basis must also work through a safeguarding competency framework with their line manager and as for staff, this is a living document and evidence can be added on an on-going basis. During 2016/17, the Wandsworth Alzheimer's Society trained and supported 75 volunteers.

6 How our Partners are making a difference

Priorities 2017/18

- Continued roll out of the Competency Framework.
- To report on safeguarding case studies in order to demonstrate where an incident has occurred, what action has been taken to ensure organisational learning
- To work with members of the board of trustees to consider where we can report and act upon external influences. For example, themes occurring within local authority safeguarding boards.

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How we make a difference – Lucia and Miriam

An Alzheimer's Society Dementia Support Worker (DSW) completed a home visit at the beginning of March 2017 with Lucia , originally from Europe, and her mother Miriam, who has a recent diagnosis of vascular dementia and was until two years ago living in Europe (Lucia has also been living with bipolar disorder for many years). Lucia had brought her mother to her own flat in London following a fall and hip fracture; Miriam has three other children in Europe, but no support in the UK other than Lucia, who has stopped working in order to care for her mother. The DSW allocated to this case speaks Miriam's language so was able to provide person-centred support and include her fully throughout.

Before the meeting, Lucia told the DSW over the phone that 'something' had happened but she did not want to discuss it in front of Miriam. At the meeting, it emerged that Lucia was becoming depressed, feeling trapped and overwhelmed by her caring role and struggling to meet financial needs (she had declined a previous offer of counselling). At the same time, her mother made it very clear that she is not happy here, feels isolated and wants to return to her home country.

The DSW then asked to speak for a moment privately with Lucia about the matter she had mentioned on the phone, and Lucia disclosed that, about two weeks previously, a domestic violence incident had resulted in the police being called to their house. Her mother had witnessed the events and was very shaken and upset. The DSW provided the Domestic Violence helpline number.

6 How our Partners are making a difference

Lucia and Miriam *Continued*

The DSW discussed this case with his manager the next day and as a result, reported the matter as a safeguarding alert on the grounds that Miriam was being deprived of her liberty, and there was a risk of further domestic violence. He called Lucia on the same day to explain his concerns and inform her that he was obliged to let Social Services know about the situation so that they could help Lucia keep herself and her mother safe. While initially dismayed and reluctant, Lucia accepted that this was a constructive step taken in her own interests, to help her at a time when she was under a great deal of stress. He assured her that she would be fully consulted at all stages, and he persuaded Lucia to consider that her mother may need to return to her country of origin as she wished.

The DSW then liaised with Social Services, providing additional background information as requested to help them assess the case. As a result, a meeting was arranged with Lucia and Miriam and this also included the Dementia Specialist Nurse and a representative from the CMHT, with an interpreter present to ensure that all parties would be able to understand and participate fully. The Dementia Specialist Nurse was able to assess and tell Lucia that Miriam does have capacity (although fluctuating) to decide where she wants to live.

At this meeting, Lucia reported that as a result of the DSW's advice and intervention, she had agreed with her siblings that Miriam would return to her home country after Easter, with Lucia and her other children working together to provide the support she needs. Lucia also reported that she had now separated from her partner and therefore she and her mother were no longer at risk of domestic abuse.

The DSW followed up again 3 weeks later and encouraged Lucia to request an assessment to start therapeutic counselling, which she has now done. She gave the following feedback to the DSW: "*I was very worried at first that I would have got into trouble with social services and that my mother had to go to a care-home. But after our meetings and telephone calls, I realised that you were only there to support me and my mother. I now am planning to go back to work as a teacher and I am grateful for your patience and for all the support from all professionals involved with the Alzheimer's Society, the Carer's Centre and Springfield Hospital*"

7 The Board's Plans for 2017/18

OBJECTIVE 1

Governance and Accountability

To establish and maintain an effective multiagency partnership to carry out the statutory duties of the Safeguarding Adults Board as defined in the Care Act.

- Establish Board website.
- Publish Safeguarding Adult Reviews.
- Disseminate learning from Safeguarding Adult Reviews and from regional and national work.

OBJECTIVE 2

Partnership

To work collaboratively in partnership to prevent abuse and neglect where possible and to respond to situations where it does occurs in a proportionate and appropriate way.

- Undertake annual self-assessment audit and review of action plans.
- Support partners to undertake preventive interventions focusing on improving practice and preventing abuse or neglect.
- Embed and deepen understanding of Mental Capacity Act and its application across the partnership, with specific reference to the Deprivation of Liberty Safeguards.

OBJECTIVE 3

Workforce and Local Providers

To seek assurance that there is a skilled and effective workforce across the partnership which promotes Making Safeguarding Personal.

- Ensure all partners have strategies in place to ensure training and refresher training of staff on all aspects of adult safeguarding relevant to their roles with a focus on self-neglect, modern slavery, domestic abuse, human trafficking and radicalisation.
- Arrange an adult safeguarding conference focussing on emerging themes for adult safeguarding and on partnership working.
- Ensure all contracts, service arrangements, policies and procedures within all member and partner organisations are fully cognisant of adult safeguarding and that audit is in place to examine outcomes.
- Further develop a multi-agency quality assurance and performance monitoring framework to report on local provision.

OBJECTIVE 4

Awareness, Engagement and Participation

To develop a safeguarding culture which promotes adults at risk as being central to and fully involved in safeguarding arrangements, plans, process and any intervention.

- Develop effective publicity material to raise awareness with a focus on self-neglect, financial scams, bullying and harassment, hate crime, anti-social behaviour, sexual exploitation, radicalisation and modern slavery.
- Deploy social media campaign to support awareness raising.

OBJECTIVE 5

Practice and Performance

To seek assurance that adult safeguarding practice is continuously improving and enhancing the quality of life of adults in the area.

- To promote person-centred practice across all organisations and embed the principles and practice of Making Safeguarding Personal.
- Develop innovative system for undertaking and learning from Safeguarding Adult reviews.
- Coordinate a safeguarding workshop on responding to modern slavery, to enhance collaborative practice.
- Gather feedback from adults at risk, carers and other significant people using adult safeguarding services.

8

Appendix 1 Business Plan March 2017 - April 2019

Governance and Accountability

Partnership

Workforce and local providers

Awareness, Engagement and Participation

Practice and performance

Governance and Accountability

Aim: To establish and maintain an effective multiagency partnership to carry out the statutory duties of the Safeguarding Adults Board as defined in the Care Act.

Outcome for Wandsworth Residents: *I am supported by organisations who work well together and I know who o contact if I need help.*

Objective	How	When	Outcome Measure	Responsible agency and Monitoring	RAG Status
Clearly defined board structure will effective sub groups to deliver on the SAB vision and business plan	Update SAB vision, values and business plan	March 2017	Signed off plans	SAB	●
	Review and update SAB sub groups and terms of reference	March 2017	Reviewed and updated SAB Terms of reference	SAB	●
	Review the board membership particularly in relation to regional and national players and how they contribute	March 2017	Reviewed and updated SAB Terms of reference	SAB	●
	The board has strategic links and alignment with other agencies including the Community Safety Partnership, Local Children's Safeguarding Board, CCG and Metropolitan Police.	Ongoing	Safeguarding Adults priorities aligned across partnership as evidenced through audit	SAB - SAB Audit	●
	The partners have clear, effective safeguarding strategies and implementation plans aligned to the SAB priorities	April 2018	Safeguarding Adults standards aligned to the care act are understood across the partnership	SAB -SAB Audit	●
	There is effective sharing of information safely and appropriately across the partnership.	April 2018	Board level information sharing agreement agreed and signed.	SAB	●
	Partners set and manage a budget to carry out the work of the SAB.	April 2017	Reports to SAB	SAB	●
Hold partners to account in terms of delivering on the SAB objectives and be accountable to the Health and wellbeing board.	Undertake annual self-assessment audit and review of action plans.	April 2018	Annual SAB audit and challenge event.	SAB - SAB Audit	●
	SAB produces annual report to account for safeguarding adult activities	July 2017	Annual report published.	SAB	●
	Co-operation with regional and national safeguarding initiates to grow local knowledge and share experiences	Ongoing	Annual report published.	SAB	●

● Completed ● Overdue ● At risk of being overdue ● In progress

Partnership

Aim: To work collaboratively in partnership to prevent abuse and neglect where possible and to respond to situations where it does occurs in a proportionate and appropriate way.

Outcome for Wandsworth Residents: *I have the information and support I need in order to remain as safe as possible and I know how to get help when I need it.*

Objective	How	When	Outcome Measure	Responsible agency and Monitoring	RAG Status
Develop effective referral and communication pathways between partners	Review referral routes for raising safeguarding concerns to enable alignment across the partnership	April 2018	Updated or developed referral routes between key partners including Council, Met Police, CCG, Housing partners and Wandsworth Prison	Wandsworth Council - reports	
	Develop shared protocols and procedures to complement the London Multiagency Safeguarding Procedures for effectively managing and delegating safeguarding enquires	April 2018	Agreed protocols signed off by SAB	Wandsworth Council - report	
Support and champion multiagency activities which contribute to preventing abuse and neglect	Further improved risk management to prevent abuse and respond to self-neglect embedding the CMARAP process	April 2018	Regular CMARAP panel meetings with wide partnership representation Regular information reports to SAB	Performance sub group - performance report	
	Partners undertake preventive interventions focusing on improving practice and preventing abuse or neglect	April 2018	Number of home fire safety visits Prevention of avoidable pressure ulcers and limiting the number of Serious Incidents or safeguarding enquiries Safeguarding concerns raised by Met police progressed as safeguarding Level of disability hate crime reported.	Performance sub group - report	
No people will be unlawfully deprived of their liberty	Managing authorities aware of Mental Capacity Act and make appropriate Deprivation of Liberty Safeguards (DoLS) referrals	April 2018	Number of appropriate requests for authorisation of DoLS.	Performance sub group - report	
	Authorisation of DoLS will be processed effectively within timescales	April 2018	Proportion of authorisations completed in legal timescale	Performance sub group - report	

Workforce and local providers

Aim: To seek assurance that there is a skilled and effective workforce across the partnership which promotes Making Safeguarding Personal.

Outcome for Wandsworth Residents: *I have considerate support delivered by competent people who work in my best interests, as I see it.*

Objective	How	When	Outcome Measure	Responsible agency and Monitoring	RAG Status
Ensure all partners have a safe and appropriately trained workforce	Agree training plan focussing on joint training opportunities	April 2018	Level of attendance at joint training across partnership	Workforce, Training and Community Awareness sub group - performance report	
	Ensure all partners have strategies in place to ensure training and refresher training of staff on all aspects of adult safeguarding relevant to their roles with a focus on self-neglect, modern slavery, domestic abuse, human trafficking and radicalisation	April 2018	Training data provide to the SAB via a survey	Workforce, Training and community awareness sub group -performance report	
	Bi-annual adult safeguarding conference focussing on emerging themes for adult safeguarding locally	December 2017	Successful conference	Workforce, Training and community awareness sub group - performance report	
	All partners have an agreed adult safeguarding appraisal objective for every member of staff	April 2018	Staff survey	Workforce, Training and community awareness sub group - performance report	
All partners have a full range of policy, procedures and guidance that provides a framework within which organisations can work together effectively to respond to abuse and neglect	Adopt London multiagency Procedures and develop a full range of complementary policy, local procedures and guidance around effective risk management	April 2018	Procedures adopted and on SAB web site	SAB	
	Ensure all contracts, service arrangements, policies and procedures within all member and partner organisations are fully cognisant of adult safeguarding and that audit is in place to examine outcomes	April 2018	Annual SAB self-assessment audit and challenge event	SAB - SAB self-assessment Audit	
SAB is assured about the safety and quality of local adult social care providers	Further develop a multi-agency quality assurance and performance monitoring framework to report on local provision	Ongoing	Proportion of Care Providers where concerns enquiries have been undertaken.	Performance sub group - performance report	

Completed Overdue At risk of being overdue In progress

Awareness, Engagement and Participation

Aim: To develop a safeguarding culture which promotes adults at risk as being central to and fully involved in safeguarding arrangements, plans, process and any intervention.

Outcome for Wandsworth Residents: *I feel safe. I can live the life I want and am supported to manage any risks.*

Objective	How	When	Outcome Measure	Responsible agency and Monitoring	RAG Status
Increased public awareness and understanding of adult safeguarding	Develop effective publicity material to raise awareness with a focus on self-neglect, financial scams, bullying and harassment, hate crime, anti-social behaviour, sexual exploitation, radicalisation and modern slavery.	April 2018	Publication of well-designed material to raise awareness of adult abuse.	Workforce, Training and Community Awareness sub group - report	
	Develop a public engagement, communication and safeguarding awareness strategy, utilising partners forums and community structures	April 2018	Programme of activities with a focus on safeguarding week	Workforce, Training and Community Awareness sub group - report	
	Deploy social media campaign to support Awareness raising	April 2018	SAB web site and social media presence	Workforce, Training and Community Awareness sub group - report	
	Increased engagement with community groups to raise awareness including Black and Minority Ethnic, faith and Lesbian, gay, Bisexual and transgendered communities.	April 2018	Improved community outreach	Workforce, Training and Community Awareness sub group - report	
Involve adults (their representatives and or their carers) who have experienced, or are at risk of abuse and neglect, to shape and influence the development of safeguarding practice.	Gather feedback from adults at risk, carers and other significant people using adult safeguarding services.	April 2018	Feedback on safeguarding experience reported to SAB	Wandsworth Council Safeguarding team	
	Ensure representation and active participation of voluntary and community sector on SAB and the SAB sub groups	April 2018	Regular community representation at SAB	SAB - Annual report	

Practice and performance

Aim: To seek assurance that adult safeguarding practice is continuously improving and enhancing the quality of life of adults in the area.

Outcome for Wandsworth Residents: *I am sure professional will work in my best interest as I see them and that I will be involved actively in any discussions or decisions about my life.*

Objective	How	When	Outcome Measure	Responsible agency and Monitoring	RAG Status
To promote person centred practice across all organisations and embed the principles and practice of Making Safeguarding Personal	To promote person centred practice across all organisations and embed the principles and practice of Making Safeguarding Personal	April 2018	People whose safeguarding outcomes are met.	Performance sub group - report	
			People who felt safer after safeguarding	Performance sub group - report	
			People who lack capacity supported by IMCA or others in the safeguarding process.	Performance sub group - report	
	Improve management of less usual forms of abuse and neglect such a self-neglect, modern slavery, human trafficking	April 2018	Recognition and reporting of self-neglect, modern slavery, human trafficking	Performance sub group - report	
	Develop an agreed Multiagency policy for working with people who self-neglect and or hoard.	April 2018	Policy agreed	Workforce, Training and Community Awareness sub group - policy	
	Ensure that the Mental Capacity Act and its application to adult safeguarding is embedded across the partnership	April 2018	All partners have up to date safeguarding policies which reflect requirements of the Mental Capacity Act	SAB - Annual report	
		April 2018	All people who lack capacity are offered access to a representative or a paid advocate to ensure that practice is focussed on the individual and their wishes	Performance sub group - report	

Completed Overdue At risk of being overdue In progress

Set out a SAB SAR policy and procedures	Publish updated SAR policy and keep it under review	April 2017	Updated policy published	SAR sub group - report	
	Robust arrangements to decide on and report back on SARs.	April 2018	Regular meetings of and reports from SAR sub group	SAR sub group - Performance Report Annual Report	
Update SAB on levels and outcomes of adult safeguarding activity	Monitor agreed Performance measures and report to the SAB	April 2018	Safeguarding referral and enquires by equality strands	Wandsworth Council - Performance report	
		April 2018	Number of repeat safeguarding enquiries	Wandsworth Council - Performance report	
		April 2018	Safeguarding concerns by type of abuse.	Wandsworth Council - Performance report	
		April 2018	Safeguarding enquires by location of abuse	Wandsworth Council - Performance report	
		April 2018	Safeguarding enquiry outcomes – risk remains, removed reduced	Wandsworth Council - Performance report	
		April 2018	Benchmarking data with analysis of Wandsworth performance	Wandsworth Council - Performance report	

9 Glossary of Terms

In using this document, a number of phrases, wording or acronyms have been used. The following provides more information and where necessary a definition

Adult at risk

A person aged 18 or over who is in need of care and support regardless of whether they are receiving them, and because of those needs are unable to protect themselves against abuse or neglect

Advocacy

Taking action to help people who experience substantial difficulty contributing to the safeguarding process to say what they want, secure their rights, represent their interests and obtain the services they need.

Cheshire West Judgement

On the 19th March, the Supreme Court published its judgment in the case of P v Cheshire West and Chester Council and P and Q v Surrey County Council. This judgment has clarified the "acid test" for all people who lack capacity to make decisions about whether to be accommodated who are:

- Not free to leave
- Under continuous supervision
- Under the responsibility of the state

The court ruled the person's compliance or lack of objection to their placement, the purpose of it or the extent to which it enables them to live a relatively normal life for someone with their level of disability were all irrelevant to whether they were deprived of their liberty

The judgement widened the application of the Deprivation of Liberty safeguards including people in care homes and supported living placements. This judgement resulted in a significant increase in the number of DOLS cases numbers regarding care home placements, and also applications to the Court of Protection to authorise deprivations of liberty in supported living.

Covert medication and deprivation of liberty

This case is known as AG v BMBC & Anor [2016] where District Judge Bellamy has given useful clarification as to the seriousness of the consideration that must be given to the use of covert medication, especially in the context of DOLS authorisation. The judge held that

- The use of medication without consent or covertly whether for physical health or for mental health must always call for close scrutiny. Covert medication is a serious interference with a person's autonomy and right to self-determination under Article 8. It is likely to be a contributory factor giving rise to the existing DOL. Safeguards by way of review are essential.

- The managing authority has a duty to monitor for any change in a person's circumstances on an ongoing basis. This obligation exists no matter how long or short the stipulated duration of the authorisation granted. There must be a care plan setting out clear roles and responsibilities for monitoring and addressing the issue of when a review is necessary.

The guidance to supervisory bodies is that

- If a person lacks capacity and is unable to understand the risks to their health if they do not take their prescribed mediation and the person is refusing to take the medication then it should only be administered covertly in exceptional circumstances;
- before the medication is administered covertly there must be a best interest decision which includes the relevant health professionals and the person's family members;
- if it is agreed that the administration of covert medication is in their best interests then this must be recorded and placed in the person's medical records/care home records and there must be an agreed management plan including details of how it is to be reviewed.

Deprivation of Liberty Safeguards (DoLS)

The Deprivation of Liberty Safeguards (DoLS) are an amendment of the Mental Capacity Act 2005. The safeguards aim to make sure that people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom. The safeguards set out a process that hospitals and care homes must follow if they believe it is in the person's best interests to deprive a person them of their liberty, in order to provide a particular care plan. The Deprivation of Liberty Safeguards can only be used if the person will be deprived of their liberty in a care home or hospital. In other settings the Court of Protection can authorise a deprivation of liberty.

Care homes or hospitals must ask a local authority if they can deprive a person of their liberty. This is called requesting a standard authorisation. A recent court decision determined that a deprivation of liberty occurs when:

- a person is under continuous supervision and control in a care home or hospital, and
- is not free to leave, and
- the person lacks capacity to consent to these arrangements.

There are six assessments which have to take place before a standard authorisation can be given.

If a standard authorisation is given, one key safeguard is that the person has someone appointed with legal powers to represent them. This is called the relevant person's representative and will usually be a family member or friend.

Other safeguards include rights to challenge authorisations in the Court of Protection, and access to Independent Mental Capacity Advocates (IMCAs).

Independent Mental Capacity Advocate (IMCA)

Established by the Mental Capacity Act (MCA) 2005 IMCAs are mainly instructed to represent people where there is no one independent of services, such as family or friend, who is able to represent them. IMCAs are a legal safeguard for people who lack the mental capacity to make specific important decisions about where they live, serious medical treatment options, care reviews or adult safeguarding concerns.

Making Safeguarding Personal

Making Safeguarding Personal is a sector led initiative which aims to develop an outcomes focus to safeguarding work, and a range of responses to support people to improve or resolve their circumstances. It is about engaging with people about the outcomes they want and ascertaining the extent to which those outcomes were realised at the end.

MSP seeks to achieve:

- A personalised approach that enables safeguarding to be done with, not to, people
- Practice that focuses on achieving meaningful improvement to people's circumstances rather than just on 'investigation' and 'conclusion'
- An approach that utilises social work skills rather than just 'putting people through a process'
- An approach that enables practitioners, families, teams and Board to know what difference has been made

MARAC (Multi-Agency-Risk-Assessment-Conference)

MARAC (Multi-Agency-Risk-Assessment-Conference) is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists from the statutory and voluntary sectors. A survivor is referred to the relevant MARAC if they are an adult (16+) who resides in the borough and are at high risk of domestic violence from their adult (16+) partner, ex-partner or family member, regardless of gender or sexuality. After sharing all relevant information they have about a survivor, the representatives discuss options for increasing the safety of the survivor and turn these into a co-ordinated action plan. The MARAC will also consider other family members including any children and managing the behaviour of the perpetrator. Information shared at the MARAC is confidential and is only used for the purpose of reducing the risk of harm to those at risk.

At the heart of a MARAC is the working assumption that no single agency or individual can see the complete picture of the life of a survivor, but all may have insights that are crucial to their safety. The responsibility to take appropriate actions rests with individual agencies; it is not transferred to the MARAC.

Organisational abuse

The mistreatment or abuse or neglect of an adult at risk by a regime or individuals within settings and services that adults at risk live in or use, that violate the person's dignity, resulting in lack of respect for their human rights.' (Care and Support Statutory Guidance, 2014)

Outcome

An Outcome is what the person who has experienced abuse or neglect wants from any work that is done with them. This may be that they feel safer but it also may mean that they feel that their choices and wishes have been respected. Measuring outcomes helps the Board to answer the question "What difference did we make?" rather than "What did we do?"

Person/organisation alleged to have caused harm

The person/organisation suspected to be the source of risk to an adult at risk

PREVENT

PREVENT is part of the government's counter-terrorism strategy. Its aim is to stop people becoming terrorists or supporting terrorism. Its relevance to the work of the Board is that safeguarding work can play a part is in protecting people at risk of harm from being drawn into terrorism-related activity against their will. All government department have been required to carry to training through approved Workshops to raise Awareness of prevent (WRAP). Compliance with this training and ensuring that the local referral mechanisms are working is a key part of the work of the Board.

Safeguarding Adult Manager (SAM)

The person who manages, makes decisions, provides guidance and has oversight of safeguarding concerns that are raised to the Local Authority.

Safeguarding Concern

This is the term used to describe when there is or might be an incident of abuse or neglect and it replaces the previously use term of 'alert'.

Safeguarding Enquiry (Section 42 Enquiry)

Establishes whether any action needs to be taken to stop or prevent abuse or neglect, and if so, what action and by whom the action is taken. Previously this may have been referred to as a 'referral'.

Safeguarding Enquiry Officer

The member of staff who undertakes and co-ordinates the actions under Section 42 (Care Act 2015) enquiries.

10 Contact Points

Reporting a Safeguarding Concern

You should always contact:
The adult social care Access Team: **020 8871 7707**
Email: **accessteam@wandsworth.gov.uk**

Community Mental Health Team: **020 8767 3411**
Safeguarding Adults Team: **safeguardingadults@wandsworth.gov.uk**

Find out more about adult abuse **www.wandsworth.gov.uk/aboutadultabuse**

Remember that in an emergency you should always call the Police or Emergency Services on: 999

Deprivation of Liberty Safeguards - Reporting And Advice

Deprivation of Liberty Safeguards (DoLS) are managed by the DoLS Team:
Phone: **020 8871 8701**
Email: **dols@wandsworth.gov.uk**

Questions about this Report

If you have any questions about this report, please email
safeguardingadults@wandsworth.gov.uk
An easy read version is available at ...

Remember, safeguarding is everyone's business

If you have difficulty understanding this publication and you would like this leaflet in a different language, large print, or Braille please call 020 8891 7971.

Wandsworth
Safeguarding
Adults at risk

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