Merton Council

Healthier Communities and Older People Overview and Scrutiny Panel

Date: 24 January 2024
Time: 7.15 pm
Venue: Council chamber - Merton Civic Centre, London Road, Morden SM4 5DX

AGENDA

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Healthier Communities and Older People Overview and Scrutiny Panel membership

Councillors:

Agatha Mary Akyigyina OBE (Chair)
Jenifer Gould (Vice-Chair)
Laxmi Attawar
Caroline Charles
Eleanor Cox
Joan Henry
Andrew Howard
Simon McGrath
Slawek Szczepanski

Substitute Members:

Sheri-Ann Bhim
Jil Hall
Linda Kirby MBE
Michael Paterson
Tony Reiss

Co-opted Representatives

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What is Overview and Scrutiny?

Overview and Scrutiny describes the way Merton's scrutiny councillors hold the Council's Executive (the Cabinet) to account to make sure that they take the right decisions for the Borough. Scrutiny panels also carry out reviews of Council services or issues to identify ways the Council can improve or develop new policy to meet the needs of local people. From May 2008, the Overview & Scrutiny Commission and Panels have been restructured and the Panels renamed to reflect the Local Area Agreement strategic themes.

Scrutiny's work falls into four broad areas:

- ⇒ **Call-in**: If three (non-executive) councillors feel that a decision made by the Cabinet is inappropriate they can 'call the decision in' after it has been made to prevent the decision taking immediate effect. They can then interview the Cabinet Member or Council Officers and make recommendations to the decision-maker suggesting improvements.
- ⇒ **Policy Reviews**: The panels carry out detailed, evidence-based assessments of Council services or issues that affect the lives of local people. At the end of the review the panels issue a report setting out their findings and recommendations for improvement and present it to Cabinet and other partner agencies. During the reviews, panels will gather information, evidence and opinions from Council officers, external bodies and organisations and members of the public to help them understand the key issues relating to the review topic.
- ⇒ **One-Off Reviews**: Panels often want to have a quick, one-off review of a topic and will ask Council officers to come and speak to them about a particular service or issue before making recommendations to the Cabinet.
- ⇒ **Scrutiny of Council Documents**: Panels also examine key Council documents, such as the budget, the Business Plan and the Best Value Performance Plan.

Scrutiny panels need the help of local people, partners and community groups to make sure that Merton delivers effective services. If you think there is something that scrutiny should look at, or have views on current reviews being carried out by scrutiny, let us know.

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Committee: Healthier Communities and Older People Scrutiny

Date: 24/1/24

Agenda item: Merton Safeguarding Adults Board (MSAB) Annual Report 2022/23

Wards: All

Subject:

Lead officer: Aileen Buckton, Independent Chair, Merton Safeguarding Adults Board

Lead member: Cllr Peter McCabe, Cabinet Member for Health and Social Care

Contact officer: Catherine Dunn, Merton Safeguarding Adults Board Manager
Catherine.dunn@merton.gov.uk

Recommendations:

A. To note the content of the Merton Safeguarding Adults Board (MSAB) Annual Report for the period 2022-23.

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

This report provides the Healthier Communities and Older People Scrutiny Panel with an overview of the Merton Safeguarding Adults Board (MSAB) Annual Report which covers the period April 2022 to March 2023. The full report can be found in Appendix 1. Comment and feedback from the Scrutiny Panel will be shared with the Chair of the Health and Wellbeing Board and the Independent Chair of the Merton Safeguarding Adults Board.

2 BACKGROUND

2.1. The Safeguarding Adults Board is an independent board which operates at a strategic level to oversee safeguarding arrangements in a local area and ensure that adults at risk being supported and protected from neglect and abuse. Core members of a SAB are the local authority, police, and Integrated Care Board (ICB) with an independent chair but will also include partners such as the fire service, probation services, housing, Healthwatch, voluntary sector and representatives from community safety, children services, and other health bodies. The Merton Safeguarding Adults Board includes the following agencies:

- St George's University NHS Foundation Trust
- Healthwatch Merton
- Merton Connected
- Probation Service
- London Fire Brigade (LFB)
- Clarion Housing Group Limited
- Mental Health Trust

- NHS Southwest London Integrated Care Board (ICB)
- Central London Community Healthcare NHS Trust (CLCH)
- London Borough of Merton
- Metropolitan Police
- Safer Merton
- Merton Children's Safeguarding Partnership

2.2. The Merton Safeguarding Adults Board has a statutory duty to publish an annual report outlining how effective the work of the Board has been against its strategic priorities as set out in its Strategic Plan for 2021-24.

2.3. The Annual Report 2022/23 provides a summary of the work that has been undertaken over the previous financial year 2022 – 23 through the MSAB as a partnership and its sub-groups but also its member agencies. This includes assurance of effective safeguarding arrangements in Merton and progress against the strategic priorities of the Board, as well as information on Safeguarding Adults Reviews (SAR) carried out that year. An overview of the MSAB governance is provided in the report itself.

3 DETAILS

3.1. A key highlight from this year in the work of the MSAB as a partnership was our engagement with people who have lived experience of safeguarding through working with the daughters of SK 'Sandra' who was the subject of a SAR published last year. Sharing their experiences of caring for their mother - as well as her experience of engaging with services - has been invaluable in giving a voice to SK as a person and identifying areas of learning and improvements for future. They have continued to work with us over the year 2023-24 and demonstrated the immense value of hearing from people with lived experience to strengthen safeguarding practice.

3.2. The successful launch of a Community Adult Safeguarding Champions Network last year was an additional highlight and an important step forward for the MSAB in strengthening connections with the wider community in Merton. This group is made up of representatives from local organisations and the wider community and meets regularly with the aim of raising awareness of safeguarding adults, sharing key messages, and building insight into key safeguarding issues for local communities across Merton.

3.3. During 2022-23, the MSAB received 3 Safeguarding Adults Review (SAR) referrals over the course of the year which were considered by the SAR Subgroup. 1 SAR was published in this reporting period – 'Annabel'. Safeguarding Adults Reviews are carried out when an adult with care and support needs dies and there are concerns about abuse and neglect or how agencies have worked together. The focus of these reviews is on learning, not blame so that actions can be identified to improve how the system work in future and better safeguard individuals.

3.4. Further detail on this SAR ('Annabel') is included in the report and work is underway to implement these actions. Members of Healthier Communities Scrutiny may wish to read more information on SARs, recent reviews and learning briefings on the MSAB website.

3.5. Merton continues to have a good track record on Making Safeguarding Person with 95% of enquiries concluded in 2022/23 where a person's preferred outcomes were fully or partially met and risk reduced in over 93 % of cases. The Annual report also includes analysis of safeguarding data for 2022-23 including more detailed ethnicity analysis of safeguarding concerns and enquiries. Further work is being carried out through the MSAB Performance and Quality subgroup to develop multi-agency safeguarding data for the Board's assurance.

3.6. The report includes detail about training and multi-agency learning sessions over the course of the year. Level 1 Safeguarding Adults Training is available on the MSAB website which can be accessed by all agencies, Members, and the wider community. This training covers awareness of adult safeguarding, recognising signs of abuse and neglect and what steps to take.

3.7. The commitments for the following year (the current financial period 2023 – 24) are set out in the report and progress on these will be reported in next year's annual report for 2023/24.

3.8. The current strategic plan runs from 2021 – 2024 so work will be undertaken by the MSAB to set a new strategic plan for the following four years to further our work as a partnership and provide assurance of effective safeguarding arrangements in Merton.

4 ALTERNATIVE OPTIONS

4.1. N/A

5 CONSULTATION UNDERTAKEN OR PROPOSED

5.1. The Annual Report has had contributions from key partners such as the ICB, Police, Health, Fire Brigade as well as colleagues internally in Adult Social Care. The MSAB Board reviewed and approved the final draft on 6 Dec 2023 and a previous draft was considered by the Strategic Safeguarding Group on 21 November 2023. The Annual Report will also be considered by the Health and Wellbeing Board on 23 January 2024.

5.2. Comment and feedback from Healthier Communities and Older People Scrutiny will be shared with the Chair of the Health and Wellbeing Board and Independent Chair for the Merton Safeguarding Adults Board.

6 TIMETABLE

There are no financial or resource implications from this report as it summarises activity over the past financial year March 2022 -March 2023

7 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

7.1. None arising from this report

8 LEGAL AND STATUTORY IMPLICATIONS

8.1. The Merton Safeguarding Adults Board has a statutory duty to produce an annual report outlining progress against the priorities in its Strategic Plan as specified in the Care Act.

9 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

9.1. N/A – none arising from this report

10 CRIME AND DISORDER IMPLICATIONS

10.1. N/A – none arising from this report

11 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

11.1. N/A – none arising from this report

12 APPENDICES – THE FOLLOWING DOCUMENTS ARE TO BE PUBLISHED WITH THIS REPORT AND FORM PART OF THE REPORT

Appendix 1 -MSAB Annual Report 2022- 23

13 BACKGROUND PAPERS

MSAB Strategic Plan 2021 - 2024

Merton Safeguarding Adults Board

Merton Safeguarding Adults Board

Annual Report 2022 - 23

Message from the Independent Chair

This report covers the work of the Merton Safeguarding Adults Board during the period March 2022 – 2023.

This year, the Board has continued to focus on how we develop our engagement with local communities and hear from people with lived experience of safeguarding, such as Sandra's Story. I am delighted to see the successful launch of Community Adult Safeguarding Champions Network this year, which is a significant development for the Board. Representatives from local organisations across Merton and members of the wider community have signed up as Champions and engaged in the network. This will be an important vehicle for reaching out to our local communities and raising awareness about safeguarding to residents across the borough.

As we look ahead to the next year, we are committed to working in partnership with the Merton Child Safeguarding Partnership to embed a Think Family and transitional safeguarding approach. As joint Chair for both partnerships, I can see how vital this work is and how it will make a difference for adults, children and young people across Merton.

I once again extend my sincere thanks to all partners in the Board and the business support team for their work over the year and look forward to continuing our ambitious programme of work. I would like to express my particular thanks to Nicola Brownjohn for covering the position of Independent Chair for part of this year.

Aileen Buckton

Independent Chair of the Merton Safeguarding Adults Board

Safeguarding Adults at Risk in Merton

Merton Safeguarding Adults Board (MSAB) is made up of a collection of local organisations both statutory members (Local Authority, Integrated Care Board (ICB) and Police) and non-statutory members (provider health services, fire, housing, probation, Healthwatch and the voluntary sector and other provider services).

We work together as a partnership to ensure adults at risk of abuse or neglect with care and support needs (whether or not those needs are being met by any agency) receive appropriate advice, support and guidance to keep themselves safe and ensure they are safeguarded in a proportionate, empowering and responsive manner.

What we do and how we do it

The role of the MSAB is to assure itself that local safeguarding arrangements are in place to help and protect adults in Merton. Our main objective is to assure itself that local safeguarding arrangements and partner organisations act to help and protect people aged 18 and over in the area who have needs for care and support and:

- are experiencing, or at risk of, abuse or neglect (as a result of their care and support needs)
- are unable to protect themselves from either the risk of, or experience of, abuse or neglect regardless of whether the local authority are funding care or not.

Core Duties

The core duties of the Safeguarding Adults Board are to:

- develop and publish a strategic plan setting out how they will meet their objectives and how their member and partner agencies will contribute.
- publish an annual report detailing how effective their work has been.
- commission safeguarding adults' reviews (SARs) for any cases which meet the criteria for these. (See -Safeguarding Adults Review Section)

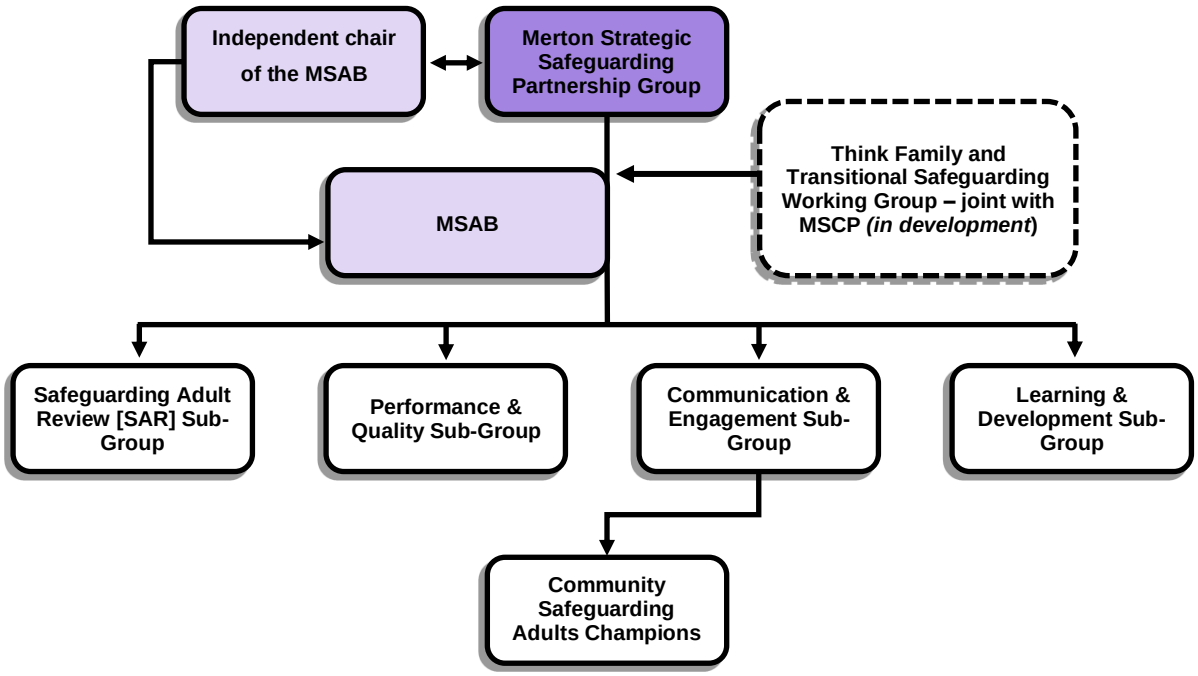
Governance Structure

In 2022-23 the MSAB continued to work closely with the Merton Safeguarding Childrens Partnership (MSCP). This included activities delivered together and the attendance of key representatives to link the MSAB, the MSCP Executive and MSCP Full Partnership. The MSAB and MSCP continued to share an Independent Chair, including via interim cover, which has further supported this.

Additionally, a Think Family & Transitional Safeguarding Subgroup will also meet for the first time in in 2023-24. This new subgroup was initiated as an outcome from the March 2023 Joint Safeguarding Conference, to work on the delivery of important

cross cutting themes, as well as building on already established links across the partnerships.

A new Strategic Safeguarding group is in the process of being set up with the first meeting in 2023-24. This new group will provide senior level strategic oversight of safeguarding for the MSAB and the MSCP.



Merton Safeguarding Adults Board

Strategic Safeguarding Group	•Chaired by LB of Merton Chief Executive and co-chaired by SW BSU Chief Superintendent •Provide senior oversight of the MSAB and MSCP, including annual reports, priority setting and key themes
Think Family & Transitional Safeguarding Subgroup	•Delivery of activity around key themes for both partnerships, including but not limited to Think Family, transitional and contextual safeguarding, housing conditions

MSAB Strategic Plan 2021-2024

Priority 1 - Prevention and Early Detection

Our aim- Adults from all communities will feel supported to keep safe. Partners, service users, carers and residents will recognise risk and be confident in their response.

Priority 2 - Building and Strengthening Connections

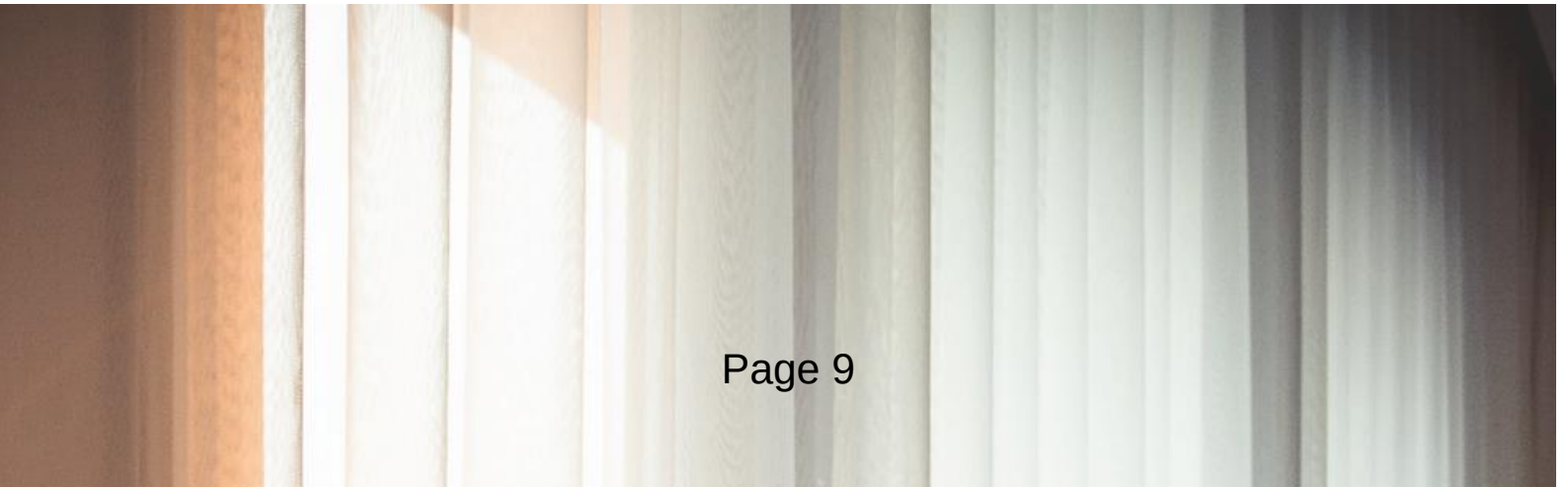
Our aim- Partners, service users and residents from all communities are engaged and working together to ensure an inclusive safeguarding framework.

Priority 3 - Making Safeguarding Personal

Our aim- People will feel listened to and have real choice and control in shaping their safeguarding journey.

Priority 4 - Quality Assurance & Embedding Learning

Our aim- Establish a Quality Assurance & Performance Framework to provide assurance that the Board and its partner agencies have effective systems, structures, processes, and practice in place to improve outcomes and experience in the context of safeguarding adults at risk.
To learn from reviews, for example SAR's, Domestic Homicide Reviews (DHR) and



In 2022-23 We Said, We Would

We set out specific commitments for action in the previous MSAB annual report 2021-22 on how we would work together in partnership to progress against the four strategic priorities in our Strategic Plan.

- Develop a program of work to engage people with lived experience and to include their voices in the work of the Board as well as the Safeguarding Adult Review (SAR) action planning process.

- Continue our work around learning from SAR's. To focus on what SAR's are telling us in terms of themes we might be seeing and how, as a partnership, we can improve our practice for those at risk.

- The Communication and Engagement Subgroup of the Board will work with Merton Connected on developing a model of Community Safeguarding Adults Champions. They will be the vehicle for raising awareness of safeguarding adults in the community and amongst its residents, as well as informing the board of what's needed to support the community and to identify any emerging issues.

- Develop a data set and analyse meaningful information to support the Board with Prevention and Detection so that adults from all communities will feel supported to keep safe.

- The MSAB will be kept updated and prepare for the implementation of the Care Quality Commission's framework on Oversight for Local Authorities and Integrated Care Systems, due to be introduced in April 2023.

What we did to achieve this

‘Sandra’s Story’ Working in Partnership with People with Lived Experience – Making Safeguarding Personal

Work has begun to engage people with lived experience to support the improvement of safeguarding work in Merton. One example of this work is how we have engaged with the daughters of Sandra. Following the SK Safeguarding Adults Review (SAR), now known as Sandra’s Story, we sought the views of Sandra’s daughters to share their experience. They have since spoken at the joint MSAB and MSCP conference well as **Epsom and St-Helier’s Hospital** Annual safeguarding conference to share their story and experience. The learning has been immense, and we thank them both for their contributions.

Plans are underway with the CLCH Patient Experience Team to produce a video which can be used on the MSAB website, for learning events and for wider SAR learning.

Comments and evaluations on ‘Sandra’s Story’ from the Joint Safeguarding conference:

“Sandra story - having people with lived experience brings so much more meaning and learning - with them bringing a perspective and details that professionals can't possibly bring.”

“Highlights the impact on the whole family and need to consider whole family needs.”

“Ensure we cross over with children and adults and understand children's experience as it will influence them in adult life, but also understanding adults’ experiences.”

“Commitment to change and hearing the voice of the child /think family.”

“Remembering the words of those who experienced our services and how we missed opportunities to support and safeguard them better and how we can remain curious and respectful and work alongside families in distress to create plans to bring about change.”

Learning from SARS and practice development – Prevention and Early Detection

Analysing themes from recent Safeguarding Adults Reviews has been a focus of the SAR Subgroup. This year the subgroup has looked at improving how agencies work collaboratively together on complex cases, particularly where there is a high level of risk and where the person with care and support needs declines support.

This work developed from a recent SAR 'Colin' and has resulted in a new framework to guide a multi-agency and coordinated approach to cases where there is a high level of risk. The 'Multi-Agency Risk Assessment Tool' is currently being used by the partnership to support their work with adults at risk and further work will continue in 2023/24 to embed this approach. Alongside this framework, the subgroup has been looking at self-neglect and supporting improved practice through a self-neglect and hoarding tool to help practitioners working on these cases.

Developing the Community Safeguarding Adults Champions Network – Building and Strengthening Connections

In 2022-23, the MSAB partners established the Community Safeguarding Adults Champions initiative. The launch took place in National Safeguarding Week November 2022 which successfully recruited representatives from the local community as well as some key organisations from the Voluntary Sector. The network has grown to 30 members since its launch. Forums have been well attended by Community Champions and key topics around adult safeguarding have been covered including a dedicated session on modern slavery and exploitation.

Meet the Champions!

"We work with vulnerable adults. By becoming Safeguarding Champions, we are making a public declaration as to the importance of safeguarding within our organisation, whilst also ensuring we are able to keep up to date and continue to cascade key messages to staff, volunteers and our beneficiaries."

Veronica Fleming and Daljinder Nagi, Imagine Independence

"Vestry Hall has hundreds of unique visitors pass through its doors every week. It is so important that we can all recognise potential safeguarding issues and know how and whom to report"

Julie Noel, Manager of Vestry Hall

I became a safeguarding champion because I want to be confident that I am doing the right thing when working with the public and the people who use our services".

Sabriti Ray, Project Manager Ethnic Minority Centre Merton

" We work to support vulnerable women and girls, safeguarding is always uppermost in our mind. It's imperative that we all can recognise signs of safety and confidently refer individuals when we have concerns".

Maureen Bailey and Camz Campbell, Inner Strength Network

Developing Data Collection - Quality Assurance & Embedding Learning

Collecting meaningful data to support the work of the Board has been a high priority for the Board over 2022-23. This includes a deep dive into ethnicity data relating to concerns and enquiries which is outlined further below in this report.

The MSAB has been working closely with partners over the course of this year to identify data by partners on key safeguarding areas and will continue to build on this work next year over 2023-24. Audits also continue to be undertaken of the safeguarding adults process and information to support quality assurance and provide learning to improve outcomes for people in Merton.

Progress on our Strategic Priorities – feedback from partners

1. Prevention and Early Detection

Partners have worked together to ensure staff and volunteers working in the community have a basic knowledge of awareness of Safeguarding Adults. The Safeguarding Adults Level 1 training which is accessible to all partner agencies, including the voluntary sector was launched in November 2022. A free E-learning package is available on the Merton Safeguarding Adults Board website training platform.

During National Safeguarding Week 2022 the **SW London Integrated Care System (ICS)** held a conference focusing on the National Themes for Safeguarding which are: "Responding to Contemporary Safeguarding Challenges". They looked at the challenges of dealing with abuse, exploitation, or neglect and how harm can have a devastating and long-lasting impact on victims, their families, and carers.

It was outlined that how safeguarding adults at risk remains a priority for Southwest London ICS and the aim of this conference was to increase awareness, so as a collective system, they can continue to keep vulnerable adults at risk safe, wherever people live and whenever they access services.

Responding effectively to domestic abuse is a priority that is woven throughout the work partners do to support adults at risk. Support from **Safer Merton** continues and in 2022-23 they funded an Independent Domestic Violence Advocate (IDVA) to join the Local Authority First Response Team initially for 12 months. This will assist with improving early identification of domestic abuse cases as well as improve staff's knowledge and understanding.

Safer Merton has also led on 'White Ribbon' accreditation and Merton Council achieved accredited status in November 2022, demonstrating the commitment in the borough to ending violence against women and girls by men and boys. Multi-Agency Risk Assessment Conference (MARAC) continues to be held regularly and has representation from the Safeguarding Adults Team as well as other partners, including statutory members of the MSAB.

Merton Housing colleagues have revised their domestic abuse processes to support improvements around prevention and early detection of domestic abuse. They are now using the Domestic Abuse, Stalking and Honour Based Violence (DASH) tool, bringing housing assessments in line with best practice.

Domestic Abuse Case Study

The example below shows how the expertise of specialist Independent Domestic Violence Advocates (IDVA) can support early intervention and prevention of further harm. In this case, effective professional expertise and partnership working ensured that the victim at risk was identified and action taken to safeguard her from further harm:

"A softly spoken male victim approached a female IDVA stating that he was being abused. His comments included "my partner hits me with an umbrella, she has mental health issues and one day she will hurt herself" as well as other comments that seemed strange. The IDVA in this case was not totally satisfied that the male was the victim and felt the female maybe the person at risk. Something did not sit right for the IDVA, so she decided to refer the case to the Multi-Agency Risk Assessment Conference (MARAC).

When MARAC discussed the case, there was not a lot of information about either from party agencies and after lengthy discussions all partners said that they felt that the female was the likely victim and were worried about her safety. Collectively we agreed to ask a male IDVA to talk with the male to help understand the dynamics of the relationship.

The male IDVA contacted the self-referred male and during that conversation he spoke completely differently to way he spoke to a female IDVA. He came across very bold, arrogant, and self-entitled and said that he would be the one to hurt the female and he was trained in martial arts and the female would not be able to defend herself. Following this disclosure, the male IDVA called 999 and the male was arrested and charged with several offences. The female partner was contacted by an IDVA, offered support and was now safe.

It is not always the case that a perpetrator presents as a victim but in this case, it showed how professional curiosity, partnership working to discuss the case, shared professional opinions and information helped to safeguard the female. It also demonstrates the effectiveness of MARAC and how agencies worked extremely quickly together to achieve an excellent outcome."

The London Fire Brigade (LFB) published its Community Risk Management Plan (CRMP) in January 2023 and includes a seven-year commitment and action plan for Londoners. There was considerable consultation with all communities in London to shape the plan and as a result it outlines how the LFB will engage with all communities going forward, including Community Forums. The Borough Commander in Merton is working closely with the Board and in particular the Subgroups to ensure the CRMP is communicated to all partners and community groups. In 2023-24 a program of learning events will be scheduled.

In 2022-23 **partners** have worked hard to get the Community Safeguarding Adults Champions network and quarterly forums off the ground. This was launched in National Safeguarding Week 2022 and Partners participated in the promotion of the network via their individual platforms as well as using the MSAB website to advertise forums and the Safeguarding Adults E-learning training, which is very much part of equipping Champions in their role.

Partners, including **Central London Community Health Care Trust (CLCH), Mental Health, St George's** as well as the Board and **Merton Childrens Safeguarding Partnership (MSCP)** have delivered safeguarding conferences in 2022-23. Focus has very much been around learning and particularly sharing learning from local and national Safeguarding Adult Reviews (SAR's).

Local Police continue to share information and intelligence with partners via systems already set up including MARAC. Working together to keep vulnerable children, young people, and vulnerable adults safe from harm, by safeguarding, initiative-taking and investigation is a priority and partners continue to improve practice in this area. A key improvement has been having the right representation at the right meetings to improve outcomes for people using safeguarding services.

Colleagues from the **MET SW Borough Command UNIT** delivered Road Shows in 2022/23 which were held virtually and in person. The events were shining a light on safeguarding during and post the COVID-19 pandemic. There was a particular focus on reaching the voluntary and community sectors who contribute towards public protection and keeping people safe during the current challenging times. Positive feedback came from the voluntary and community sectors in relation to the improved relationships between them and the police.

3. Making Safeguarding Personal

In 2022, **Merton Adult Social Care,** led on the introduction of a new process called 'Discovery Interviews' to support the gathering of feedback and gaining valuable insight, directly from people who had been through a Safeguarding Adult Enquiry.

Over the coming year, plans are in place to role this approach out further with the Safeguarding Adults Managers (SAM's) taking the lead. This will help strengthen the voice of people going through the safeguarding process, as well as to identify learning areas, make improvements to the systems used, and support people through what can be a difficult process.
Colleagues from the **SW BCU** have been trained in trauma informed practice and utilising this approach when working with individuals with complex needs. Officers have reported listening to adults at risk and respecting their views as well as working with them to achieve the desired outcomes. This includes considering alternative

avenues for addressing behaviour and not unnecessarily criminalising adults at risk, where this is appropriate.

The **SWL ICB** have supported the introduction of new approach to patient safety incidents – PSIRF (Patient Safety Incident Response Framework) –which came into place this year. This new approach will change the way that the system learns from patient safety incidents and events. Compassionate engagement and involvement of those affected has been highlighted as an important aspect of the PSIRF framework.

The MSAB SAR Subgroup has been focusing on the voices of people with lived experience who have gone through the SAR process and continues to develop this work. Feedback from family and friends with lived experience remains a focus to inform how people using services are supported.

4. Quality Assurance and Embedding Learning

As done in previous years, Board partners completed the Safeguarding Adults Partnership Audit Tool (SAPAT), followed by a Challenge Event to look at the findings and to inform the annual priorities.

In 2022-23 we have seen good engagement and representation from diverse partners from all the MSAB Subgroups which has enhanced ownership of the MSAB priorities and contributed to improving practice for those at risk. Co-chairs, include partners from **CLCH, Integrated Care Board (ICB), Merton Connected and Adult Social Care (ASC).**

Achievements in 2023 have included the launch of a New Multi-Agency Risk Assessment Framework and Tool following the 'Colin' SAR as outlined above. This was signed off by the Board in December 2022. Further work around the implementation and review of the Framework will take place in 2023-24. The Board continues to undertake and learn from SAR's. Three SAR's have been completed in 2022-23 and one has been published (See Section on SAR's).

In February 2023 Michael Preston Shoot, who led the review of the SAR Analysis 2018-19, provided a workshop for Board members around the SAR process. It covered decision making, legal literacy, commissioning, Quality Markers and learning and service improvement. The Merton SAR Protocol was reviewed to incorporate this information as well as any learning from the review process in Merton and included the updated SCIE Quality Markers.

Following feedback from managers and staff regarding the SAR Process and challenges often faced in terms of the issues raised by staff and how they might be left feeling, the SAR Subgroup Co-Chair delivered a workshop on Compassion Fatigue. Also led by the SAR Subgroup, guidance to support managers and staff has been produced and is available on the MSAB website.

7-minute briefings have been developed to share the learning and they sit alongside published SARs on the website. Learning Events are also arranged to share SAR learning and further work is underway to measure the impact of learning on practice as well as for people using services, asking the key question 'What difference has this made?'.

The Work of the Subgroups

Safeguarding Adults Review (SAR)	Considered SAR referrals and commissioned reviews in line with the SAR Protocol	**Learning and Development**	Level 1 Safeguarding Adult Training available free and to the Voluntary Sector, Faith communities, volunteers and the wider community.
	Raised awareness of the contribution of people with lived experience in the SAR process at the Joint Conference 2022		Online training now available on the website to raise awareness of prevent, radicalisation and extremism
	Guidance for Managers and Staff to support them during the SAR Process.		Raising awareness of Fire Safety through promoting news, campains and engagement from the LFB
			Promoted the Think Family approach in collaboration with the MSCP
Performance and Quality	Continued to progress the work on gathering data for MSAB quality assurance	**Communication and Engagement**	Launched the Community Safeguarding Adults Champion Network November 2022
	Produced a Multi-Agency Risk Assessment Framework and Tool for complex and high risk cases		Arranged quarterly forums for the Champions with speakers on topics such as the work of the Board, Scams and Financial Abuse
	Developed and piloted 'Discovery Interviews' to hear the voices of people having experienced the safeguarding adult enquiry process.		Advertised events for National Safeguarding Week November 2022 as well as MSAB partner events
			Updated and maintained the MSAB Website as a resource for partners

(MSCP) and the Merton Safeguarding Adults Board (MSAB) Joint Conference – March 2023

On 15th March 2023, Nicky Brownjohn, the interim joint chair led the annual conference for Merton's Safeguarding Adults Board and Safeguarding Children's Partnership: ***Domestic Abuse Safeguarding: "Learning from the Lived Experience of Trauma from Child to Adult".***

Councillor Peter McCabe, Cabinet Member for Health and Social Care, and Councillor Brenda Fraser, Cabinet Member for Children's Services provided the opening addresses.

Hayley Tuffin delivered a keynote speech on trauma informed practice which set the scene for the afternoon, looking at the lifetime impact of childhood trauma.

CLCH followed with a session about Safeguarding Adult Reviews, taking us from an overview of the national learning from reviews to a Merton SAR. Lorel and Kerylyn were introduced as the daughters of SK and spoke from their lived experience of being hidden young carers, when they were children, to their parent who could not manage their own care and support needs.

This provided the conference with a vital picture of how services saw the adult at risk without seeing the children. Lorel and Kerylyn showed us how important it is for professionals to 'think family' to prevent harm. Lorel has since presented their story in video form that is accessible via the MSAB website.

Feedback has demonstrated the impact and learning gained from people with lived experience as well as giving an opportunity to people to describe how it was for them, which does not always happen.

For the final part of the conference, Safer Merton spoke about the impact of domestic abuse on children, and their lifelong trauma. They provided advice on how to approach individuals who disclose domestic abuse: '*Begin from a place of empathy'.*

The conference ended with break out room activities to consider the next steps in our learning. Key outputs were:

1. Continue strengthening relationship-based practice
2. Let's be bold, let's create a Think Family charter
3. Focus on children, don't just listen to the adult
4. Adult and children services working together
5. Consider the recurring themes: Relationships

This year the MSAB and MSCP Joint Chair and Statutory partners have been reflecting on the key outputs for the conference and are working together to develop the Strategic Safeguarding Partnership to support the safeguarding strategic priorities and governance of both partnerships. This group will be jointly chaired by Merton Chief Executive and the Met Police.

A joint Think Family and Transitions working group will also be developed in 2023-24 to look at areas such as learning from reviews, transition from Children to adults and other agendas that impact on both adult and children's safeguarding.

Safeguarding Adult Reviews- 2022-23

The Board received three SAR notifications during 2022-23. One notification was approved for an in-depth review, and one other is awaiting further information and one did not meet the criteria for a review.

Three other reviews were concluded during the last year, two of which were not published. The Board considers the publication of each review on a case-by-case basis recognising that in some situations, there are factors which mean that is not appropriate to publish – such as the wishes of the family or where the individual has suffered serious harm or neglect.

SAR Notifications received	**3**
Reviews initiated	**1**
Reviews completed	**3**
Reviews published	**1**

SAR Annabel (published 31st March 2023)

Annabel was a mother to several children from different relationships. At the time of her death, she was still considered a permanent resident in LB Merton but had been living in temporary accommodation in Brighton & Hove since January 2021. In her short life, Annabel had experienced multiple trauma, through rape as a teenager, significant domestic violence and abuse in several relationships, multiple miscarriages and the separation from her children due to care proceedings.

Annabel and her family had been known to several agencies within and outside of Merton due to incidents of domestic abuse leading her to seek emergency accommodation outside of Merton. During the time period under review, Merton Children's Services escalated their involvement to child protection and subsequently issued care proceedings in relation to four of Annabel's children, which was an enormous shock to the whole family and devastating for Annabel.

Annabel experienced multiple crises of physical and mental ill health, including several attempts to take her life. In December 2020, a road traffic collision left Annabel temporarily paralysed and with care and support needs. The children's care

proceedings concluded with the judge ordering for the children to live with extended family members and limited contact was granted to Annabel. Annabel sadly took her own life on 5th March 2021 by taking an overdose. She was 34 years old.

Key Learning Points

- Adequately managing risk for vulnerable mothers if the local authority proposes care arrangements for their children outside the family home.

- A think family approach is required to be fully embedded in circumstances where children's services are initiating court proceedings. Adequate input is required from a range of adult services who know the mother, to feed into planning at the stage of the child protection processes.

- Vital information must be shared about risks of self-harm or suicide linked to their despair, so support can be provided.

The MSAB and the MSCP are committed to the learning from the Annabel review and are working together to ensure system changes and improvements are made.

Learning from Life and Death Reviews (Previously LeDer)

The National programme aimed at making improvements to the lives of people with learning disabilities is known as “Learning from Lives and Deaths” People with a learning disability and autistic people, previously known as The Learning Disability Mortality Review (LeDeR). It requires that reviews are carried out following the death of anyone with a learning disability and those people who have a diagnosis of autism.

The purpose of the review is to identify whether there are any concerns or areas of learning to improve the health and quality of care for people with learning disabilities. These reviews are conducted by South West London Clinical Commissioning Group (CCG) and the findings are reported to NHS England.

All deaths notified to the programme are reviewed locally by trained reviewers. The focus of each review is to identify good practice and what has worked well, as well as where improvements to the provision of care could be made.

In 2022-23 there have been nine reviews carried out for Merton.

The figures show for completed reviews to date, out of the nine, one person had a Learning Disability and Autism, whilst eight recorded a Learning Disability. Five people had ethnicity classed as white British and one white Irish. Two were from a Black Asian Minority Ethnic community (one ethnicity was not recorded).

Over the year, three males and six females were reviewed. Four lived in care homes, two in supported/sheltered living, whilst three lived at home with family. All died in hospital except for one person who had good end of life care at home with services to support. The youngest was 18 and the oldest 73 (both females). There were no unavoidable deaths.

Concerns identified in Life and Death Reviews:

- Concerns were raised around neglect.
- Lack of appropriate weight management and dietary management in the community.
- Delay in accessing a timely mental health assessment.
- Non-attendance for health screening or appropriate age-related screening.
- Reported delays in specialist equipment being put in place.
- Transition handover, including communication from Children’s to Adults could have been improved.

Positive Practice identified in Life and Death Reviews

- One report showed good planning and end of life care at the care home (which were the persons wishes).
- Report of good care in hospital and another report of excellent end of life care provided in hospital.
- Two reports showed good GP involvement, with timely access to care and services with dignity, kindness, compassion, and respect.
- One report identified very good care and relationships between the carers and the person.
- Demonstration of comprehensive community assessments by dementia diagnostic team, and same person whilst in hospital a non-pharmaceutical approach via one-to-one support was used rather than medication. The day centre in this case were also able to refer directly to dysphagia team without having to go via GP.
- A review showed cultural awareness on death, hospice had open door policy and supported the person and family well at home.

Learning and Development

The Board has offered several learning and development opportunities for partners over the course of this year. The delivery of Blue Light training was a key action which emerged from the recommendations of the SK SAR review to improve how services work with people who are alcohol dependent.

Safeguarding Adults Level 1 E-training is now available on the MSAB website where it can be accessed by partners, voluntary sector and the wider community – including our Community Champions Network. 62 people have booked onto this training, with 24 completing and 34 ongoing.

Overview of learning events and training sessions	
Multi Agency Learning Events	**Compassion Fatigue 1st March 2023.**
	WDP Drug & Alcohol Treatment in Merton 8th July 2022.
	Bitesize training London Fire Brigade 30th June 2022.
SGA Champions Network,	**Safeguarding Community Awareness film**
	Financial abuse and Scam Awareness – Dec 22
Public Health-Blue Light Training,	**1 day training =79**
	2-day Train the Trainer =7
MSAB Learning Sessions	**February 2023 - Decision Making Regarding SARs (Michael Preston-Shoot).**
	December 2022 - Office Public Guardian

Merton Council Adult Safeguarding Training	
Safeguarding Adults Level 1	82
Safeguarding Adults Level 2 ASC Health 2020	**38**
Safeguarding Adults Level 3	**9**
Care Certificate - Standard 10: Safeguarding Adults	**1**
Modern Slavery and Human Trafficking	**17**
Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS)	**58**
Safeguarding Adults	**47**
Mental Capacity Act Level 1	**2**
Mental Capacity Act Level 2	**36**
Safeguarding Adults - Basic Awareness	**1**
Safeguarding Adults Managers - Level 3	**15**

Safeguarding Adults Data 2022 - 23

During 2022-23 850 concerns were received by Merton Local Authority in total. This is an increase of 40 (5%) on the number of concerns raised in 2021-22 Section 42 enquiries were commenced in 392 cases and Other enquiries commenced in 64 cases, giving a total of 456 enquiries commenced. This is an increase of 9 (2%) on 2021-22 and represents a conversion rate (concerns raised to enquiries started) of 54%.

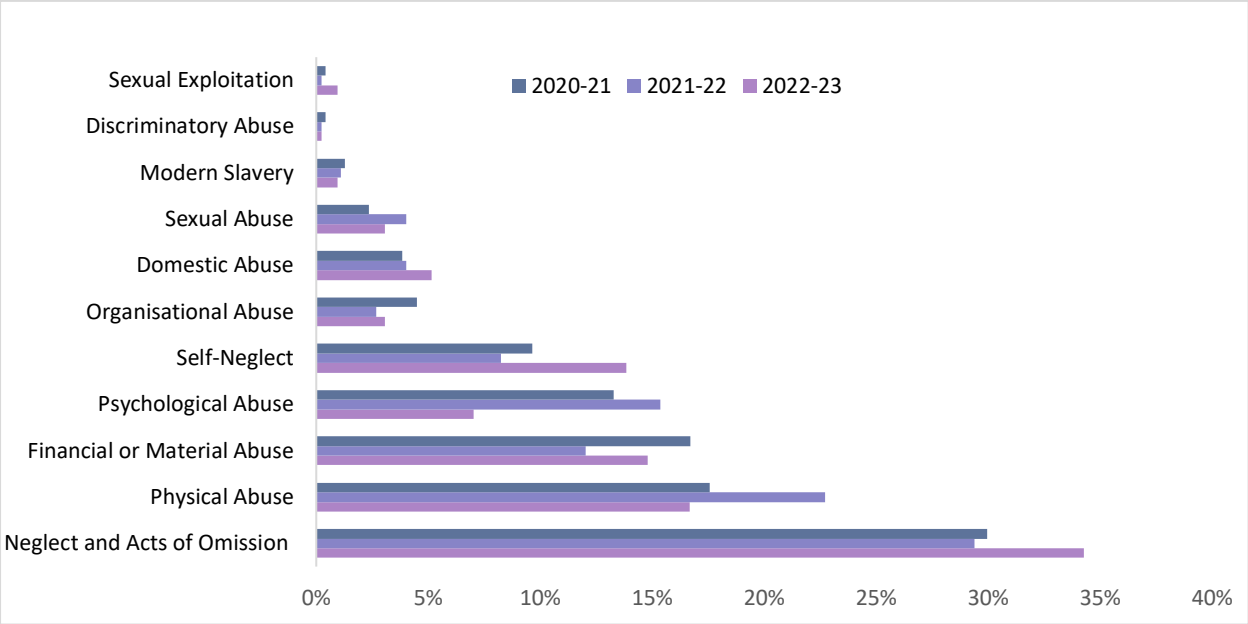
The percentage of the conversion rate is slightly lower this year and is attributed to improved understanding of the thresholds for safeguarding adults at risk. In 2023/24 further work is planned in the Safeguarding Adults and DoLS Team to address the conversion rate to ensure it reflects closer to the national and London average.

In terms of type and location of risk in enquiries, 61% were reported to be in people's own homes, in common with previous years, and there was a slight increase in percentage of 'Neglect and Acts of Omission' risks (4%). Safeguarding Adults data for all local authorities is published by the Department for Health and Social Care each year including all London boroughs and can be viewed here.

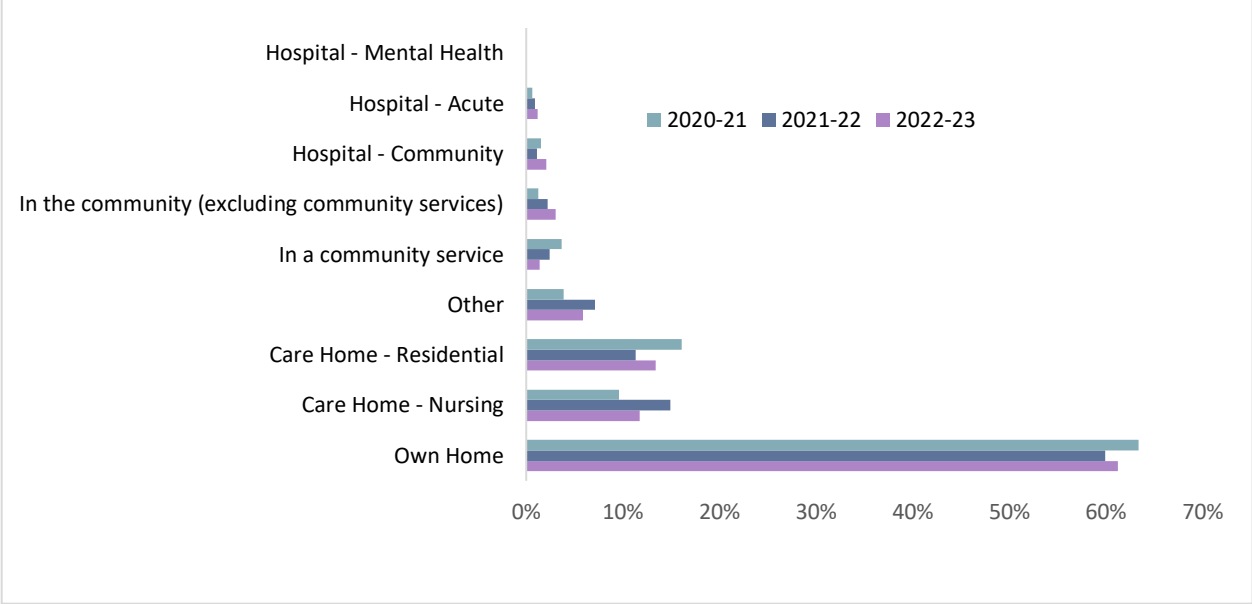
Year	2022-23	2021-22	2020-21	2019-20
Total number of Adult Safeguarding Concerns raised during the year	**850**	**810**	**830**	**732**
Total number of Adult Safeguarding Enquiries commenced during the year	**456**	**447**	**379**	**366**
Conversion Rate in Merton (Number of Section 42 Enquiries + Number of Other Enquiries) /Number of Concerns	**54%**	**55%**	**46%**	**50%**
Conversion Rate (England)	**33%**	**34%**	**34%**	**37%**
Conversion Rate (London)	**35%**	**33%**	**33%**	**41%**

Type and location of risk in enquiries 2022-23

Type of risk in concluded enquiries during the year 2022-23



Location of risk in concluded enquiries during the year 2022-23

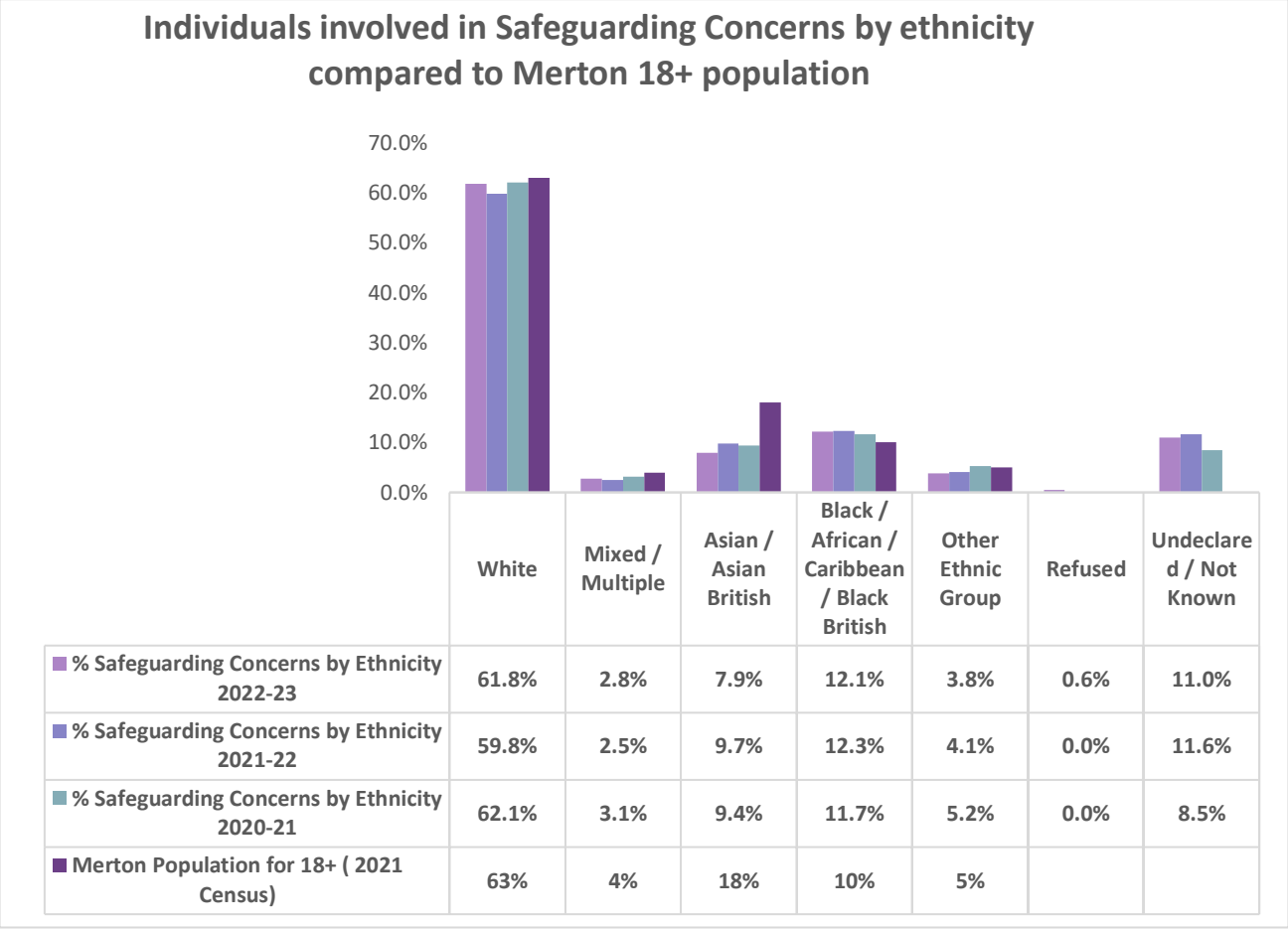


Safeguarding Ethnicity Data 2022-23

This year we have continued to analyse our data in relation to Ethnicity. This analysis helps us to understand inequalities but also identify where we need to focus our work to address where there are disparities. The Performance and Quality Assurance Group will continue to review this data.

During 2022/23 7.9.% of people from Asian/Asian British were involved in safeguarding concerns and 8.8% were involved in safeguarding enquiries. There is a decrease in the proportion involved in safeguarding concerns and safeguarding enquiries compared to 2021/22.

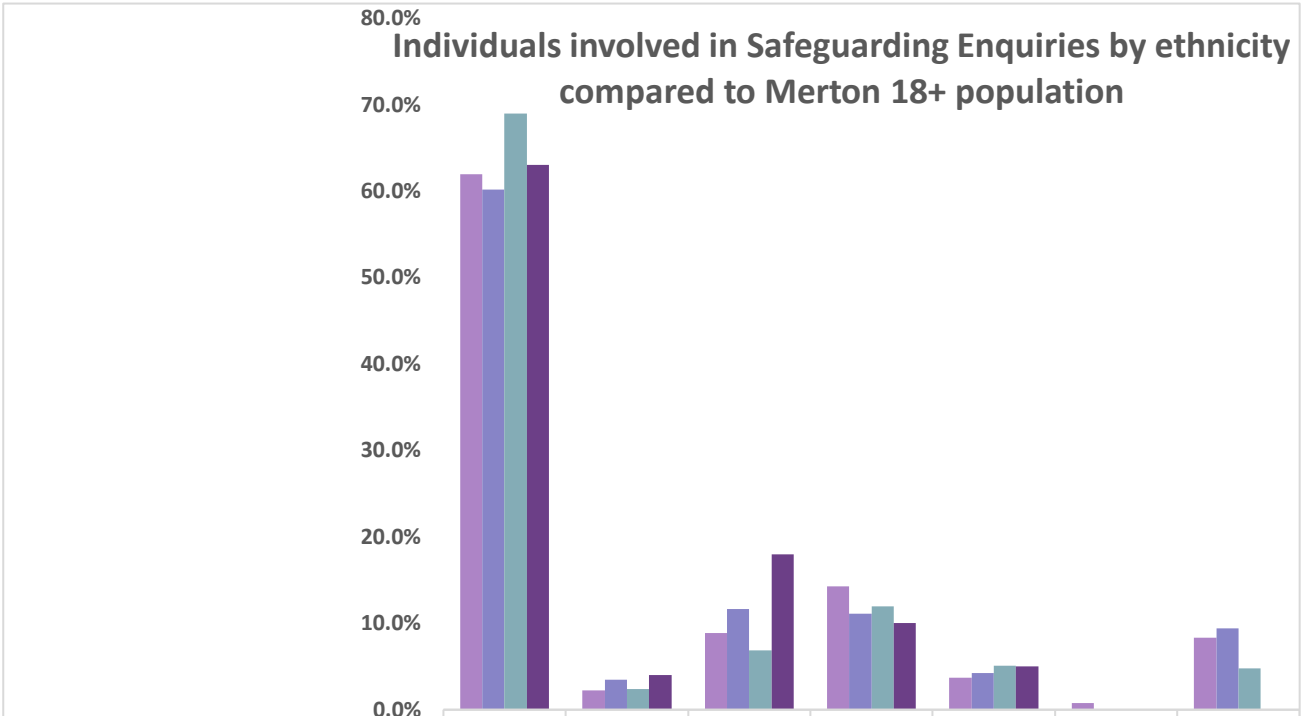
During 2022/23, 12.1% of people involved in safeguarding concerns and 14.3% of people involved in safeguarding enquiries were Black/ African/Caribbean/Black British. This compares to 10% of the Merton 18+ population who are Black/African/Caribbean/Black British. Work is underway in the Safeguarding Adult Review (SAR) Subgroup to consider why this is the case as we see a similar picture for this group of people involved in SARs in Merton.



	White	Mixed / Multiple	Asian / Asian British	Black / African / Caribbean / Black British	Other Ethnic Group	Refused	Undeclared / Not Known
% Safeguarding Concerns by Ethnicity 2022-23	61.8%	2.8%	7.9%	12.1%	3.8%	0.6%	11.0%
% Safeguarding Concerns by Ethnicity 2021-22	59.8%	2.5%	9.7%	12.3%	4.1%	0.0%	11.6%
% Safeguarding Concerns by Ethnicity 2020-21	62.1%	3.1%	9.4%	11.7%	5.2%	0.0%	8.5%
Merton Population for 18+ (2021 Census)	63%	4%	18%	10%	5%		

In terms of action to address disparities, developing how we hear from people with lived experience will feed into this and our new Community Adult Safeguarding Champions Network will play a crucial role.

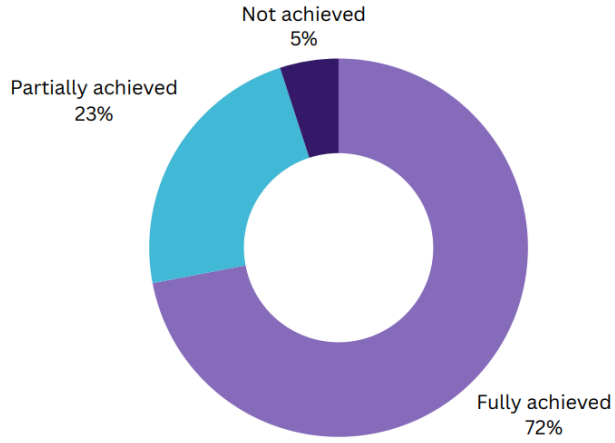
This network is comprised of a range of local voluntary sector organisations, including faith groups, so it is an important initiative for reaching the community and hard to reach groups and get key messages out. It is hoped that these Community Champions can help people across the community to recognise and report cases of suspected abuse and neglect but they will also be important in alerting and engaging the Board around potential safeguarding issues in the community.



	White	Mixed / Multiple	Asian / Asian British	Black / African / Caribbean / Black British	Other Ethnic Group	Refused	Undeclared / Not Known
% Safeguarding Enquiries by Ethnicity 2022-23	61.9%	2.2%	8.8%	14.3%	3.7%	0.7%	8.4%
% Safeguarding Enquiries by Ethnicity 2021-22	60.1%	3.5%	11.6%	11.1%	4.2%	0.0%	9.4%
% Safeguarding Enquiries by Ethnicity 2020-21	69.0%	2.4%	6.9%	11.9%	5.1%	0.0%	4.8%
Merton Population for 18+ (2021 Census)	63%	4%	18%	10%	5%		

Making Safeguarding Personal

An important success measure of ‘Making Safeguarding Personal’ is the extent to which the person’s desired outcomes are met. Locally, Making Safeguarding Personal is well embedded in practice, with **95% of people’s outcomes being fully or partially met.**



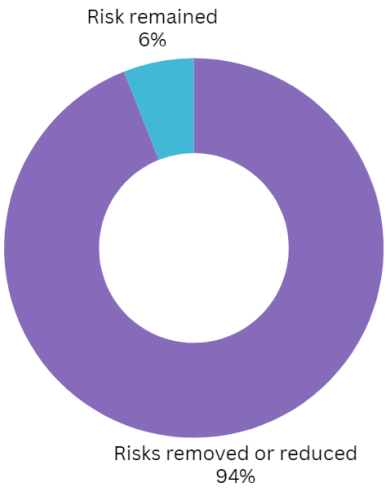
Percentage of enquiries concluded where outcomes were fully or partially met over 2022-23

Where outcomes were not met, this is usually due to the person not engaging with the process or being unable to articulate if they consider that their outcomes were met.

There was a slight increase in the number of people who expressed a desired outcome compared to last year.

Safeguarding aims to remove or reduce the risk to the adult. It is not always possible to completely remove risk and the risk will remain in cases where adults with capacity make a decision to continue living with an elevated level of risk.

The impact of safeguarding on risk is good with the risk removed or reduced in over 93% of cases. Where the risk remains, this is usually the result of people choosing to live with risk and understanding the implications of it.



Percentage of enquiries concluded where risk was removed or reduced over 2022-23

Making Safeguarding Personal Case Study- Robert

“*Robert was a 76-year-old man who grew up in Merton. He lived in a ground floor rental flat. He was a sociable person and enjoyed conversations and visiting the local pubs.*

He had a diagnosis of Chronic Obstructive Pulmonary Disease (COPD) and was living with dementia. A few years prior he invited a friend to move into this home and he was helping with practical tasks. As well as this a care package was provided for one care call daily to assist with personal care.

This arrangement appeared to be going well, however, his GP contacted Merton Adult Social Care to raise a safeguarding adult referral after noticing at a visit by medical staff, that he had bruises to his face.

As part of the Safeguarding Enquiry a Team Manager and an Assistant Social Worker undertook an urgent visit. During the visit he disclosed that the person living with him was drunk and had hit him. At this time a place of safety was offered, however this was declined.

Early in 2022 a new concern was raised, and a subsequent safeguarding referral was received from the care agency. Robert had a bruise above his eye and a cut on his cheek. The team manager and a Senior Social Worker visited Robert, however, once again he refused a place of safety in a care home. Consent for a Safeguarding Enquiry to proceed was sought, however, Robert's mental capacity needed to be assessed. He could not remember what happened or when he sustained the bruise and cut. A referral was made for an Independent Mental Capacity Advocate (IMCA) to act on Robert's behalf to make certain decisions.

As part of the Safeguarding Enquiry the carer and the neighbour were interviewed. The neighbour disclosed that they had called the Police during the previous weekend as she could hear the friend shouting at Robert."

Outcome of the Safeguarding Adults Enquiry

- A referral was made for an Independent Mental Capacity Advocate (IMCA)
- Locks were changed for Robert's friend so he could no longer access his home.
- The friend agreed to present at Homeless Person Unit and was placed into B&B due to his homelessness.
- Robert's care package was increased to 2 care calls daily.

Making Safeguarding Personal

- **Empowerment –** Robert was supported and encouraged to make his own decisions via an Independent Mental Capacity Advocate (IMCA) support.
- **Prevention –** locks to the external doors were changed.
- **Proportionality –** using the least restrictive option i.e., Robert wished to stay in his home.
- **Partnership working –** with Police, GP, Social Services, Care Provider, Housing and IMCA
- **Protection Plan –** the friend could only access his belongings when escorted by a social worker after the locks were changed.
- **Accountability –** clearly defined roles/responsibility for each organisation.

Our priorities for 2023-24

- Improve the multi-agency approach to complex and high-risk cases by providing practitioners with new guidance and approaches to use in their work.

- Support the development of the Community Safeguarding Champions Network with a focus on hearing the voices from our communities, encouraging participation and raise awareness about safeguarding in the wider community.

- Develop an approach to working with people who have lived experience of safeguarding so that their voices are heard and make a difference, including through the SAR process.

- Strengthening our work across children and adult services by:
    - embedding a Think Family approach
    - improving how we support the transition of children and young people into adulthood

- Continue the work with all partners on bringing together key data on safeguarding to provide better quality assurance arrangements in Merton.

Merton Safeguarding Adults Board

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LONDON BOROUGH OF MERTON

Committee: Healthier Communities and Older People Overview and Scrutiny Panel

Date: 24th January 2024

Wards:

Subject: Treating People outside a Hospital Setting

Lead Director: Mark Creelman, Place Executive, Merton and Wandsworth, SWL ICB

Lead member:

Contact officer:

Recommendations:

A. Members of the Panel are asked to note the progress made in developing out-of-hospital services.

B.

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 The purpose is to bring members of the Panel up to date with the latest initiatives to treat people outside a hospital setting where it is clinically appropriate to do so.

2 DETAILS

2.1. Hospital admission is necessary for people who are seriously injured or acutely unwell. The treatment required in those cases can be most safely and effectively delivered in a hospital setting. However, for those people whose health challenges are less acute hospital is not necessarily the best place to be. Treatment can often be delivered more safely and effectively at home or in other settings outside hospital. This provides benefit to the patients concerned by maintaining them in a familiar environment, close to family and other regular sources of support, whilst protecting them from the potential downsides of hospital admission, such as hospital acquired infections. It also protects hospital capacity for those most acutely ill who do need hospital admission. The details of the schemes are set out in the accompanying presentation. They have been broadly divided into Primary Care and Community schemes but there is a lot of overlap and the aim is to provide seamless care. This approach is to be developed further in the form of Integrated Neighbourhood Teams.

3 ALTERNATIVE OPTIONS

3.1. The only other option to the initiatives set out in the attached presentation is to treat all of these patients in hospital. This would be less clinically effective for the patients as well as adding to the severe pressures that the hospital system is already under.

4 CONSULTATION UNDERTAKEN OR PROPOSED

4.1. There is engagement activity associated with all of these initiatives as described in the detail.

5 TIMETABLE

5.1. The timescales vary – see the detail by scheme in the attached report.

6 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

6.1. The financial implications vary by scheme but as a general rule

7 LEGAL AND STATUTORY IMPLICATIONS

7.1. None

8 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

8.1. All service developments overseen by the ICB are subject to Equality Impact Assessments

9 CRIME AND DISORDER IMPLICATIONS

9.1. None

10 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

10.1. None

11 APPENDICES – THE FOLLOWING DOCUMENTS ARE TO BE PUBLISHED WITH THIS REPORT AND FORM PART OF THE REPORT

- See presentation attached.

12 BACKGROUND PAPERS

12.1.

Department Approval	Name of Officer	Date of Comments
Legal		
Finance		
Executive Director		
Cabinet Member		

NHS
South West London

Keeping People Out of Hospital

Healthier Communities and Older People Overview and Scrutiny Panel
24th January 2024

Mike Procter
Director of Transformation – Merton and Wandsworth
SW London ICB

NHS
South West London

Keeping People Out of Hospital

Three Stages of Intervention:

- Primary Care
- Community-Based Services
- Acute Services

This presentation focuses on the first two elements as acute services are mainly hospital-based

Keeping People Out of Hospital –

South West London

1. Primary Care

Three Broad Areas of Work:

a) Access
b) Proactive Care
c) Prevention

A - Primary Care Access in Merton

South West London

Primary Care Services available 8am-8pm, 7 days a week
Appointments can be booked via practices, NHS 111, Emergency Departments (ED)

- 21 GP Practices
  - Core Hours 8am-6:30pm Monday – Friday
  - Additional hours – varies by practice
  - 85,000+ appointments a month
- 6 Primary Care Networks (PCNs)
  - Enhanced Access: Network Standard hours: 6:30pm-8pm Monday to Friday; 9am-5pm Saturday
  - Additional hours – varies by PCN
  - Available to all patients registered at practices within the PCN
  - 4000+ appointments a month
- 2 Borough Wide Extended Access Hubs
  - Friday 4pm-8pm; Saturday/Sunday/Bank Holidays 8am – 8pm
  - Delivered by Merton Health Ltd from Wide Way Medical Centre & The Nelson Health Centre
  - Available to all Merton registered patients
  - Offers GP and nurse (specifically wound care and childhood immunisations) appointments
  - 800+ appointments a month

Additional Capacity December & January to cover Christmas / New Year / Industrial Action

- Over 1000 additional GP Hub appts.)
- Weekend telephony service on 3 weekends (over 1000 calls answered)

New Access Requirements

NHS South West London

NHS England Delivery Plan for Recovering Access	GP Contract Requirements
Empower patients to manage their own health including using the NHS App, self-referral pathways and through more services offered from community pharmacy.	Offer of assessment will be equitable for all modes of access. Patients should be offered an **assessment of need, or signposted to an appropriate service, at first contact** with the practice, with practices no longer able to request that patients contact the practice at a later time.
Implement **Modern General Practice Access** to tackle the 8am rush, provide rapid assessment and response, and avoid asking patients to ring back another day to book an appointment	Patients seeking routine care should have an **appointment within two weeks** of contact where appropriate
Build capacity to deliver more appointments from more staff than ever before and add flexibility to the types of staff recruited and how they are deployed.	**Prospective (future) record access** to be provided by 31st October 2023
Cut bureaucracy and reduce the workload across the interface between primary and secondary care, and the burden of medical evidence requests so practices have more time to meet the clinical needs of their patients	Mandated use of a **Cloud based telephony** (CBT) national framework

Improving Access in Merton

NHS South West London

- 75% Practices already using Cloud Based Telephony
- All practices have Online Consultations available
- Promoting use of NHS App
- Digital Change Managers to support practices
- All PCNs had Capacity and Access Improvement Plans approved
- All practices on track to enable prospective records access by 31st October 2023
- Recruitment and Retention programmes in place
- Use of Additional Roles e.g. Clinical Pharmacists, Social Prescribing Link Workers, Mental Health Practitioners, Paramedics, First Contact Practitioners
- Patient engagement including through surveys, patient groups; Patient communications on new roles and changes to access routes

B - Proactive Care

South West London

- Enhanced Health in Care Homes
- End of Life and Complex Patients Local Scheme
- Integrated Locality Teams
- Medication Reviews and Medicines Optimisation
- Annual reviews for Long Term Conditions (e.g. Diabetes, asthma, COPD)
- Annual Health Checks (inc. Serious Mental Illness (SMI), Learning Disabilities)
- Multidisciplinary working

Proactive Care: Enhanced Health in Care Homes

NHS South West London

- 869 Care Home Beds covered by 10 practices
- Lead Practice for each Care Home
- Named Clinical Lead
- Weekly “Ward” Round
- MDT Reviews
- Care Planning and Reviews for all residents
- Structured Medication Reviews
- Universal Care Plans developed

Proactive Care: End of Life and Complex Patients

South West London

- Cohort of Patients (Complex including severe frailty / in last year of life)
- Individual case review (approx. 4000 pts discussed per year)
- Care planning and review
- End of Life planning where appropriate
- Integrated Locality Teams - MDT input and reviews (approx. 240 MDTs per year)

C - Prevention

South West London

- **Merton Health & Care Plan 2022 to 2024** – Prevention of hospital starts with good health and care which starts from an early age. The plan sets out priorities for Start Well, Live Well and Age Well. This gives an overview of ambitions for the borough, which should be reflected in Public Health initiatives and the services on offer. The plan reflects a commitment from health and care organisations to work together, with a shared vision of a more locally focused, person-centred model of care.

- **Primary Care Delivered Prevention Services**
- Immunisations
  - Including Childhood imms / Flu / Covid / shingles / pneumococcal
  - Covid Autumn campaign: Merton 43% Uptake (SWL 44.5%; London 37%) as of January 2024
  - Flu: Merton 43% Uptake (SWL 47%; London 40%) as of December 2023
- Cancer Screening
  - Cervical / breast / bowel
- Smoking Cessation
- Weight Management
- Social Prescribing

2. Community/Integrated Care Services

Universal Care Plans

- An NHS service that enables every Londoner to have their care and support wishes digitally shared with healthcare professionals across the capital.
- This helps with a more coordinated approach to health and care.
- The numbers of UCPs in Merton are increasing.
- Social Prescribing service is one of the providers helping support promotion of this offer.

Carers

- Unpaid carers play a vital part in the health and care for Merton residents.
- Primary Care continues to increase identification and provision of carer friendly services, including health checks for unpaid carers.
- All carers are supported through improved access to social prescribing & voluntary services to reduce social isolation and to reduce emergency presentation. Unpaid carers are identified and supporting during their cared -or person's hospital admission and subsequent discharge.

Community/Integrated Care Services

SWL 111 Service

- A free to use telephone number and website, offering healthcare advice and the ability to refer patients to the appropriate care setting.
- The SWL 111 service usage has improved this year,
- A new way of managing more urgent primary care cases, reduces the number of handoffs that a patient experiences in their interaction with the 111 service.
- The 111 service also provides a clinical assessment service helps give advice to health care professionals, helping to avoid admissions.

SWL Mental Health –

- Supporting people in mental health crisis / reducing attendances at EDs.
- Work is being undertaken at SWL level, to review the crisis support offer available in SWL and how this model might improve for greater coordination across boroughs.

Community/Integrated Care Services

Virtual Wards and Hospital at Home

- Virtual wards (also known as hospital at home) allow patients to safely get the care they need at home.

- The Hospital at Home Virtual Wards help to avoid admissions, whilst Centrally Remote Monitored (CRM) Virtual Wards facilitate earlier discharge. We are increasing the uptake of these by:
  - Changing the operational model and clinical thresholds for access from both primary and secondary care
  - Continuing to engage with clinicians, to build their awareness of and confidence in the use of Virtual Wards
  - Introducing a ‘pull’ model on wards with assigned staff and/or Electronic Patient Records (EPR) systems proactively identifying patients suitable for discharge to CRM Virtual Wards.

- Initial thinking on virtual wards supported an earlier supported discharge model. However more recent activity has shown that the bigger opportunity is in the prevention of admission (hospital at home).

Community Services

South West London

- **Community Health Teams** – A wide range of services are provide by Central London Community Healthcare, our community provider (e.g. district nurses, case managers, care navigators, dementia specialist nurses, end of life care nursing).
- **Urgent Community Response Service** – Urgent community response teams provide urgent care to people in their homes, which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, older people and adults with complex health needs who urgently need care, can get fast access to a range of health and social care professionals within two hours. This includes access to physiotherapy and occupational therapy, medication prescribing and reviews, and help with staying well-fed and hydrated. The UCR service provides an alternative to hospital, which helps reduce the need for ambulances to take patients to hospital. The pathways for ambulance and 111 services are being reviewed to make it easier for the services to access UCR successfully.
- **A new 'Integrated Care Transfer Hub**' team is being implemented at St. George's hospital. The team brings together the expertise of social workers and community therapist partners, working together with the hospital staff. The team will help support earlier and more effective discharge planning for patients, which will help to reduce readmissions to hospital.
- **Intermediate Care** – An Intermediate Care (IC) Seminar was held on 6th December 2023, reviewing a proposed new service model for Integrated Urgent, Rehab and Reablement. The seminar was well attended by partners across the Wandsworth Health & Social Care System. The group were supportive of developing a new model that better helps the whole system.

Community Services

South West London

- **Age Well Programme**

  - Enhanced Support to Care Homes – Remote monitoring, digital initiatives, use of voluntary sector services, staff training. Implement telehealth services to enable healthcare professionals to conduct assessments, referrals, and consultations remotely. This can bridge the gap in reduced access to on-site healthcare professionals during evenings and weekends.

  - Falls – falls training. 9% of all non-elective admissions are for falls. this is a significant growth in admissions beyond what is expected and represents a greater opportunity to manage mild / moderate frailty cohorts more effectively in the community via rapid response. Based on the current trend, by March 2025, the number of people being admitted to hospital with a fall in SWL will have reduced by around 30 a month to on average 250.

  - Dementia – dementia adviser service and BACSS Behaviour and Communication Support services.

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Healthier Communities Overview & Scrutiny Panel
Date: 24 January 2024

Agenda item:

Subject: CQC Assurance: Progress and Departmental Preparations Update

Lead Director: John Morgan

Lead Officer: Phil Howell

Lead Member: Cllr Peter McCabe, Cabinet Member for Health & Social Care

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Recommendations:

1. For Panel to note the developments within the national role out of CQC assurance and the department's continued preparations for both LGA peer review (planned for June 2024) and CQC assurance

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1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 CQC Assurance is being rolled out nationally across Adult Social Care departments. Five local authorities volunteered to take part in pilot assurance activity in the autumn of 2023. The findings and individual assurance reports of these pilot assessments were published in November 2024. Four Authorities were rated as 'Good'. One was rated 'requires improvement'.

1.2 At the same time the CQC published it's Information Request template. This is the core information the CQC is required to receive ahead of Assurance visits. This allows all local authorities to prepare this portfolio in full knowledge of the request, without waiting to be advised they will be visited by CQC. Effectively giving the department more time to prepare exactly what is needed.

1.3 In December, the CQC issued letters to three authorities – Hounslow, Hertfordshire and West Berkshire – notifying them they will be the first three Authorities to be subjected to the full assurance process. This phase of the process is intended to undertake 20 assurance process and as such, the department is still preparing in the event we are one of the 20 Authorities.

1.4 The department has also put itself forward for an LGA Peer Review in preparedness for assurance. This was originally planned for February, however due to LGA capacity this had to be revised. We have now received confirmation this will take place 5 – 7 June 2024.

1.5 The purpose of this report is to provide CMT with detail on the national process, as it progresses to the next phase and to provide an update on the departments preparedness for both LGA peer review and CQC assurance.

2. DETAILS

1.1 The new Care Quality Commission (CQC) assurance framework for adult social care came into operation on the 1st of April 2023 as a result of the Health and Care Act 2022. The Act places a new duty on the CQC to assess local authorities' delivery of adult social care duties under part 1 of the Care Act 2014.

1.2 There have been some significant updates over the last 9 months including:

· 5 LA pilot sites have completed inspections, and each have received a report and rating,

· the development of a clearer process involved during a CQC assessment,

· the development of a new Information Return,

· 3 local authorities have recently been selected in the first wave of assessments.

1.3 During April 2023 CQC requested local authorities to volunteer to test out the assurance process across the 4 themes (working with people, providing support, ensuring safety within the system and leadership). The assessments were completed over the summer period and the final reports were published in November 2023. North Lincolnshire County Council, Lincolnshire County Council, Suffolk County Council and Birmingham City Council were rated as Good and Nottingham City Council was rated as Requires Improvement.

1.4 Areas of strengths highlighted included: Senior staff were reported to be accessible and visible, good strengths based and person centred practice, commitment to learning, people's needs assessed in a timely way, cohesive preventative offer, embedded co-production approach and positive feedback from users involved, good use of data, positive integration at an operational level and staff knew their communities, all staff and leaders have a good understanding of inequalities in their area, staff overwhelmingly positive about working for the local authority.

1.5 Areas for improvement highlighted included: gaps in provision of accessible information, delays when contacting the local authority to get assessed, links with health partners were informal rather than structural, more work needed to include the views of people within safeguarding enquiries, recruitment difficulties, greater focus needed in identifying and understanding the needs of seldom heard groups, improvements in transition to adulthood required, pathway for autistic people unclear.

1.6 The feedback from the pilot sites enables a greater understanding of the areas which will need specific focus upon and will need covering within the self-assessment e.g., having a narrative in relation to management of

waiting lists, improving transition to adulthood, knowing our community, being aware of and highlighting any recruitment issues, being aware of any gaps and stating them in the self-assessment and having plans to improve.

Roll out of full inspections.

1.7 The CQC intend to carry out a baseline assessment of all 154 local authorise over the next two years and will give a narrative report alongside a rating. Three local authorities were selected at the end of December 2023 to undertake the first wave of assessments which are due to start in 2024. The local authorities selected are Herefordshire County Council, London Borough of Hounslow and West Berkshire County Council.

Process

1.8 The assurance process has become clearer as a result of the pilots, updated CQC guidance and intelligence gathered from various national and local networks which officers attend e.g., Principle Social Worker network, London ADASS. Officers will continue to be involved in these networks in order to gain insight and keep up to date with developments.

1.9 Once a local authority has been selected by the CQC, the Director will receive a notification email titled 'Notification of CQC inspection' with a formal letter detailing the process which will include completing an Information Return, providing details of key personnel for interview and the development of onsite visits and interviews. Indications are that leaders will be interviewed approximately four weeks from the notification, this is likely to include the DASS, Principal Social Worker and senior leaders. Onsite visits will take place nine to eleven weeks after the notification.

1.10 The onsite visits will include key people for example, people who use services, the independent chair of the safeguarding adults board, a range of providers, a large range of voluntary and community sector agencies, the adult social care portfolio holder and shadow portfolio holder, the chair of the health and wellbeing board, front line staff, director of public health, chair of the Integrated Care Board.

Local Authority Information Return

1.11 On December 8th the CQC issued updated guidance in relation to the type of information and evidence that they will require. This is called the Local Authority Information Return (the equivalent of Annex A for children's inspections).

1.12 There are 38 categories contained within the information return. Examples include the self-assessment (optional), feedback from compliments and complaints, feedback from staff and partners, processes and pathways (e.g., care assessments, reviews, financial assessments), waiting list size and management of, market position statements, market shaping plans, safeguarding adult reviews and action plans, adult social care risk register, unpaid carers strategy.

Case tracking.

1.13 An important part of the Information Return will include case tracking. Details will be provided by CQC at the time of notification. However, this is likely to centre on producing 50 case summaries with a focus on the customer journey and practice across a range of groups e.g. older people, transition, autism, learning disability, safeguarding, mental health, unpaid carers. This will help the CQC understand people's journey through the social care system and their experience of how care and support decisions were made.

1.14 The CQC will select 6 of the cases randomly and hold 4 in reserve. They will speak to the individual as well as any significant people and agencies involved. The lived experience of people who are supported by adult care is key to the assessment. The allocated workers for the cases chosen by the CQC will also form part of the interview schedule.

Update on CQC preparation.

1.15 Two staff conferences were held in December 2023 with 101 staff attending across both events. Key themes included an overview of progress on the Towards Outstanding Programme, the current and future budget position, an overview of the CQC framework and feedback from the pilot inspections, an overview of the annual account with a focus on 'how well do you know our demography / community'.

1.16 There was also a feedback and celebration session gaining views from staff in relation to our strengths and what they are most proud of. Some of the examples included;

- challenging opinions of others for the benefit of the individual,
- utilising community resources and sign posting,
- direct payments monitoring and claiming back unspent money,
- supporting individuals to apply and obtain NHS continuing health care funding,
- promoting an integrated approach with health,
- strengths based working,
- good relationships with providers and working through issues,
- OT assessment centre providing quick assessments whilst promoting independence.

Adult Social Care Policy & Procedure repository

1.17 Working with an independent provider of web based policy platforms, we launched Merton Adult Social Care Tri.x site on 20th November 2023, and ran 3 staff sessions to support them to become familiar with the site.

1.18 The site provides our staff with consistent guidance, easier to access, up to date information. The guidance on the Tri.x site is based on national legal requirements and best practice.

1.19 The information included will:

- Guide and inform practice,
- Provide information about local policy and procedures for social workers, occupational therapists and other social care practitioners in the London Borough of Merton in one easy to use site; and
- Keep practitioners up to date with local and national developments in adult social care.

External web page review

1.20 All external adult social care pages have been reviewed, and are being updated to ensure there is up to date information for people using adult social care services, including providing information and advice. They have also been reviewed to ensure our documents published online are accessible to people with disabilities, including using simple language and structure, style and formatting.

Questionnaire

1.21 A questionnaire covering the four CQC themes was carried out with staff and partners and ran from July until December 2023. In all there were 39 responses with an even distribution of staff and partners. The results have been analysed and will be used to inform the self-assessment and action planning. Some of the feedback received included:

1.22 Strengths: Some recurring themes in relation to staff approach being well intentioned, competent, caring and person centred; Partnership and collaborative working appears to be strong and valued within Merton; Response to crisis and incidents of increased risk appears to be proactive; Strong safeguarding partnership and making safeguarding personal evident.

1.23 Areas for development: lack of a self-assessment at the first point of contact; information can be confusing and complicated for people; a perception that people can wait a long time for assessments to be completed and services to be started. The questionnaire also highlighted a

lack of a response and awareness in relation to the areas of equality of experience in outcomes and awareness of learning and innovation which suggests that promotion and further development within these areas is needed.

1.24 In response to the new guidance in relation to the Local Authority Information Return a new spreadsheet has been created to map the evidence that the CQC will require. For each of the 38 evidence areas, key documents or links to documents will be stored, these will be reviewed and updated to ensure that this process runs smoothly at the time of an inspection. Where there are gaps in the Information return an action plan will be created to address the shortfall and these will be tracked to measure progress.

CLD submission

1.25 The Client Level Data (CLD) collection represents an evolution of the annual aggregated Short and Long Term (SALT) collection by asking Councils to submit the underlying data instead. The intention is that quarterly CLD returns will replace the existing annual SALT collection from 2024-25.

1.26 CLD submission is carried out by detailing information on the client's journey through the adult social care system. The CLD return will provide data on individual person details, all requests, assessments, reviews, services, service costs and funding details. Adult Safeguarding activity, Deprivation of Liberty Safeguards (DoLS) assessments and Mental Health Act assessments are excluded from CLD. The first quarterly submission was in July 2023 and currently we are working on the third submission, covering April – December 2023.

1.27 In order to provide accurate data, we have developed dynamic Power BI Dashboard reports which will provide visually interactive dashboard along with client level data output and data quality reports and data output. These reports are specifically written to help social workers and managers to provide performance information and data quality insight into client journey through adult social care system. These reports are used during monthly Quality Assurance meetings with managers to monitor and to improve ongoing missing data and data quality issues.

1.28 We are minimising the missing data for CLD return by making all the necessary CLD data mandatory where possible and a mandatory data recording checklist has been provided to staff to provide context and explain what needed to be selected from the picklist. This helps to improve data quality.

1.29 The main data source for CLD comes from Mosaic and additionally we receive monthly carer and equipment data from external providers. Data is combined and all the necessary quantitative and logical qualitative checks are carried out and a data submission is provided to NHS Digital's Data Landing Portal (DLP).

1.30 Following submission, we are provided with a data quality report, which shows how we compare to our previous submission and to other LAs. NHSE also carry out NHS number matching process after each return and any missing numbers which are found (based on name, date of birth and postcode) are sent to us, this report is fed back to teams to update Mosaic.

CLD data publication and national statistics

1.31 During 2023-24 both SALT and CLD will be used to provide Adult Social Care Outcomes Framework (ASCOF). However, from 2024-25 CLD will be the main source of ASCOF and other reporting.

1.32 Currently Adult Social Care Client Level Data dashboard for Local Authorities has been developed via Athena (ardengemcsu.nhs.uk), It is still at the early stages of the development and only has your own council's data. During 2024, the tool will be developed to include some SALT and ASCOF measures derived from CLD. It will also include metrics and benchmarking to support service planning and commissioning, as data quality and completeness improves. It is intended to provide benchmarking statistics on a quarterly basis.

1.33 In addition to this dashboard DHSC will publish statistics on CLD to provide useful new information to the public, local and national government. It is intend to begin publishing some activity statistics derived from CLD in the Monthly statistics for adult social care (England) publication from March 2024.

3. ALTERNATIVE OPTIONS

3.1 The CQC have stated that producing a self-assessment is optional. We will be producing a self assessment and accompanying report together with a Local Account document that is intended to be published. Deciding to not complete a self assessment would likely result in the CQC spending more time during the onsite visit stage and a lack of a clear narrative being produced in relation to strengths and areas for improvement.

4. CONSULTATION UNDERTAKEN OR PROPOSED

4.4 There has been no formal consultations completed at this moment in time. A number of engagement activities have taken place with staff and partners to gather feedback (see 7.6 above). Feedback will continue to be sought from people with a lived experience, and this will help to inform the self-assessment, improvements action plan and our evidence for coproduction.

5. TIMETABLE

5.1 A CQC inspection could occur at any point over the next 2 years. Over the next 3 months the priorities will include ensuring that a self-assessment report is completed, an action plan is completed, and the Information return is populated, and any gaps are highlighted and there is a plan in place.

6. FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

6.1 There are no additional financial implications arising from this report.

7. LEGAL AND STATUTORY IMPLICATIONS

7.1 The CQC assessment will test LBM compliance with part 1 of the Care Act 2014. Any issues with the application of the Care Act will be highlighted in the CQC narrative report which will result in further work being undertaken in relation of an improvement plan.

8. HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

8.1 N/A

9. CRIME AND DISORDER IMPLICATIONS

9.1 N/A

10. RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

10.1 Reputational. CQC will issue a rating and a narrative report. A low rating is likely to affect LBM reputation in terms of the local community, morale of officers, it may affect staff recruitment, and the wider view held nationally.

11. APPENDICES – the following documents are to be published with this report and form part of the report

N/A

12. BACKGROUND PAPERS

i. Local authority assessment reports - Care Quality Commission (cqc.org.uk)
ii. Information return guidance - Care Quality Commission (cqc.org.uk)
iii. Assessment framework for local authority assurance - Care Quality Commission (cqc.org.uk)

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Healthier Communities and Older People Work Programme 2023/24

This table sets out the draft Healthier Communities and Older People Panel Work Programme for 2023/24. This Work Programme will be considered at every meeting of the Panel to enable it to respond to issues of concern and incorporate reviews or to comment upon pre-decision items ahead of their consideration by Cabinet/Council.

The work programme table shows items on a meeting-by-meeting basis, identifying the issue under review, the nature of the scrutiny (pre decision, policy development, issue specific, performance monitoring, partnership related) and the intended outcomes. The last page provides information on items on the Council's Forward Plan that relate to the portfolio of the Healthier Communities and Older People Panel so that these can be added to the work programme should the Panel wish to.

Chair: Councillor Agatha Akyigyina
Vice-chair: Councillor Jenifer Gould

Scrutiny Support

For further information on the work programme of the Healthier Communities and Older People please contact: -
Octavia Lamb (Policy and Scrutiny Manager)
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For more information about overview and scrutiny at LB Merton, please visit www.merton.gov.uk/scrutiny

~~Meeting date:~~ ~~5th September 2023 (Deadline for reports – 24th August)~~

Item/Issue	How	Lead Member/ Lead Officer	Intended Outcomes
Update on primary care services in: Mitcham well-being Hub at the Wilson, Rowans Surgery and Colliers Wood Surgery	Report to the Panel	Mark Creelman Place Executive, NHS SW London.	Panel to review when services will open what provision will be available to the community.
SW London Primary Care Strategy	Report to the Panel	Mark Creelman Place Executive, NHS SW London.	Panel to review primary care services.
Work Programme 2023-2024	Report to the Panel	Cllr Agatha Akyigyina, Healthier Communities and Older People Panel Chair	To review the topics this Panel will consider in 2023-24

~~Meeting Date~~ ~~21st November 2023 (Deadline for reports – 5pm, 10th November 2023)~~

Item/Issue	How	Lead Member/Lead Officer	Intended Outcomes
Budget and Business Plan – Round 1	Report to the Panel	Councillor Billy Christie, Cabinet Member for Finance and Corporate Services	Scrutinise the budget and any send comments to the Overview and Scrutiny Commission
Carer's strategy	Report to the Panel	Phil Howell Interim Assistant Director for Commissioning	
Update from St George's NHS Trust	Report to the Panel	Kate Slemeck, Managing Director of St George's)	Panel to receive an overview of key issues and priorities
Heathlands Proposal	Report to the Panel	Mark Creelman	
Report and Recommendations arising from the review of Employment opportunities for people with autism	Report to the Panel	Cllr Caroline Charles, Task Group Chair	To agree the report and recommendations
Work Programme 2023-2024	Report to the Panel	Cllr Agatha Akyigyina, HCOP Chair	To review the topics this Panel will consider in 2023-24

Meeting date – 24th January 2024 (Deadline for reports – 5pm, 15th January 2024)

Item/Issue	How	Lead Member/ Lead Officer	Intended Outcomes
Budget and Business Plan 2023-2026	Report to the Panel	Councillor Billy Christie, Cabinet Member for Finance and Corporate Services	Scrutinise the budget and any send comments to the Overview and Scrutiny Commission
Adult Safeguarding - Annual Report to the Panel	Report	Aileen Buckton, Independent Chair of the Safeguarding Panel; Catherine Dunn.	To review work undertaken over the last 12 months.
How to keep people out of hospital	Report to the Panel	Barry Causer, Head of Strategic Commissioning Mark Creelman Place Executive, NHS SW London.	To look at the work undertaken to treat people outside of a hospital setting The report will focus on: Primary care, Secondary care, Tertiary service, With a look at virtual wards – people cared for at home with remote monitoring.
CQC	Report	John Morgan	Update on preparations
Work Programme 2023-2024	Report to the Panel	Cllr Agatha Akyigyina, Healthier Communities and Older People Panel Chair	To review the topics this Panel will consider in 2023-24

Meeting Date – 14 February 2024 (Deadline for reports 5 February 2024)

Item/Issue	How	Lead Member/Lead Officer	Intended Outcomes
Health services for women Focus on: menopause, gynaecological issues, breast screening	Report to the Panel	Barry Causer, Head of Strategic Commissioning Mark Creelman Place Executive, NHS SW London.	To review local health services and identify any gaps in provision
Health services for men - Focus on prostate, heart and bowl cancer.	Report to the Panel	Barry Causer, Head of Strategic Commissioning Mark Creelman Place Executive, NHS SW London.	To review local health services and identify any gaps in provision
Work Programme 2023-2024	Report to the Panel	Cllr Agatha Akyigyina, Healthier Communities and Older People Panel Chair	To review the topics this Panel will consider in 2023-24

Meeting date – 12th March 2024 - Deadline for Reports 1st March 2024

Item/Issue	How	Lead Member/Lead Officer	Intended Outcomes
St Helier Hospital – update on disrepair	Report to the Panel	James Blythe, Managing Director for Epsom and St Helier.	Review the plans to for the building repair schedule at St Helier Hospital
Bowel and Cancer Screening Schedule	Report to the Panel	Dr Josephine Ruwende (Consultant in Public Health and the Cancer Screening Public Health Lead for NHS London)	Review the take up of local screening in Merton.
Adult Immunisation Schedule	Report to the Panel	Susan Elden, Public Health Consultant – Immunisations, Rehana Ahmed, Senior Immunisation Commissioning Manager, Eleanor Walker-Todd, Immunisation Commissioning Manager NHS England	Review the take up of local immunisation in Merton.
Report of the Health and Wellbeing Board	Report to the Panel	Director of Public Health Councillor Peter McCabe, Cabinet Member for Health and Social Care	Review of the work undertaken by the Board over the previous year.

New homecare contract	Report to the Panel	Phil Howell Interim Assistant Director for Commissioning	Review delivery of the process and if new providers are performing well.
Work Programme 2023-2024	Report to the Panel	Cllr Agatha Akyigyina, Healthier Communities and Older People Panel Chair	To review the topics this Panel will consider in 2023-24

Carry over to June 2024

Annual Public Health Report 2023 **The report will not be ready for March*	Report to the Panel	Director of Public Health	Members informed of key issues arising from 2022 Annual Public Health Report

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