Southampton Safeguarding Adults Board

Annual Report 2013 - 2014

Independent Chair's Foreword

I am delighted to have the opportunity to introduce the Southampton's Safeguarding Adults Board ['SSAB'] Annual Report for 2013-14. I was appointed as Independent Chair in January 2014 and I am grateful for the achievements made by the Board under the former Chair, Carol Tozer, who steered the SSAB from September 2012 and made good progress in raising the profile of the Board's work. I intend to build on this success in the coming year. My role is to support the effective operation of the SSAB, ensure that it achieves its objectives by developing clear, evidence based priorities and identify targeted actions required by partners to constantly improve multiagency working. In addition, as an Independent Chair, I am able to offer constructive challenge to drive continued improvement in the work of all agencies responsible for providing protection and support to 'adults at risk' in Southampton.

Whilst the need to protect adults at risk is receiving greater media attention there is still limited understanding regarding adult safeguarding responsibilities and, specifically, the work of the Safeguarding Adults Board. The Care Act 2014, due to come into force in April 2015, will for the first time place safeguarding responsibilities for adults on a statutory footing. It will require Local Authorities to undertake safeguarding enquiries where abuse or neglect is suspected. It will also require local authorities to establish a Safeguarding Adults Board and the Care Act provides some details of the membership, functions, funding arrangements and reporting requirements of the Board. The new responsibilities under the Care Act will, however, need to be interpreted within the pre-existing wider legal and cultural framework of obligations owed to individuals who, notwithstanding their vulnerabilities, are entitled to live free from unwarranted or disproportionate interventions.

The implementation of the Care Act will, hopefully, raise the profile of safeguarding adults work nationally. But there is always more that can be done to communicate the key message, that '***safeguarding is everyone's business'*** and ensure that this is widely understood across Southampton.

I am very grateful for the commitment that all members of the Board have demonstrated throughout the year, but also want to take this opportunity to thank Carol Judge and Eleanor Wilson for the support they have offered me as Chair.

I look forward to an exciting year ahead for the Board and commend this Annual Report to you.

Fiona Bateman
Independent Chair
SSAB

1. SSAB Structure

The Southampton Safeguarding Adults Board ['SSAB'] is a standing committee of senior/lead officers within adult social care, health, housing, community safety, criminal justice, voluntary organisations and service user/ carer representative groups. The SSAB's role is to promote the wellbeing and protect 'adults at risk' of harm in its area. Its remit is to set priorities and coordinate the strategic development of adult safeguarding across all sectors in Southampton and to monitor the effectiveness of safeguarding practice within statutory partner agencies.

Adult safeguarding responsibilities arise where there is reasonable cause to suspect that an adult:
(a) has needs for care and support (whether or not the local authority is meeting any of those needs), .
(b) is experiencing, or is at risk of, abuse or neglect, and .
(c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

The SSAB aims to achieve those objectives whilst supporting individuals in maintaining control over their lives and in making informed choices without coercion. In 2013-14 the Board met quarterly and was supported by sub groups and, for specific one off issues, task and finish groups. The work sub-groups undertook for the board varied. For example, the Serious Case Review sub group considered specific cases to ascertain if those cases demonstrated a need for improvements in operational practice or action which might be required at a multi-agency strategic level to better protect adults at risk of abuse and harm. The Board also has a Learning and Development sub group, a Quality Assurance sub-group and a Communications and Community Engagement sub group.

During 2013-14 the priority for the SSAB was on the membership of the main board. As a consequence it is fair to say that many of the sub groups were poorly attended, with the exception of the SCR sub group which continued to meet and in fact increased its meeting schedule to monthly. The Board also prioritised developing clear links with other strategic forums, such as the Health and Wellbeing Board, Safer City Partnership and the Local Safeguarding Children's Board. This work continues in 2014-15 and we are working to re-establish the sub-groups as well as develop solid links with neighbouring Safeguarding Adults Boards in Hampshire, the Isle of Wight and Portsmouth.

2. What has driven the Board in 2013-14?

The Association of Directors of Adult Social Services ['ADASS'] published guidance in March 2013 on the priority areas to improve safeguarding practice. The vision it set for Adult Safeguarding was simply that "*People are able to live a life free from harm, where communities have a culture that does not tolerate abuse, work together to prevent abuse and know what to do when abuse happens"*. Achieving such a vision, particularly in a time of unprecedented organisational change across the statutory sector will take considerable strategic planning; require regular, careful monitoring to evidence improvement in practice and outcomes for individuals as well as close scrutiny of the qualitative and quantitative data collected by statutory partners to identify and resolve practice issues.

The focus for the Southampton Safeguarding Adults Board in 2013-14 was on ensuring that the Board had effective and collaborative leadership. The Independent Chair led on a review of membership so as to secure appropriate seniority and consistent attendance from partner agencies. The SSAB also reviewed the collection of qualitative and quantitative data so as to better understand safeguarding practice in the area. To this end the Board agreed to collate information on an integrated 'Dashboard' which collated key performance indicators from all partner agencies. The performance indicators were identified as those most likely to provide an indication of how safe practice was and whether principles crucial to safeguarding were embedded within the culture of each agency. The SSAB, through its Inter Agency Working Group, continues to review the performance indicators to ensure they remain relevant as practice and the law in this area evolves. The Board also agreed during this period on a new method of collecting direct feedback from service users and carers who had been involved in the safeguarding process. These results are analysed in more detail below. The changes made to data collection during this period, however, ensures that the SSAB is now better informed to guide agencies regarding strategic decision making, it also provides greater transparency to the work of the SSAB.

The SSAB's 2012-13 Annual Report detailed the significant changes within the public sector to those agencies responsible for Adult Safeguarding which either occurred or was anticipated during that period. Much of the changes in functions and responsibility only took effect during 2013-14 and as such the SSAB focus was understandably on ensuring that safeguarding responsibilities maintained a high profile within partner agencies whilst they sought to manage change in both governance arrangements and personnel. In 2013-14 further significant restructures were again anticipated for the Probation Service, Hampshire Constabulary, CCG's Joint Commissioning Unit and Southampton City Council's Adult Social Care Department. SSAB membership certainly helped those agencies to minimise the impact of such changes may have otherwise had on practice and outcomes for adults at risk as reflected in the statistical analysis below. Attendance at Board meetings was consistent and, as a result, SSAB members were well informed about changes in operational arrangements. Attendees were also able to consult partner agencies on proposed restructures and, through a clear common understanding on local needs, were able to work collaboratively to prioritise key issues for the Board to address.

The SSAB members during this period also worked to provide a clear policy framework and guidance to all agencies involved in safeguarding. In May 2013 SSAB ratified the 'Safeguarding Adults Multi-agency Policy, Procedure and Guidance for Southampton, Hampshire, Isle of Wight and Portsmouth' establishing a common threshold for referrals and articulating clear processes for

investigation and decision making across the four Local Authorities in Hampshire. With the adoption of the Multi- agency policy the SSAB continued throughout this period to work with partner agencies to shift the focus of practice away from a statutory support based intervention for safeguarding responses so that safeguarding responses better reflected the wishes of the person affected. The Policy aims to promote a culture of positive risk taking, offering individualised support so that choice and control is maintained by the individual. The SSAB, through its members, seeks to embed a culture of personalised, asset based responses which aim to give individuals the information and support they need so that they and/or their existing support networks, where appropriate, are empowered by the safeguarding process and thereafter in a stronger position to protect themselves from harm in the future. The SSAB continues to promote the ideals that practice must be guided by the principles of:

- Empowerment and a presumption of person led decision making
- Protection by providing support for those in greatest need
- Prevention by taking action before harm occurs
- Proportionality by making the least intrusive response to risk
- Partnership by services working with their communities
- Accountability through accountable and transparent service delivery

Traditionally Safeguarding practice has focused on abuse or neglect perpetrated against an adult at risk by another person. The Multi-agency Policy provided enhanced practice guidance on managing cases involving individuals who self neglect or place themselves at risk of significant harm as a consequence of mental ill health. In 2013-14 the Board recognised the real challenges posed to the provision of care to those who refuse to engage with much needed services and the risks that those who self neglect may pose to themselves and the wellbeing of those in the wider community. Southampton City Council ['SCC'] took the lead in running a workshop involving staff from across the Council (including the Adult Social Care ['ASC'], Housing and Environmental Health departments), Hampshire Fire and Rescue Service and Southern Health Mental Health Access Team so as to discuss and share best practice. As a consequence of this workshop the agencies were able to produce local response guidelines for working with such a vulnerable client group.

Finally the SSAB also provided a regular forum for detailed scrutiny of agency action plans to respond to the recommendations arising from the Francis report into the abuses which took place in Mid Staffordshire NHS Foundation Trust and Winterbourne View Review Concordat as well as recommendations arising from local learning following the Serious Case Review and Domestic Homicide Review in Southampton.

3. Who are 'Adults at Risk' in Southampton and how well are we supporting them?

Each year Southampton City Council's ASC department submits data to the Department of Health on key safeguarding activities, including the number of alerts (that is the first contact between a person concerned about the alleged harm to an adult at risk to Adult Social Care), the number of new and closed referrals (i.e. those alerts which are deemed to meet the safeguarding threshold) and repeat referrals (namely a safeguarding referral where the adult at risk has previously been the subject of a safeguarding referral about a different incident and both of these referrals were in place during the same reporting period). A closed referral is where an investigation has been undertaken, all evidence has been assessed, a conclusion and outcomes have been agreed and the case has been closed. There will be some investigations that start at the end of the reporting year or where, for various reasons, it has not been possible to conclude an investigation during the reporting period and these are recorded as 'new referrals'. The report also details the finding of a completed investigation.

It should be noted that, in line with national guidelines the figures in this report only include new and closed safeguarding referrals where an alleged perpetrator has been identified and which become full safeguarding investigations. It will not therefore reflect in full the wider ranging work with adults at risk undertaken by member agencies to prevent abuse or with those who self neglect. Nor will it represent the work of the Voluntary sector and SSAB in raising awareness of safeguarding responsibilities. It does however provide a useful benchmark for how well statutory agencies are working together to identify and protect adults at risk in Southampton.

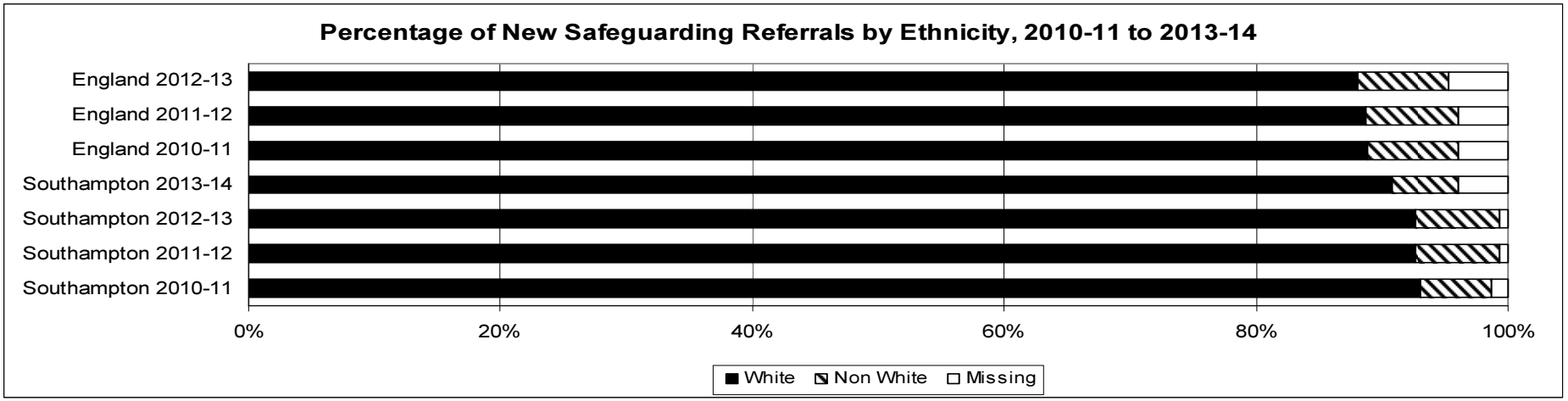
Alerts: In 2013-14 SCC recorded it had received 574 safeguarding alerts. It should be noted that, during this period, there was no single point of access for safeguarding alerts as a consequence staff reported that this may in fact represent an under reporting of alerts. The number of alerts which reached the threshold for a safeguarding investigation was 305, leaving 46.9% to be addressed by other means. At the time of writing this report we do not have the comparative data for England or similar authorities in 2013-14. But when one compares the comparative data for England in 2012-13 (where the alert to referral conversion rate was 64.8% as opposed to 59.4% in Southampton for the same period) , the SSAB acknowledged that alert rates were already lower in Southampton than would otherwise be expected so a further, significant drop in this conversion rate will require careful examination. The SSAB understands that the difference may be explained in part because of inconsistencies in the recording process for alerts which should be addressed by the introduction, in April 2014, of the Single Point of Access for social care and safeguarding enquiries and a dedicated safeguarding team within SCC's ASC department. In addition it should be noted that the alert statistics does not include those received from the Police (known as CA12) which do not result in a safeguarding investigation. In 2013-14 the Local Authority received 1864 such CA12 notifications (compared to 1645 the previous year) the majority of which were for information only. This is an increase of 13% against the number of CA12 alerts received from the Police in 2012-13.

The SSAB previously agreed to set up a task and finish group to conduct an audit of alerts so as to better understand why the conversion rate to referrals was so low. The task remains outstanding and will be a priority for the Quality Assurance and Performance Management sub group in 2014-15. However the Board did recognise that there needed to be one clear route for alerts, that alerts must

be consistently recorded and that those submitting alerts receive specific feedback on the outcome, including where no further action was taken or the matter was referred for action by care management or through another agency. The Board made recommendations to this effect throughout 2013-14 and it is understood that these recommendations helped to shape the design of the customer journey transformations which took place within the ASC department. A key performance indicator for the SSAB to monitor in 2014-15 will be this conversion rate between alerts and referrals so as to demonstrate members of the statutory and voluntary agencies and the private sector understand the Safeguarding process, particularly how to make appropriate alerts. The SSAB must be confident there is a easy, well signposted route for individuals to raise an alert and, once the alert is raised, there is an efficient process within the safeguarding team to best manage screening and signposting so that resources are readily available to carry out investigations and provide support to adults experiencing abuse or neglect.

Referrals: As mentioned above the number of referrals for full investigation increased slightly to 305 from 285 the previous year. It is noteworthy however that during the period there were 26 repeat referrals (8.5%) which is a significant rise from the repeat referrals recorded in 2012-13 (4.2%). Whilst it remains significantly lower than the national comparator for 2012-13 (17.8%) the repeat referral rate is something that the SSAB's Quality Assurance and Performance Management sub group will continue to monitor throughout 2014-15 so as to ensure protection plans are effective at continuing to safeguard individuals after the initial investigation is concluded.

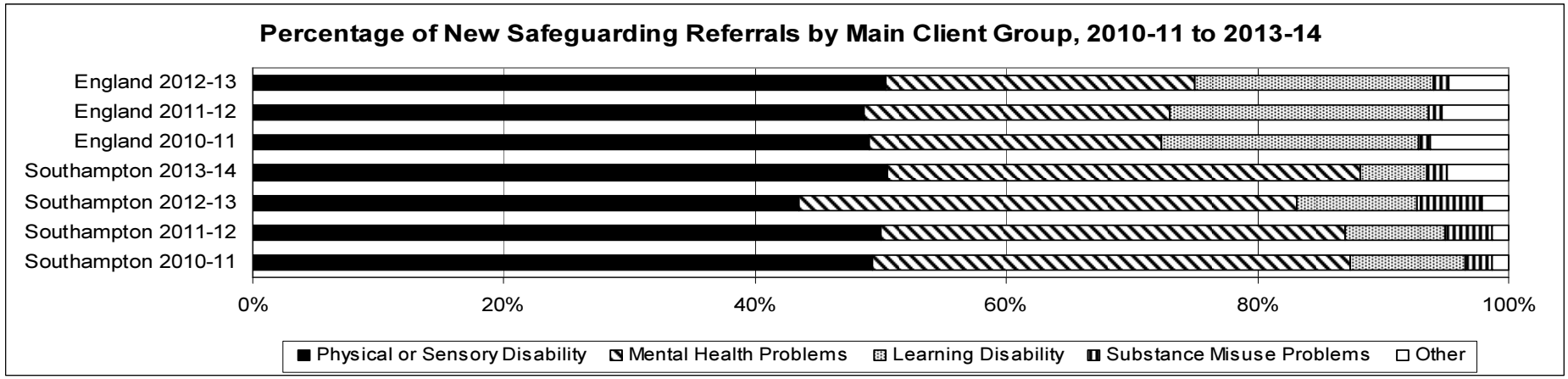
The data suggests that the age range and gender of adults at risk are broadly similar to the national pattern. However, whilst the percentage of new safeguarding referrals involving individuals from ethnic minority backgrounds is only slightly lower than the national percentage it is significantly lower than what might be expected from the adult population living in the city. There seems to have been little change in Southampton's percentages compared with 2010-11. It may be that this reflects a lack of awareness regarding the safeguarding process within these specific communities. In 2014-15 SSAB's community engagement sub group will work to identify why the discrepancy exists and address any actions which arise with established community groups.



Southampton has recorded a higher percentage of alleged victims with mental health problems than the national pattern (37.7 % compared with a national comparator of 24.6 % for 2012-13). This percentage equates to 115 referrals, 48 of which were identified as under 65 years old where their primary need for care was mental ill health. Only 47 of the 115 referrals were received from Southern Health Foundation Trust practitioners who are responsible for providing services to that client group in Southampton. It should also be noted that a further 55 referrals (18%) related to individuals whose primary need related to dementia, which is far higher than the 2012-13 comparator for England (10.7%). This will remain a key performance indicator for the SSAB to monitor in 2014-15 and further work will need to be undertaken to understand whether the data accurately reflects the primary care needs of those requiring safeguarding interventions in Southampton and, if so, what action can be taken to prevent abuse or neglect to this client group and ensure they have adequately protection and redress if harm does occur. The SSAB are also aware that in 2014-15 the way in which this data set is collected will change so that a person's primary support need will be recorded rather than categorise individuals according to the nature of statutory service they receive. Consideration will need to be given as to how this might impact on the Board's ability to monitor emerging trends.

Correspondingly the percentage involving people with learning disabilities is much lower (5.2 % compared with 19.1 % in 2012-13). This may partly be caused by the fact that cases involving alleged victims with learning disabilities tend not to be closed as quickly as other kinds of safeguarding investigations or again could reflect a lack of awareness within this client group so that abuse or neglect is not identified or, where it is, it is addressed through ASC care management rather than the Safeguarding process. In 2014-15 the Quality Assurance and Performance Management sub group will undertake a review of alerts and referrals involving clients with Learning Disabilities so as to identify any issues in either data collection or care management/ safeguarding practice which could account for this discrepancy. Thereafter the SSAB board will develop an action plan to address any concerns.

In 2013-14 the percentage of referrals involving clients with physical or sensory disabilities was 50.5%. This has, for the most part, remained consistent since 2010-11and in line with the national comparator (49.1% for 2012-13). Conversely the percentage of referrals where substance misuse was the primary care need more than doubled between 2010-11 (2.2%) to 5.3% in 2012-13 and then fell dramatically in 2013-14 to 1.6%. Whilst the figure for 2013-14 is similar to the 2012-13 national comparator of 1.1% a more detailed investigation is required to understand what this indicates in respect of safeguarding practice and data collection. To this end the SSAB has already identified a need for the Quality Assurance and Performance Management sub group to conduct an audit of referrals for this client group. Furthermore the Southampton City Clinical Commissioning Group ['SCCCG'] are working with NHS provider trusts to devise an action plan on how to better target interventions for adults at risk with dual diagnosis of mental health and substance misuse. Southern Health NHS Foundation Trust carried out a thematic review of internal investigations into serious incidents involving individuals with a dual diagnosis of mental health and substance misuse problems between 2010 and 2013. Following on from this review a dual diagnosis working group has been hosted by Southern Health and attended by statutory partner agencies, voluntary sector providers, and commissioning representatives across Southampton.

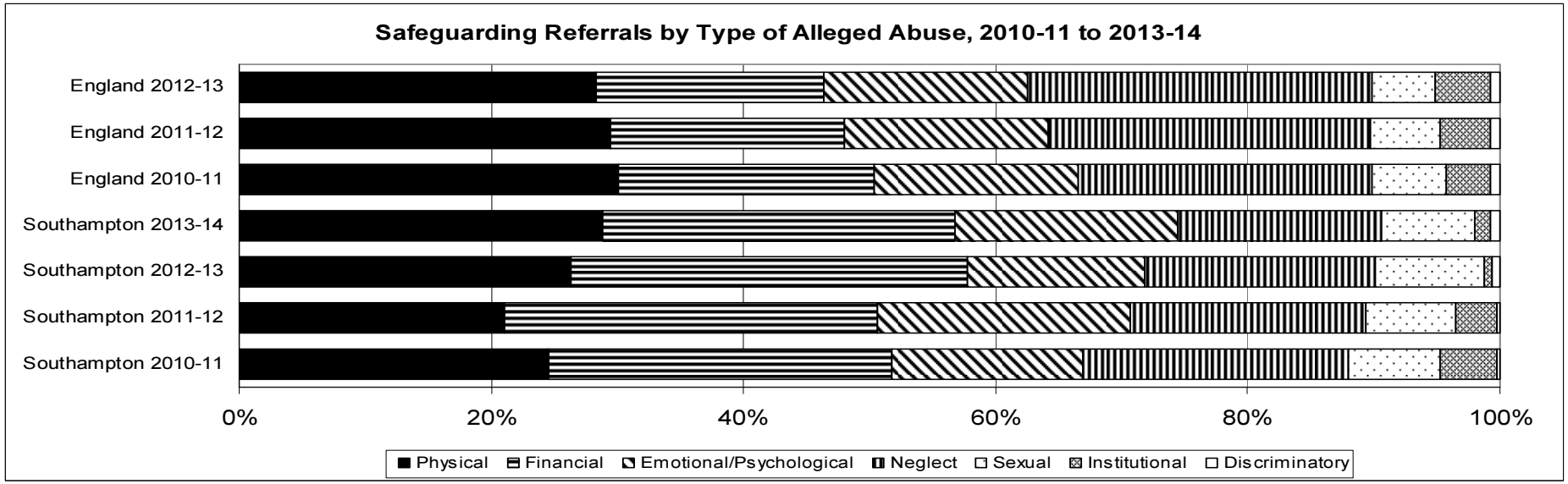


The source of referrals was noted by SSAB members as the data suggested that almost 60% of referrals were made by care managers, social workers and secondary health staff (mainly ward-based NHS staff). This is a different distribution to the national picture for 2012-13 when only 18 % of safeguarding referrals were made by these sources. This could indicate awareness of the safeguarding thresholds and referral routes are very high, as one would expect, among this sector. It could also, in part, be explained by errors in the way this information was recorded, for example, it is understood that during this period if a member of the public or family member raised concerns to the named social worker who then referred the matter for a safeguarding investigation it was the social worker's referral which was likely to be recorded as the source rather than the family member's original alert. Whilst these inconsistencies should

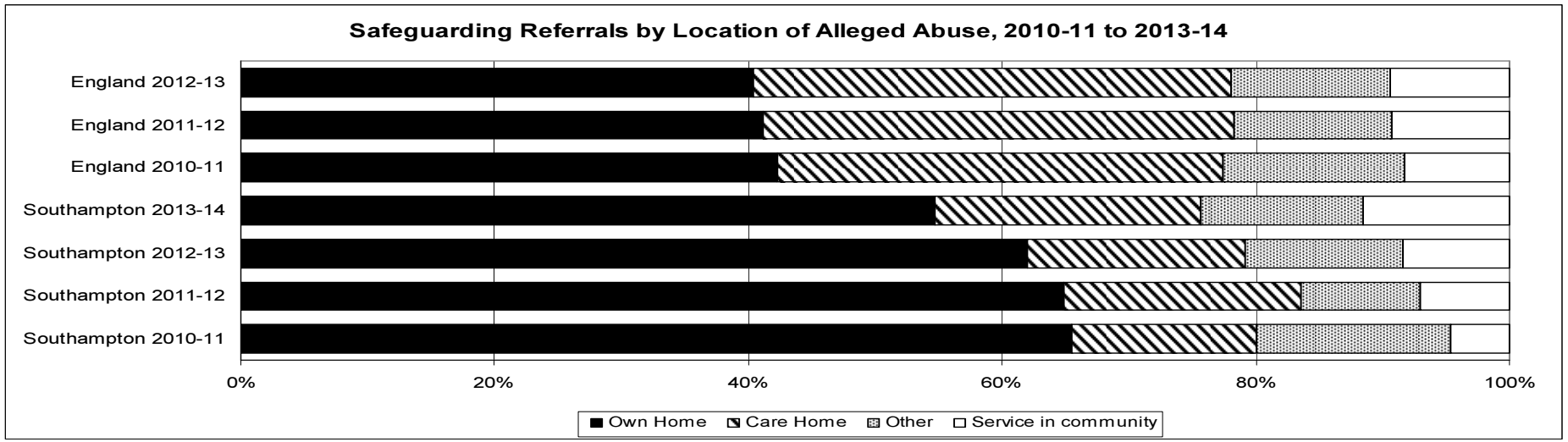
have been addressed through the implementation of the Multi-agency Policy and the introduction of a new Safeguarding Team with consistent practices for collating this information the difference is still so substantial that it will be a performance indicator that the SSAB monitor closely during 2014-15. It is also of note that Southampton has a lower percentage of new safeguarding referrals made by staff in residential/nursing homes (8.8 % compared with 18.3 %). Again this will be monitored closely so as to evidence campaigns to raise public awareness and the Learning and Development sub group's work is having a positive impact on the dissemination of information to this sector and the public.

Southampton has noticeably more safeguarding referrals involving alleged financial abuse than recorded nationally; in fact it was the second highest authority nationally in 2012-13. There has been a small fluctuation in percentage of referrals involving financial abuse (27.2 % in 2010-11 to 31.4 % in 2012-13, reducing again in 2013-4 to 27.8% but this is far higher than the comparative national figure of 18%). This could indicate that a high level of awareness in relation to financial abuse and it is certainly true that the sustained campaigns by SCC regulatory services, specifically Trading Standards' "Support with Confidence" and "Buy with Confidence" will have raised the profile among the population of unacceptable practices so could account for a higher level of referrals relating to financial abuse. The cause, and more importantly actions to address this need, is something that SSAB will investigate further in 2014-15 not least because changes introduced by the Care Act should result in increased financial support for those in need of care and attention. It is therefore anticipated that referrals for financial abuse may rise in the coming year. The SSAB recognises that this does not necessarily indicate an increase in abuse of this nature; rather it is evidence that abuse is identified more frequently and individuals offered greater support and protection from such abuse. It is important however that the SSAB can evidence successful outcomes for individuals who experience such abuse and, in the interim, prioritise planning at a strategic level so that agencies have a clear plan to respond to this challenge collectively.

Allegations of physical abuse are at a similar level in Southampton to those recorded nationally (for 2013-14 the figure was 28.9% in Southampton compared to 28.4% nationally for 2012-13). However allegations involving neglect are far lower in Southampton (16.2% in 2013-14 compared with national figures for 2012-13 of 27.4%. This could be a reflection of the excellent work undertaken by SSAB partner agencies during 2013-14 to address neglect within care settings. For example SCC's Safeguarding in Provider Services ['SIPS'] team worked closely with domiciliary care providers and residential care homes to improve practices. This team has been incorporated into the SCCCG/SCC Integrated Commissioning Unit's Quality Assurance team which is taking a lead on preventative work with health and social care providers. In addition, Solent NHS Trust in partnership with SCC and Southern Health Foundation Trust ran a preventative training programme for social care providers looking at pressure ulcer care. This was a targeted campaign working in the first instance with providers for who repeat grade 3 and 4 ulcer care remained a chronic issue. Solent provided mini-training sessions to staff teams to improve local understanding and practice. Presently the SSAB's Performance Monitoring and Quality Assurance sub group continues to collate data from care and NHS providers regarding avoidable pressure sores (grade 3 and 4) so this remains under observation.



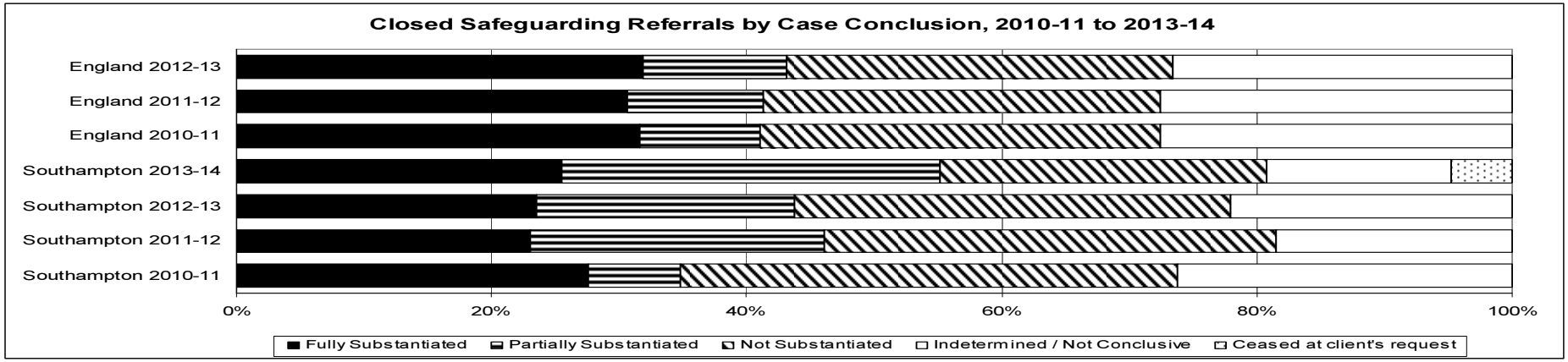
The returns indicate that a far higher proportion of adults at risk experience abuse or neglect in their own home than is recorded nationally, which reflects the fact that Southampton has one of the highest per capita rates of service provision in people's own homes (10th highest domiciliary care/re-enablement in England). By contrast Southampton has lower percentages involving people living in permanent residential or nursing care (20.4 % compared with 36% nationally). When compared with the statistics of the previous year the decline in alleged abuse taking place in permanent nursing home placements is noticeable. Whilst it is possible that there may have been underreporting of incidents where multiple allegations were made against one address it does also demonstrates the positive impact achieved by the SIPS team in targeted interventions within that sector. The SSAB want to be confident that this data accurately reflects the true picture of need in Southampton. For this reason the data collected through the 'dashboard' will be crossed referenced against the returns so as to ensure that allegations of neglect are recorded even where the issue is first raised through an agency's or provider's complaints process.



The 2013-14 returns indicated that 58.6% of alleged perpetrators in Southampton are relatives, carers or otherwise individuals known, but unrelated to the adult at risk. This is the first year that the Department of Health has required this information; it has been collected via the use of new recording during 2013-14. As it is a new set of data it has been contrasted in this report to data regarding the location of alleged abuse. Previously the SSAB had noted that the percentage of referrals where the alleged perpetrator was living with and/or caring for the alleged victim is much higher in Southampton than the comparative national figures, but this could simply reflect the higher percentage of people who remain cared for at home within Southampton. These statistics will warrant closer examination if a trend does emerge.

It is also important to comment that 21% of all new referrals identified that the source of the risk was social care paid support. This refers to any individual or organisation that is paid, commissioned or contracted to provide social care support either through direct payments, directly commissioned by SCC ASC or SCCCG in line with their Continuing Healthcare obligations or privately self-arranged care. It doesn't include social care and health staff who are responsible for assessment and care management functions, GPs, NHS trusts and the Police as these are recorded separately. However, that cohort was identified as the source of the risk for a further 15% of referrals. It should be noted that these figures are lower than the national comparative figures and it is not an indication that the allegations against the Police, Social care or Health staff have been substantiated. It is nonetheless a matter for the SSAB to keep under close scrutiny as it could identity practice issues better addressed at strategic multi-agency level e.g. commissioning and performance management or contract monitoring concerns.

Completed investigations: In total 337 investigations were completed and closed during this period. These are further broken down by the conclusions, on the balance of probabilities, of the investigations; namely whether the allegations of abuse was **substantiated**, **partly substantiated** (i.e. some, but not all, allegations of abuse can be proven on the balance of probabilities), **not substantiated** (because the allegation of abuse has been disproven on the balance of probabilities) or **not determined / inconclusive** (this could be either because the evidence was inconclusive or the investigation is stopped before it is fully completed). The SSAB wish to take this opportunity to commend those undertaking safeguarding investigations during 2013-14 and would wish to highlight the impressive rate of cases concluded. It is also highly noteworthy that of the 337 investigations only 49 cases were recorded as inconclusive, with a further 16 cases ceasing at the service users request. This is lower than the national average (14.5% in 2013-14 compared to 26.7% for England in 2012-13) but the SSAB remains keen to reduce this figure further in 2014-15.Conversely the number of cases classified as Partially Substantiated is still much higher than the national average and in 2011-12 was the 10th highest of the 152 authorities. This is only a matter of concern if there is evidence of failings by the partner agencies to work collaboratively and effectively when gathering evidence at present there is no evidence to suggest this is the case, but more qualitative data analysis might be useful to fully explore this. In particular it would be useful to investigate why only 19% of alleged financial abuse is fully substantiated (compared to 25% across all investigations). In addition, further scrutiny would help the Board to understand why allegations of abuse/ neglect against those over 85 are most likely to be not substantiated. Whilst it is accepted that it can be difficult to secure evidence where the victim may lack mental capacity or of financial abuse, especially where this occurs within familial relationships, the SSAB's sub groups will conduct audits of inconclusive and partly substantiated cases and, if necessary, produce an action plan to address any issues of concern which do arise. This audit will also identify good practice among investigative staff which can then be shared locally and nationally to further improve safeguarding practice.

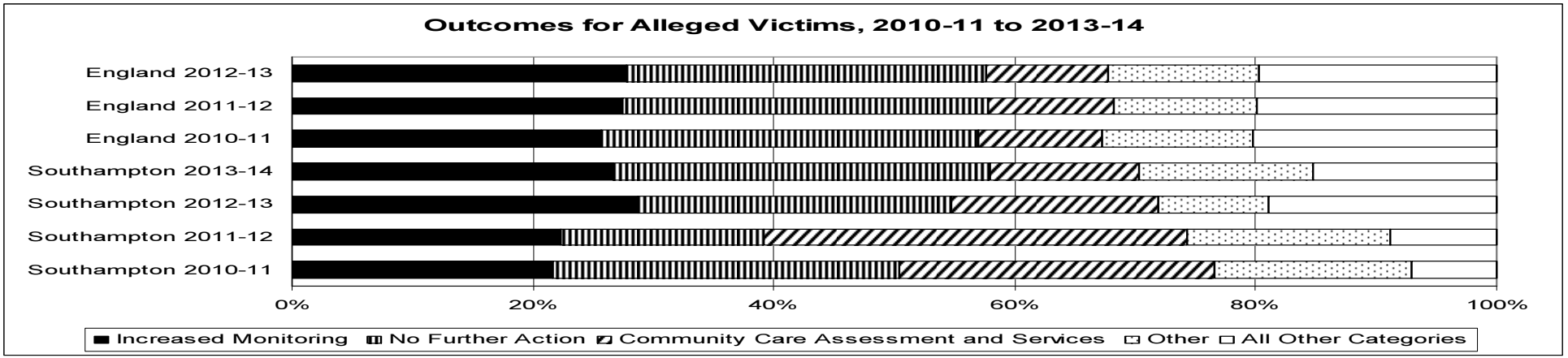


It is reassuring that, despite the low level of referrals involving victims with learning disabilities detailed above, investigations are most likely to conclude that the allegation is substantiated or partially substantiated (77 %) and least likely to be classified as inconclusive or not determined. These findings were quite different to the situation nationally where, in 2012-13, only 35 % of investigations involving victims with learning disabilities were classified as fully substantiated This is evidence, if more were needed, of the particular vulnerabilities of this group it may also identify that there are particular pockets of good practice within the agencies responsible for investigations or supporting this client group which should be shared locally and nationally to improve practice for this client group. This information will be utilised by the SSAB to inform discussions about how to best target provision to this client group so as to prevent abuse and neglect, identify when it is occurring and assist individuals to protect themselves from likely sources of harm.

Key to the safeguarding process is the outcome for the victim, including whether they were adequately protected and were able to secure criminal or civil justice. As mentioned previously the SSAB reviewed the process for securing feedback from service users and carers who had been through a safeguarding investigation using "I" statements which were created to reflect the key outcomes for customers ADASS had recommended within their 2013 guidance. In the main, service users who responded are satisfied with the safeguarding process. In 2013 the SSAB had proposed to conduct a more intensive review of service user feedback because it was accepted that data regarding outcomes and user experience was not as comprehensive as it could and should be. Specifically the SSAB wanted to understand why individuals refused or were unable to respond it was accepted that the number of people unable/unwilling to respond was too high (over a third of all completed investigations the service users were unable to respond to the feedback questions), so the SSAB had recommended advocates be involved in this feedback data collection process. Work continues within the SSAB to support the use of advocates throughout the safeguarding process, but it should be noted that 82.6% of those who were assessed as lacking mental capacity received support to understand the safeguarding process by an advocate, family member or friend. Work has also already begun on reviewing way in which the SSAB capture user feedback including reviewing whether the "I" statements are user friendly. Consideration is also being given to how best to secure anonymous feedback so that the service users or their advocate/ representative is not prevented from giving an honest response for fear of causing offence to the staff who have supported them during the safeguarding process.

Objectively, records show that of the 337 investigations concluded in 2013-14 72% were recommended for either no further action (36.2%) or for a community care assessment or increased monitoring. The percentage of outcomes which recommended 'increased monitoring' has grown from almost 22 % in 2010-11 to 29 % in 2012-13. This percentage is quite similar to the national pattern. The percentage of cases with a recommendation that the victim receives a community care assessment/services has fallen but this is still above the national figure for 2012-13. Often where an investigation has been inconclusive the recommendation may be for no further action. Similarly it may be that the interim protection plan put in place at the start of the safeguarding investigation has worked effectively such that at the conclusion of the process there is no further need for statutory input. However it is alarming that a large proportion of concluded investigations during this period recoded that the risk either remained (6.5%) or was reduced (38.6%) with only 18.7% of cases concluding with the risk having been removed. It is also of concern that 79% of cases recommended no further action, continued monitoring or Police action (e.g. a caution) for the alleged perpetrator. Again this information will be considered by the Board

to determine how best to secure outcomes which not only protect individuals but also seek to prevent reoccurrence and achieve a restorative result for the victim. To this end the SSAB will ask that agencies to collate figures for 2014-15 on access to civil and criminal justice following safeguarding investigations.



4. Review of the SSAB Business Plan 2013/14

The SSAB's Business Plan for 2011-14 outlined 12 key priorities for adult safeguarding which were intended to reflect local priorities and needs. This has been kept under regular review and progress reported in each annual report during this period as such it is not intended to repeat the objective achieved in previous years, but rather concentrate on those objectives which were outstanding. It should be noted that in some cases it has been difficult to accurately measure the success of some outcomes and other matters identified have, because of changes in national policy or practice not progress, but where work remains outstanding this has been commented on and identified as a priority for 2014-15 below.

The SSAB's business plan expected to undertake a range of activities aimed at the prevention of harm and promote awareness of safeguarding. The SCC's website was central to the delivery of this objective; however with the Customer Journey transformation within SCC's ASC department it is fair to say that the website now does require further work to update it. The Safeguarding Team Manager is working with SCC to ensure information on the website reflects accurately the safeguarding process and contact details are clear and accurate. The SSAB are also looking to develop separate web presence so that the work of the SCC Adults Safeguarding team and the SSAB are differentiated and more carefully defined within the public consciousness. The 2013-14 programme of public awareness training was unfortunately reported to have had limited impact outside SCC ASC staff. Though it is understood that safeguarding awareness training was made available to all SCC departments and through the VIP (Voluntary and Independent Sector) Training Programme, that sector later reported it was not easily accessible to the voluntary or private sector providers. Developing an accurate picture of training needs throughout the sector will therefore be a key priority for the Pan Hampshire Learning and Development sub-group and local task and finish group in 2014-15.

The organisational changes across the statutory sector and the resulting changes in personnel also impacted on the advances that had been made in developing close links with other strategic forums. Despite these changes the SSAB continued to operate throughout 2013-14 and benefit from consistent attendance by members from partner agencies who worked hard to maintain links. This has made it considerably easier to re-establish these links quickly. The SSAB has worked with key strategic partnerships such as Safer City Partnership so that there is now a clear reporting structure between the two; recommendations from Domestic Homicide Reviews or Safeguarding Serious Case Reviews are shared and inform practice across the sector. There remains work to be done, e.g. operational staff are working to agree clearer referral routes between community safety casework and adult safeguarding. This should ensure the work undertaken by the SSAB and SCP is better understood and that Boards' work complements, without duplication, to more effectively and efficiently achieve our respective objectives. In addition, the SSAB is now represented on the LSCB and remains keen to work more closely with the LSCB in the future particularly in developing good practice models across agencies responsible for safeguarding so that practitioners do 'Think Family' when safeguarding issues arise. In addition links between the Chairs of the SSAB's in Hampshire, Isle of Wight and Portsmouth have been established and SSAB is represented on the Inter-Agency working group which meet to ensure that policies, process and practice are consistent across the Pan Hampshire authorities so as to minimise duplication or opportunities for miscommunication.

As set out above in 2013-14 the SSAB provided clear policy framework in ratifying the Multi-agency policy, which includes guidance on information sharing. It also published a self neglect policy and local guidelines. Member agencies have also adopted the Domestic Violence pledge.

During 2013-14 the SSAB remained committed to shaping services according to feedback from service users. The Board worked with Choices Advocacy to improve the way in which information was presented to services users and carers within feedback surveys so that this might better inform practice at operational level. In addition the SSAB continued the practice of real life case examples discussion at each meeting. Work continues to encourage greater participation at SSAB meetings and sub group level from voluntary groups who represent the voice of the user and carers and direct consultation with relevant carer and service user forums are anticipated for 2014-15 to discuss the SSAB's strategic plan.

5. SSAB Actions and Priorities 2014/15

As you will note from the above report the SSAB has an ambitious programme for 2014-15. A key priority is to re-establish the sub groups and ensure effective participation within these groups from across partner members. To this end the SSAB held a business planning meeting in May and agreed a new structure for the Board. The Independent Chair has also met with representatives from the voluntary sector to increase membership on the sub groups so as to promote the voice of the service user and carers and secure wider constructive challenge when reviewing safeguarding policy and practice.

The SSAB's current business plan was due to be completed by the end of 2014. The Care Act 2014, in force from April 2015, will require the SSAB to publish a strategic plan outlining the actions it will take to help and protect adults at risk of abuse or neglect in its area. It is the SSAB's intention to re-establish the sub groups so that they are able to undertake the tasks already identified within this report. This should ensure that the Board is in a good position in Winter 2014 to consult with partner agencies, Healthwatch and service users/carers before finalising the plan.

The SSAB, with the support of the Quality Assurance and Performance Management sub group, will conduct and report the findings of detailed audits in relation the conversion rate of alert to referrals, review protection plans for cases where repeat referrals have occurred. They will continue to review the data collected both for the Department of Health and through the 'dashboard' and advise the Board of any trends emerging so that this can inform the strategic plan for 2015. The Quality Assurance and Performance Management sub group will undertake a review of alerts and referrals involving client with Mental Health issues and Learning Disabilities so as to identify any issues in either data collection or care management/ safeguarding practice which could account for respective high and low referral rates in relation to this client group.

The Learning and Review sub group will conduct themed audit of closed investigations involving specific user groups, such as those with Learning Disabilities, Dementia etc so as to understand how the safeguarding process and practice could and should be changed to improve the outcomes for these groups. Furthermore this group will audit closed referral by type of abuse where there is a substantial difference

between the figures in Southampton by comparison to the national figures. The priority will be to review cases involving allegations of financial abuse and neglect so that any good practice can be identified and adapted to improve outcomes across investigations for all types of abuse.

The SSAB will also ask the Prevention and Community Engagement Sub-group to review the low referral rate for service users from ethnic minority backgrounds and identify why the discrepancy exists and, if need be, devise an action plan to address concerns with established community groups. This group will also be asked to consider the findings of more detailed auditing undertaken in respect of the referral rate for vulnerable service user groups and devise a sector wide action plan so preventative and awareness raising work can be effectively targeted to these specific vulnerable groups of service users.

Finally a Learning and Development task and finish group will be established to focus specifically on the safeguarding training needs of services operating within Southampton to map what is currently available and what is required against the National Competency Framework for Safeguarding Adults so that partners can more closely align their individual training programmes, avoid duplication and provide a comprehensive training programme across the statutory, voluntary and private sector in the most cost effective manner.

Recommendations

6.1 SSAB to endorse and ratify the Annual Report.

6.2 Once the Annual Report is ratified, SSAB's Independent Chair and Board Manager will develop an action plan to enable the priorities highlighted above to be realised, to agree a work programme for the coming year and to assign lead roles amongst member organisations. Implementation of the action plan will be monitored and contributions from member organisations secured as appropriate.

6.3 The Annual Report to be presented at a range of senior management and strategic forums as follows:

- SSAB Independent Chair to present to People Director, Overview and Scrutiny Committee, Council Management Team, Health and Wellbeing Board and Southampton Connect

- SSAB member organisations to present to chief officers and relevant strategic forums within their own organisations.

6.4 SSAB to agree (in accordance with the SSAB media protocol) a media release to promote the positive work on safeguarding at a local level highlighted in the report.

6.5 A SSAB development day to be held in January 2015 to review progress and to ensure appropriate arrangements are in place for April 2015 when the Board is placed on a statutory footing.