LSAB
Southampton
Local Safeguarding
Adults Board

Annual Report

2015-2016

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Contents

Introduction

This report is produced by Southampton Local Safeguarding Adults Board (LSAB) in accordance with the Care Act 2014 which requires the LSAB to publish an annual report detailing what each member and the LSAB has done collectively during the year to achieve its main objective and implement its strategic plan.

This report provides a summary of safeguarding activity carried out by the partners across the social care, health and criminal justice sectors in Southampton. The report will focus on:

- Adult protection work to investigate and resolve cases where allegations of abuse and neglect were raised in respect of adults at risk in Southampton.
- Work undertaken to raise awareness of safeguarding; the types of risks faced by adults who need care and support in our city.
- Reviewing the impact that the LSAB has had by seeking assurance that work undertaken by providers, regulatory or commissioning bodies to prevent abuse and neglect before any concerns arise or respond to actual or perceived safeguarding risk so that harm is averted.
- Set out the findings of any Safeguarding Adults Reviews and subsequent action taken to implement the recommendations arising from those.

Chair's Foreword

As Chair I welcome the commitment partners have shown to the work of the LSAB throughout the course of the year. When I first started in this role, in 2014, I was fully aware of the significant impact that financial restraints and organisational changes across partner agencies could have on the ability of LSAB to improve practice in this field. Notwithstanding these challenges I was optimistic that partnership working was the best model available to offer effective protection for adults at risk of abuse and neglect. Since this time, the Board and I have witnessed unprecedented change. At times this has felt unrelenting, but throughout it frontline staff and strategic leaders have remained focused on developing and improving services for those in need of care and support. Motivated, I believe, by the importance placed by the community on protecting the most vulnerable members of our society. This was confirmed in a survey by Southampton City Council of residents in 2015, which rated '*people in Southampton are safe and protected from harm*' as the most important outcome out of 14 possible.

Year on year partners have shown a passion for innovation; rising to the challenge of new legal responsibilities and to counter considerable pressure on financial and staffing resources. Many of those initiatives are set out in detail later and I would thoroughly recommend taking time to read through this report. However, I particularly want to draw attention to initiatives this year that raised awareness of new challenges, such as risks posed to those 'wandering with purpose' or from 'honour' based violence, and those that brought heightened awareness of safeguarding responsibilities to GPs and other primary health professionals and to those working with social care providers to raise standards.

In April 2015 the Care Act came into force and with it clear statutory responsibilities for safeguarding. Whilst section 42 of the Care Act defined an 'adult at risk' and set out it was for the local authority to lead enquiries,

the Care and Support Guidance explicitly provided that safeguarding responsibilities must be undertaken in partnership with the individual, their carers and any 'relevant partner' who might be in a position to assist with an enquiry or take action to protect the adult from abuse, neglect or exploitation. It is a very wide duty; requiring carers, professionals and volunteers to protect an adult from harm whilst respecting their wishes and rights to privacy and family life. We must all better understand the standards of lawful enquiry and safe, effective protection planning that the 'making safeguarding personal principles' encompass. A summary of which is included within the report.

The nature of this report means that the focus will be on the exceptional; we do not necessarily report on activities carried out in 2015-16 as part of our usual business. For example, as Chair I have attended many forums to raise the profile of adult safeguarding and the statutory responsibilities owed to adults at risk. The LSAB is also now recognised as a useful body to consult where partners are proposing changes in policy, practice or service delivery that might impact of safeguarding responsibilities. I also want to take this opportunity to comment on the contribution made by many people to the work of the LSAB's sub groups, their commitment enables the LSAB to carry out many of its functions. These functions focus on the need to offer constructive challenge about how local services, (be that statutory, voluntary or community groups) work to provide safe, effective care to adults in need and support for their carers. Equally the quality assurance functions of case review, multi-agency auditing and measuring policy implementation allows the LSAB to better understand if partners are responding in line with adult protection obligations. I would encourage anyone who is interested in this work to get in touch with me or the safeguarding board team as we would welcome involvement, particularly from community groups.

2015-16 has seen many positive improvements, but there is never room for complacency. I understand that it may take time to embed practices that ensure all partner agencies can evidence full compliance with new statutory duties. However, one of the LSAB's key functions does require specific comment within this section. As a multi-agency partnership the Board is perfectly placed and is therefore expected to gather data to establish a picture of the prevalence of abuse and neglect in the area. The main body of this reports sets out just how important this is to the work of the partners and why it is so vital. It is disappointing that, for the third year running, many partners remain unable to provide key performance data and there are still too many gaps in what is recorded. Data reported within the national Safeguarding Adult Collection is incomplete and though this has been rectified where possible with data available to the LSAB, we do not have a reliable profile of need in the city. It is unacceptable for poor recording or reporting to go unchallenged. The LSAB understands that resources are constricting across the entire partnership, but it isn't correct to require 'back office functions' of quality assurance to compete with frontline responsibilities. Safe, effective recording leads to more informed, better decision making both at an operational and strategic level and it is for this reason that the LSAB will continue to push partners to comply in full with this expectation. I recognise some members have only been able to put in place measures this year to improve practice, but the LSAB must start to reap the benefits of these changes quickly if we are to better support partners meet their statutory duties to protect adults effectively.

Finally, I would like to extend my gratitude to members of the public, frontline staff and volunteers who have attended training sessions or taken time privately to develop a better understanding of their role in safeguarding adults from harm. It is so important that professionals working within partner agencies understand the risks and respond effectively when an adult is facing abuse or neglect, but we must also work in partnership with the

public. I would like to therefore take this opportunity to recognise the positive impact of countless volunteers and carers without whom many more adults would experience abuse or neglect. I also want to express heartfelt thanks those who responded to the appeal that "***Safeguarding is everyone's responsibility"*** by raising a concern about an adult at risk. Without such vigilance and courage to report many cases would not have come to light and, I have no doubt, many more people would have experienced abuse and neglect.

Fiona Bateman
Independent Chair of Southampton LSAB

What is meant by ‘Making Safeguarding Personal’?

We know that residents in Southampton place a high value on safe, effective services that work together to keep vulnerable adults safe from abuse and neglect. We also know that for adults who are at risk of, or have suffered abuse or neglect, their families and carers it is important that any safeguarding intervention is focused on the wishes and needs of the ‘adult at risk’ and achieving outcomes that support people to improve or resolve their circumstances.

Making Safeguarding Personal (MSP) is a set of principles which aims to develop safeguarding practice to ensure services are engaging with people about the outcomes they want at the beginning and middle of working with them, and then ascertaining the extent to which those outcomes were realised at the end.

MSP is a national initiative which seeks to achieve:

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

In 2015-16 our strategic plan recognised the need to ensure these principles were embedded into practice and an action plan was devised to encourage positive change in practice. The SAB held a workshop for professionals from across the partnership and community networks who considered these

principles and the challenges faced in changing practice from a process based approach to a person led, outcome focused one. All those attending fully endorsed the principles and understood the treating people as '*experts in their own lives*' shows respect for the individual and enabled flexible responses that recognise diversity in the City. There is widespread understanding of the significant benefits in working alongside adults at risk and the people that matter to them as this enables them to better understand the risks and find resolution of their circumstance and recovery.

The LSAB has made use of a nationally developed MSP toolkit to ensure these principles shape data collection, audits and our quality assurance framework. Many of the training events hosted by the LSAB had MSP as a theme. The principles have also influenced the 2016-18 Strategic plan where embedding this practice change across the partnership remains a key priority.

There is, however, still much to be achieved before we can evidence a universal shift in practice across the partnership. The LSAB will continue to work with partners, supporting them to implement changes and seeking assurance that they are working alongside clients, their families and carers to identify and respond to safeguarding risks. Key to success will be demonstrating this programme has positively improved the adult at risk's quality of life, wellbeing and safety.

Case Study: Ms P

Ms P is a 38 year old lady with Learning Disabilities & Autism who finds a change of environment very difficult. Previous hospital admissions had proved distressing for her and resulted in delays to a surgical procedure to treat an aggressive carcinoma. Ms P also found it difficult to understand the importance of keeping her wound clean and therefore consequently picked at her dressings post operatively. This resulted in delayed wound healing and increased risk of infection.

Prior to subsequent admissions, staff arranged a 'Best Interest' Meeting to included her consultant, parents, Learning Disability Nurse, carers and LD Liaison Service to ensure that the treatment plan was in her best interest and that all reasonable adjustments considered. A number of adjustments were agreed and communicated in advance to the admitting ward staff, for example, ensuring she was first on the list to reduce waiting, appropriate sedation and support by familiar carers and providing treatment in a side room. Staff were also supported to better understand her behaviours so that they could recognise when she might be anxious. Post operative care was also adapted to better meet her needs safely, wound sprays and barrier creams were available at home straight after the procedure and the liaison team worked with both the CLDN and the local LD Intensive Support Team to produce practical guideline for her carers to follow post operatively.

This cohesive working across the community and with day surgery colleagues ensured Ms P was relaxed and comfortable on arrival to theatre which made treatment straightforward. Carers were available to support when Ms P was in recovery and on return to ward and she was discharged home in a timely way following successful surgery. The Liaison Team kept in touch with the carers and ward during this time. Her carers and treatment team all confirmed that the work undertaken prior to admission ensured a positive experience for Ms P, her carers and treating staff.

How has the prevalence of abuse experienced by adults changed in Southampton in 2015-16?

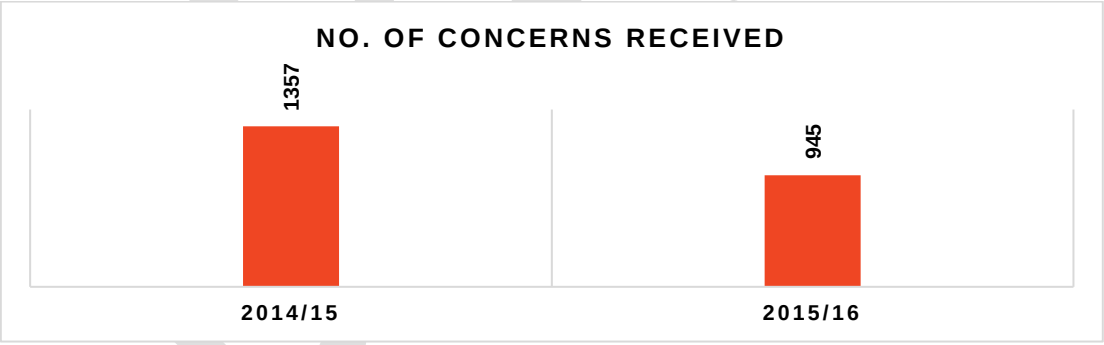
Number of Concerns

The following is the number of concerns received for 2015/16 as reported on the quarterly dataset.

Adult Social Care

Number of concerns received by Adult Social Care has decreased from last year by 30%. This is the number of concerns received after the initial triage. The decrease in the number of concerns received does not represent a fall in the workload; rather this could be as a result of better practice in the recording and capturing of data as well as a change in decision making with regarding to triaging safeguarding concerns. But it is also worth noting that comparative national data, published by NHS Digital (05.10.16 at http://www.content.digital.nhs.uk/catalogue/PUB21917/SAC_%201516_report.pdf) shows a rise in reported concerns. The LSAB will continue to monitor this to ensure that staff are able to effectively respond to concerns of abuse or neglect.

Figure 1. Number of concerns received that have been triaged in 2015/16 compared to those in 2014/15



Partner Providers

The following are the number concerns raised by partner agencies to Adult Social Care.

Figure 2. Number of concerns made to Hampshire Fire and Rescue Services (HFRS), SCC Regulatory Services, Southern Health Foundation Trust (SHFT), Solent NHS and University Hospital Trust (UHS)

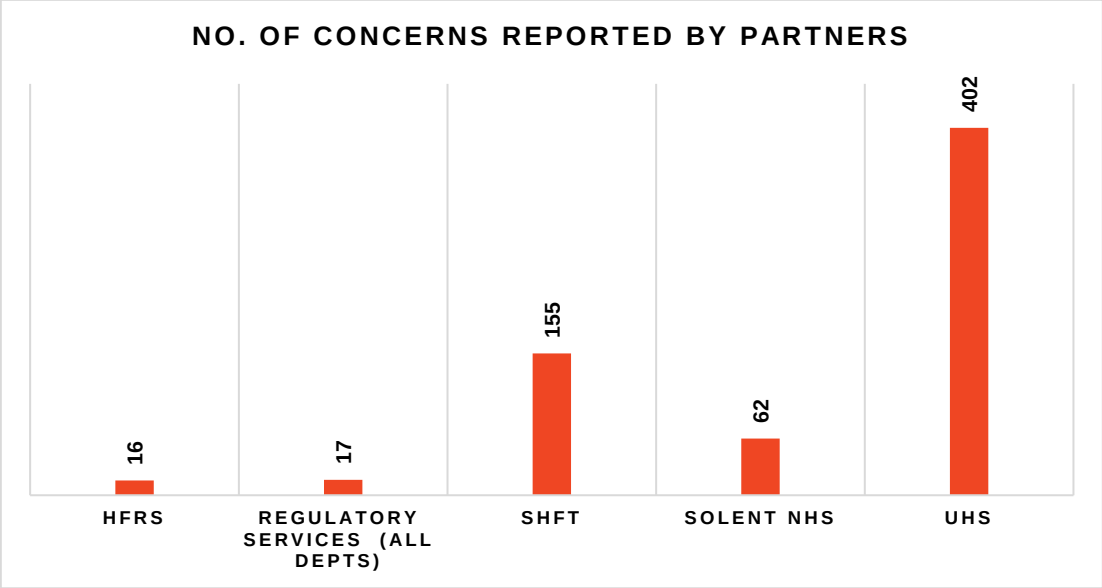
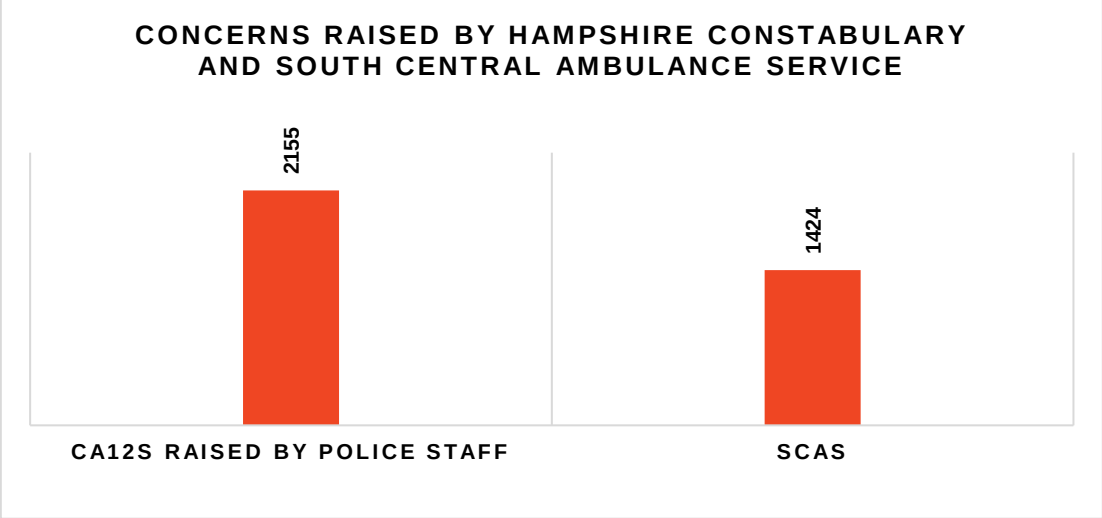


Figure 3. Number of CA12's and Concerns by Hampshire Constabulary and South Central Ambulance Services respectively.

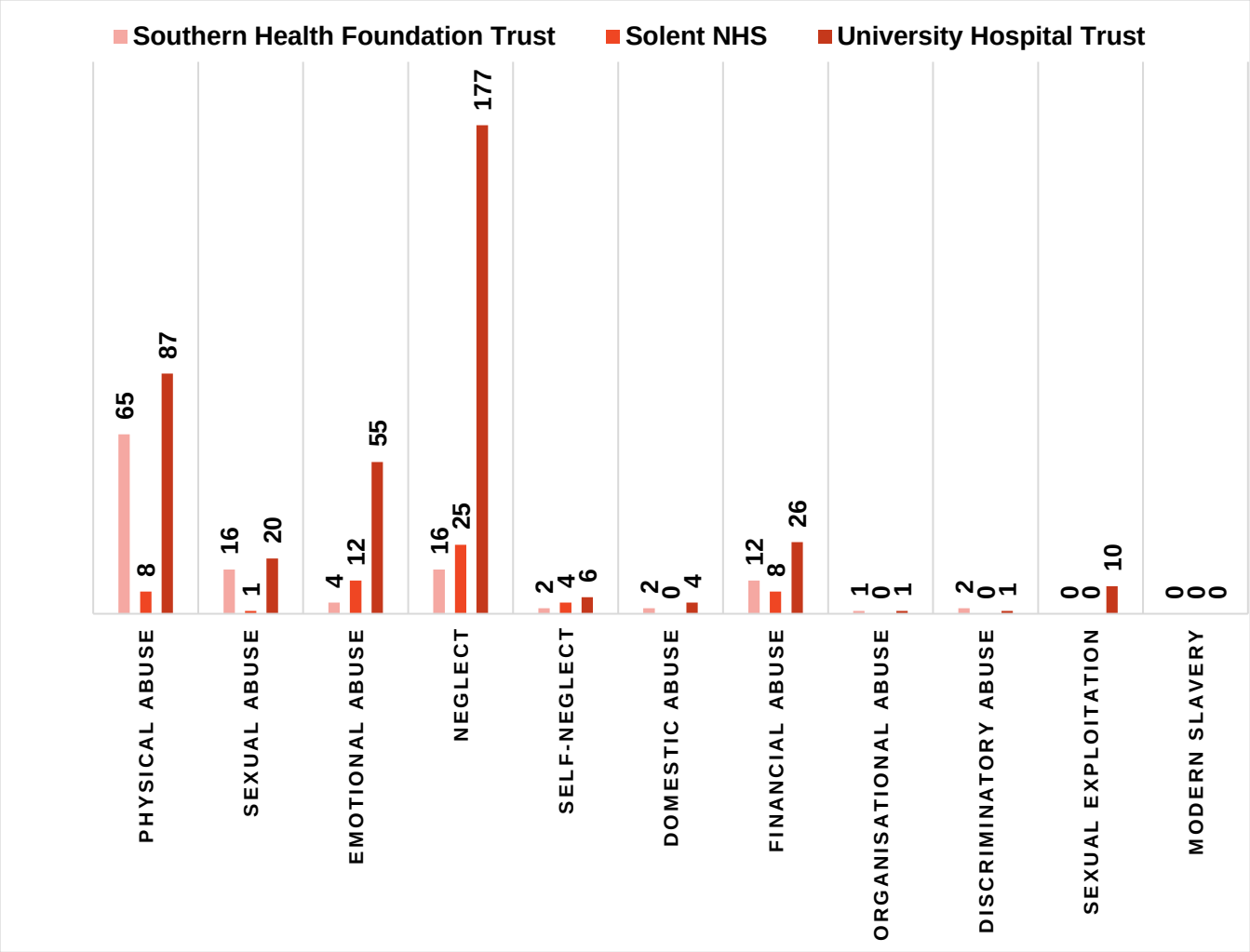


It is important to note that the number of concerns raised by partners will not be equivalent to the number of concerns treated, post triage as s.42 enquiries. In particular not all concerns raised by SCAS or Hampshire Constabulary are necessarily related to safeguarding, so many are initially filtered out. The LSAB are aware that the gap between those concerns that come in to Adult Social Care and those that then go on post triage is very large (3286 concerns). It suggests an over-reliance by partners on the Single Point of Access to make decisions and manage potential lower level safeguarding concerns.

Type of abuse seen by Health Providers and Hampshire Constabulary

The following is a breakdown of the different types of abuse as seen in the concerns raised by the health providers, Southern Health, Solent NHS and University Hospital Trust. The most prevalent types of abuse are neglect, physical and emotional abuse.

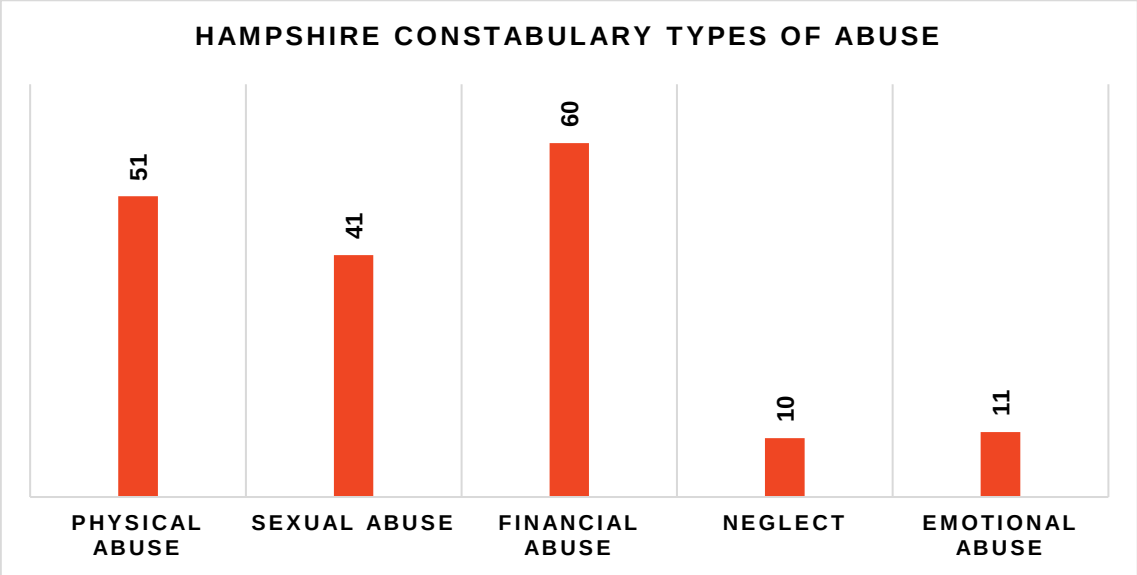
Figure 4. The breakdown of the types of abuse seen by University Hospital Trust, Solent NHS and Southern Health Foundation Trust. These categories of abuse are those categories in the Care Act.



The following is a breakdown in the types of abuse seen in concerned raised by Hampshire Constabulary. The most prevalent type of abuse is financial abuse followed by physical and sexual abuse. Hampshire constabulary report cases of financial abuse in Southampton are consistent with other areas, whilst all allegations are not substantiated the Force believes this demonstrates improved identification of possible abuse and improved cooperation and reporting by providers and services, including SCC's regulatory services, working with adults who are targeted by

fraudsters. It is also an indication of the commitment by the Police to complete robust investigations where financial abuse is alleged.

Figure 5. The categories of abuse seen by Hampshire Constabulary.

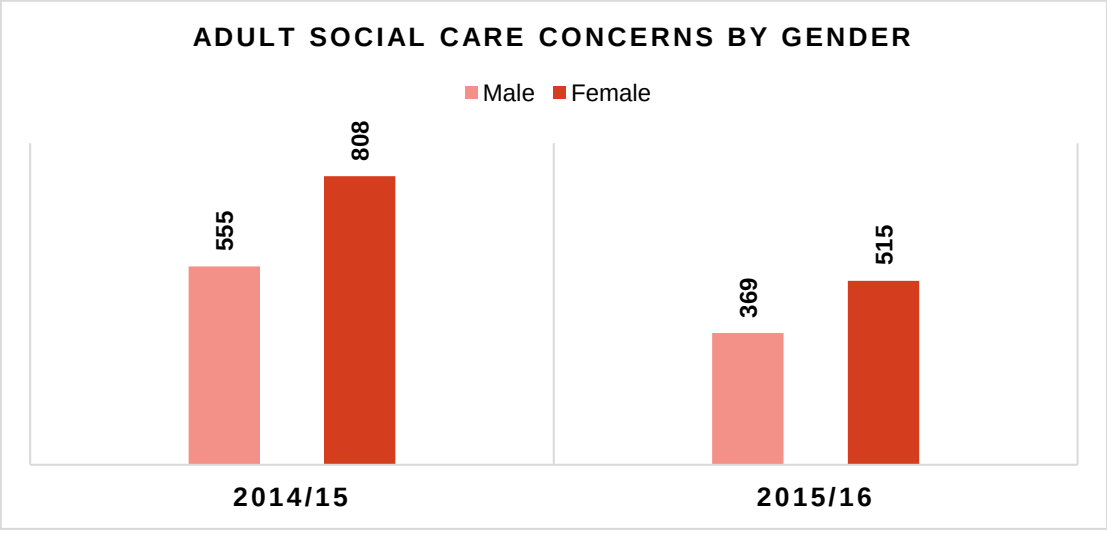


Profile of concerns and Section 42s in Adult Social Care

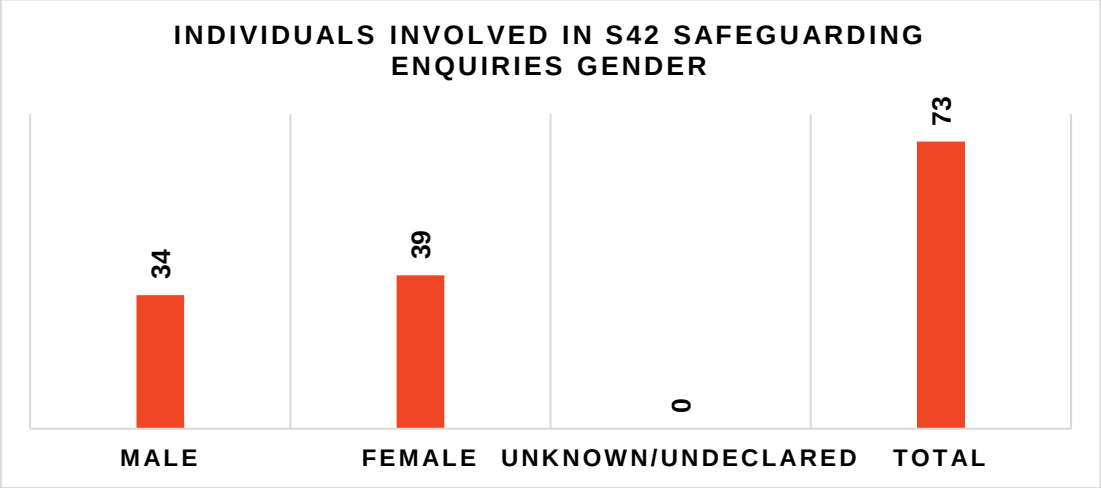
Gender

This year the number of concerns related to women was 30% higher than those concerns related to men. This is in line with the gender breakdown seen last year. This difference is more marked than reported nationally so more needs to be done so that the Board can better understand whether women in Southampton are more at risk or if it may be due to a lack of awareness within the male populations.

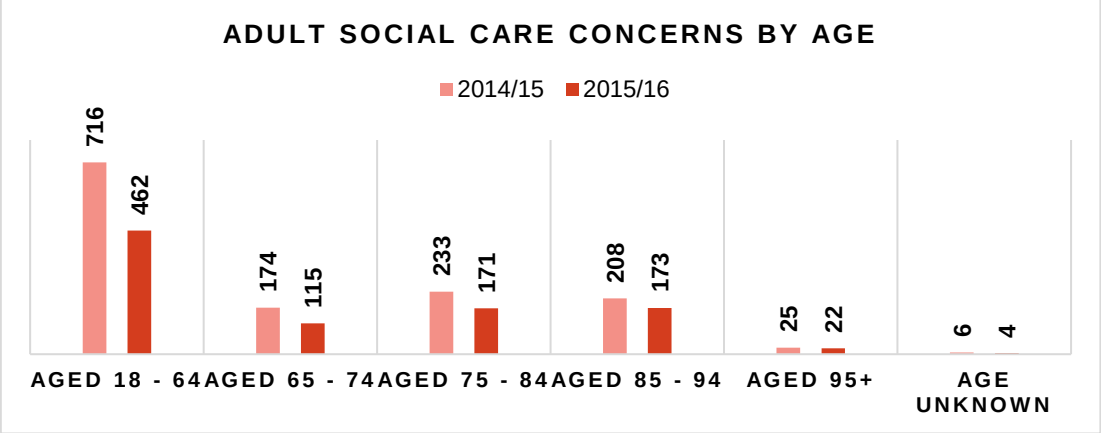
Figure 6. Gender profile of concerns received by Adult Social Care in 2015/16 and 2014/15.



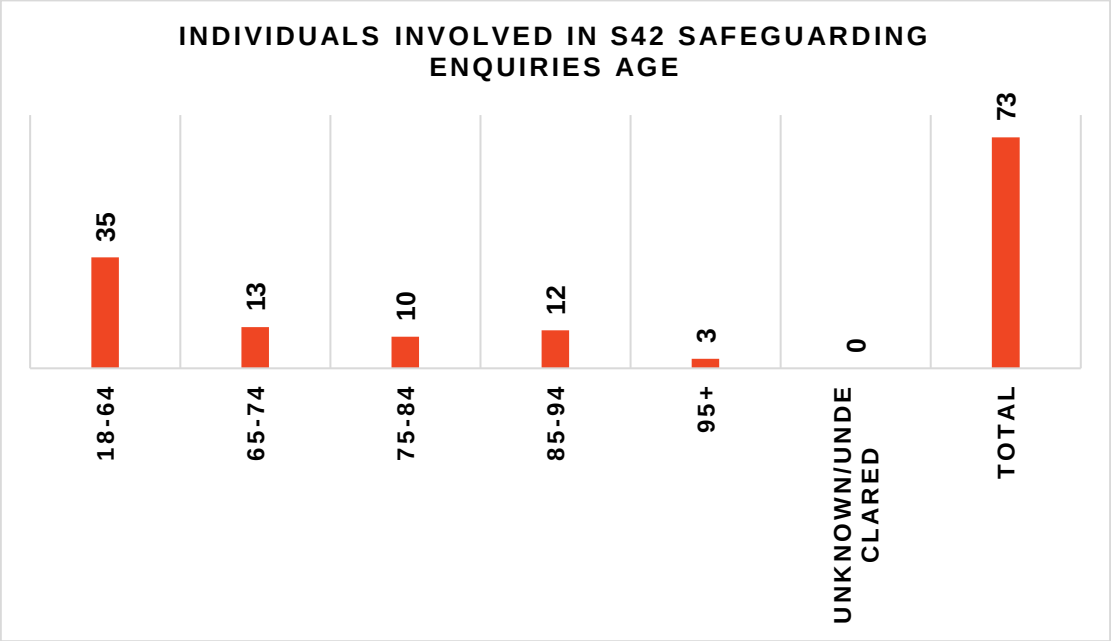
Of the concerns that become Section 42 enquiries, 10% more enquiries relate to women as compared to men, as seen in the figure below. However, given that this data is based only 73 cases completed during the period this may give a false impression of the gender profiles.



Age

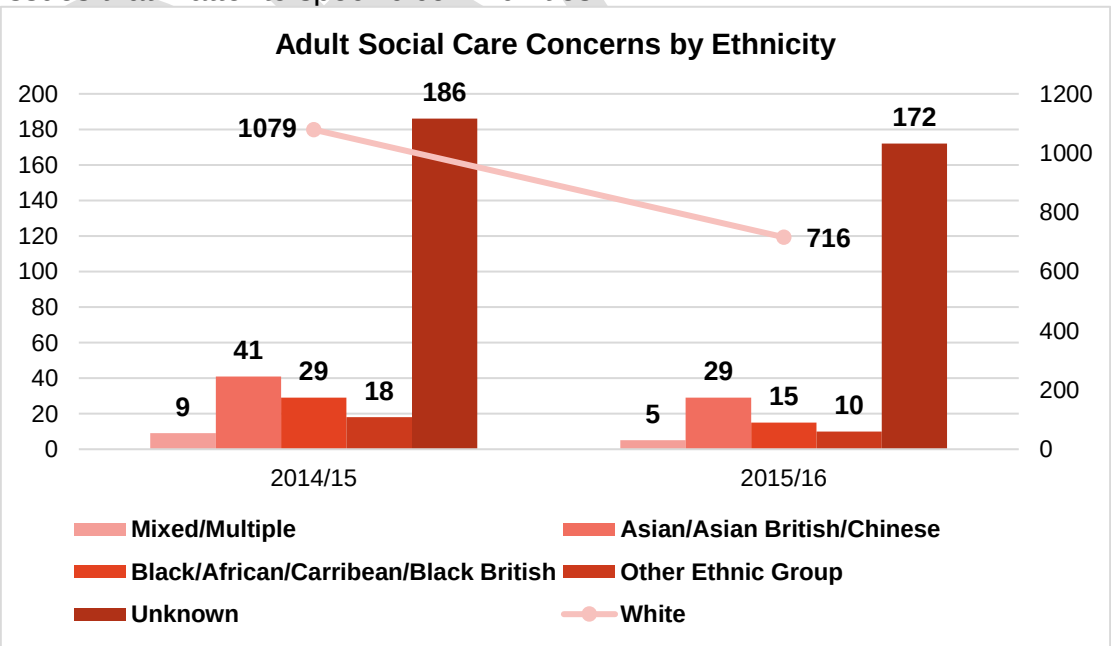


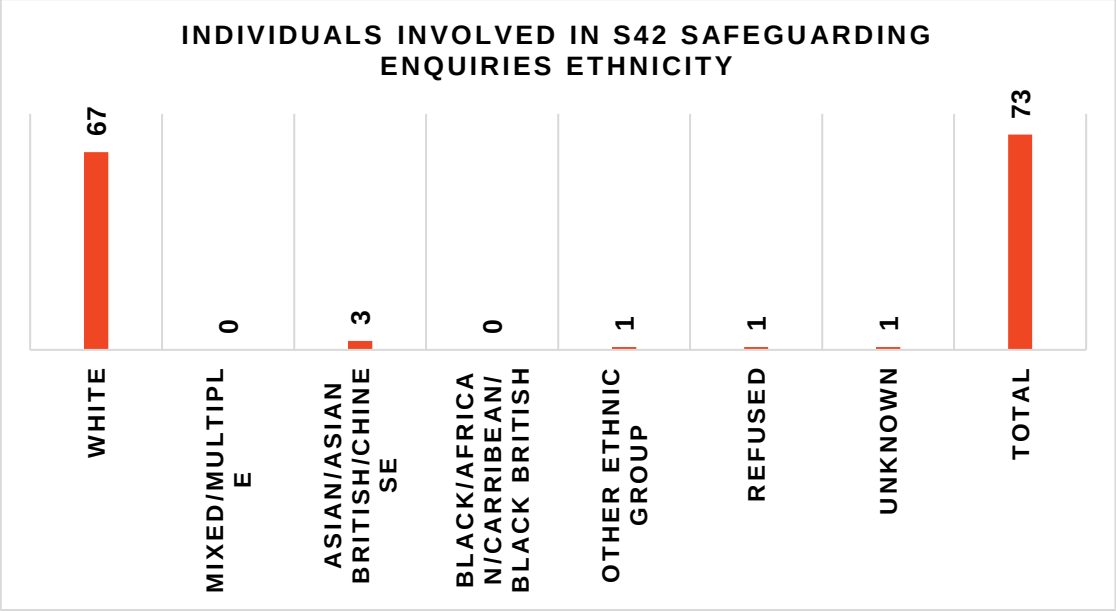
The age group with the most number of concerned raised is the 18-64 year age bracket. This is followed by the 85-94 and 75-84 age brackets. This is in line with what was seen last year, but again very different to the profile of need reported nationally which identified those aged 85+ as most likely to be subject to safeguarding interventions. The following figure shows the number of Section 42 enquiries that resulted from these concerns and as with the trend in the number of concerns, most section 42 enquiries are for the 18-64 age bracket.



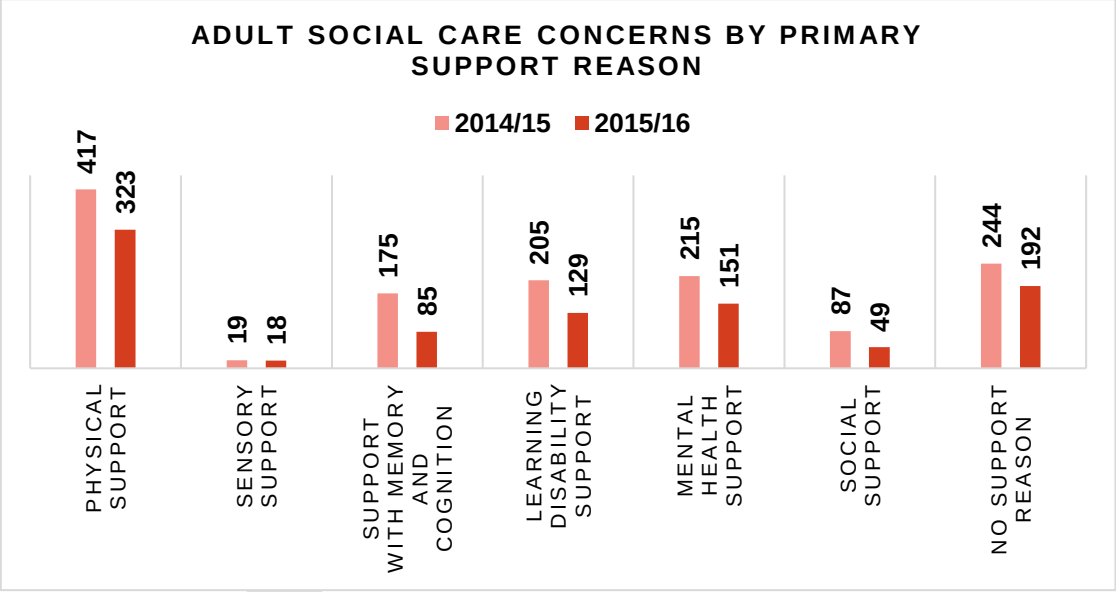
Ethnicity

The following figure shows the number of concerns received by Adult Social Care in terms of ethnicity. By far the most number of concerns were for the White Ethnic group. This is followed by the Unknown ethnicity group. A key priority for the LSAB and partners is to ensure more effective recording of ethnicity so that this can be more carefully monitored. We know that all our communities are at risk of abuse and neglect, we monitor this so that we can target information and support and engage more effectively with the issues that matter to specific communities.





Primary Support Reason

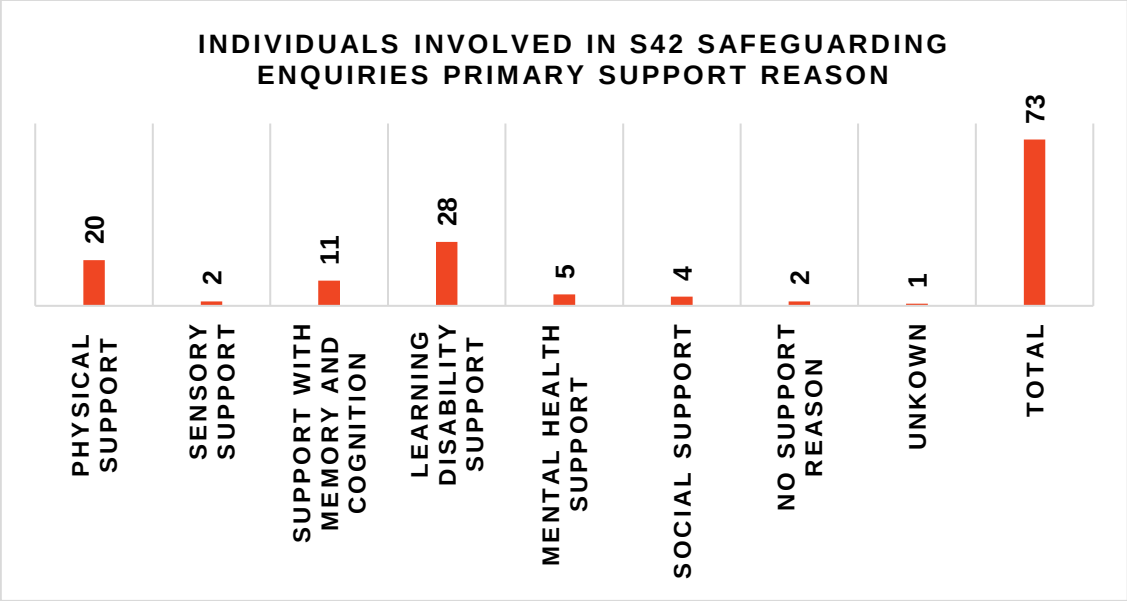


The figure above shows the number of concerns according to the primary support reason. Physical support is the most prevalent primary support reason. The next largest group is that of No Primary Support Reason and Mental Health Support. This is largely consistent with what it reported nationally.

Again it is believed that the number of 'no support reason' is as a result of poor recording or a misunderstanding by those raising concerns of the need for this information. The safeguarding obligation arises in respect of adults

who are in need of care and support. They do not need to be eligible for social care services, but it is vital that practitioners understand they notify (within the referral) why the adult is in need and therefore unable to protect themselves. This greatly assists those responsible for triaging concerns and ensures that the adult receives assistance at the earliest opportunity.

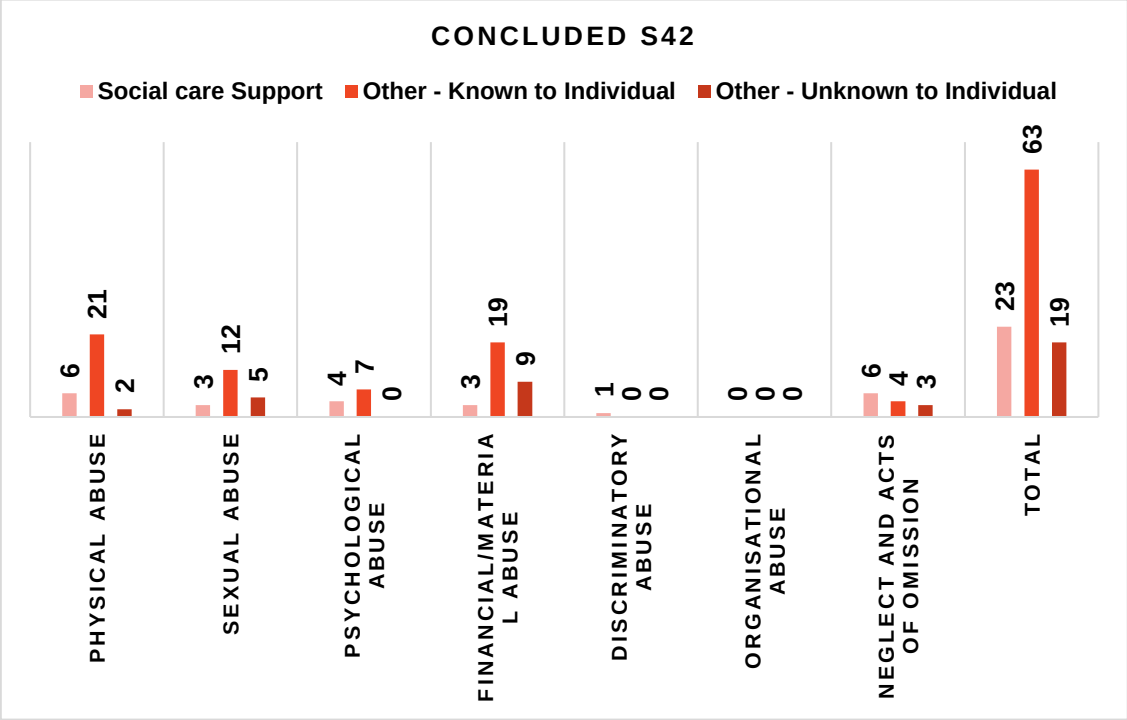
The LSAB will look to agree targets to reduce the numbers of not known or not recorded across all data fields so as to challenge professionals to ask these questions and record accurately. In addition, we will continue to closely monitor the primary support needs of adults when concerns arise to ensure that we are targeting our awareness campaigns and to ensure sufficient resources are made available to support those most at risk in Southampton.



Concluded Case Enquiries

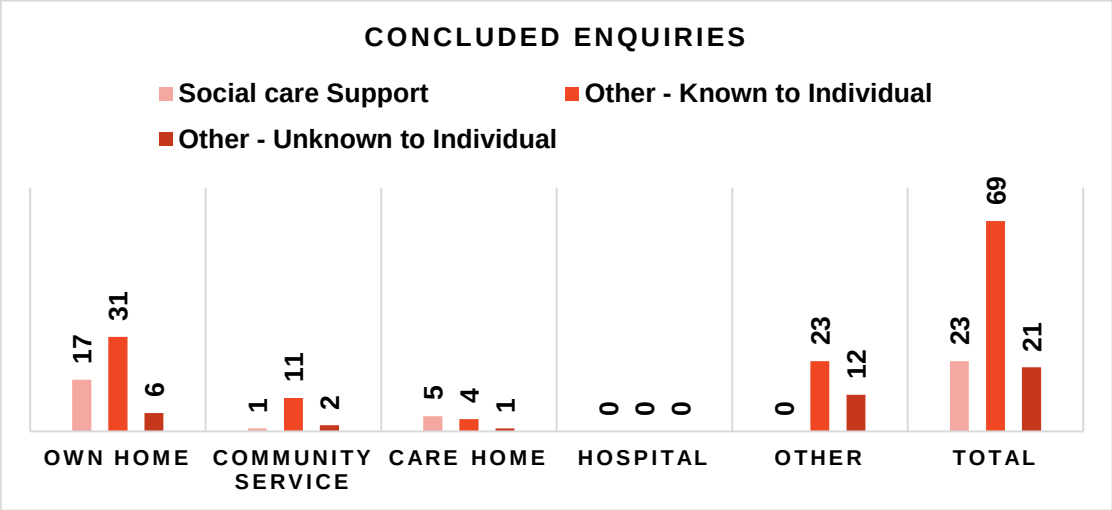
The following figures break down the number of the concluded Section 42 Enquiries.

Concluded case enquiring by type and source of abuse



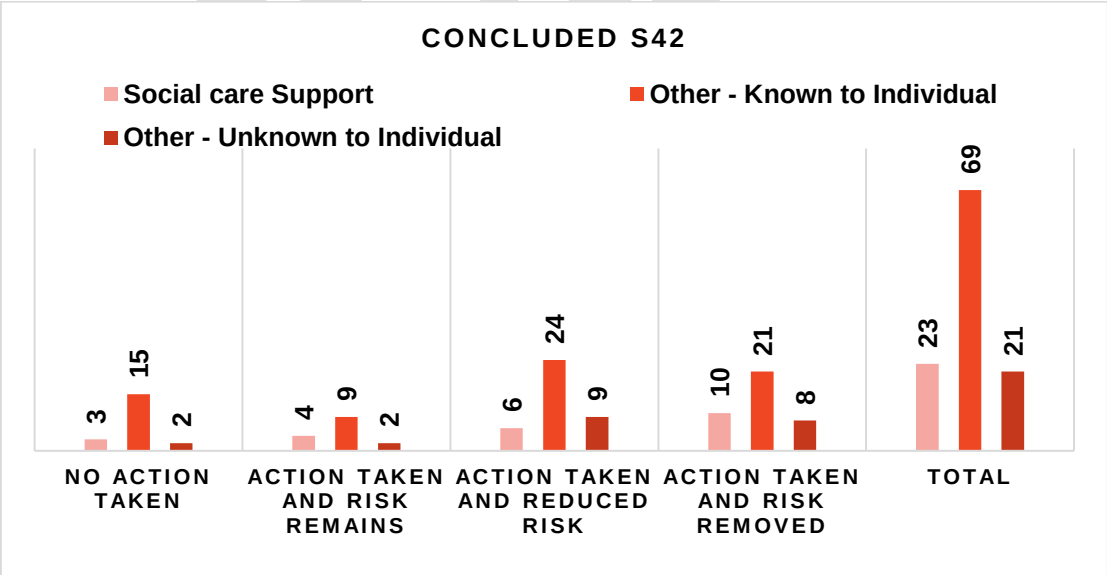
From SAC 2016, as reported by Adult Social Care, the category of abuse most prevalent in concluded Section 42 Enquiries is physical abuse and financial abuse. The data also shows that the source of risk for these types of abuse is mostly by someone known to the individual at risk. Again this is broadly consistent with what is reported nationally.

Concluded case enquiring by location and source of abuse



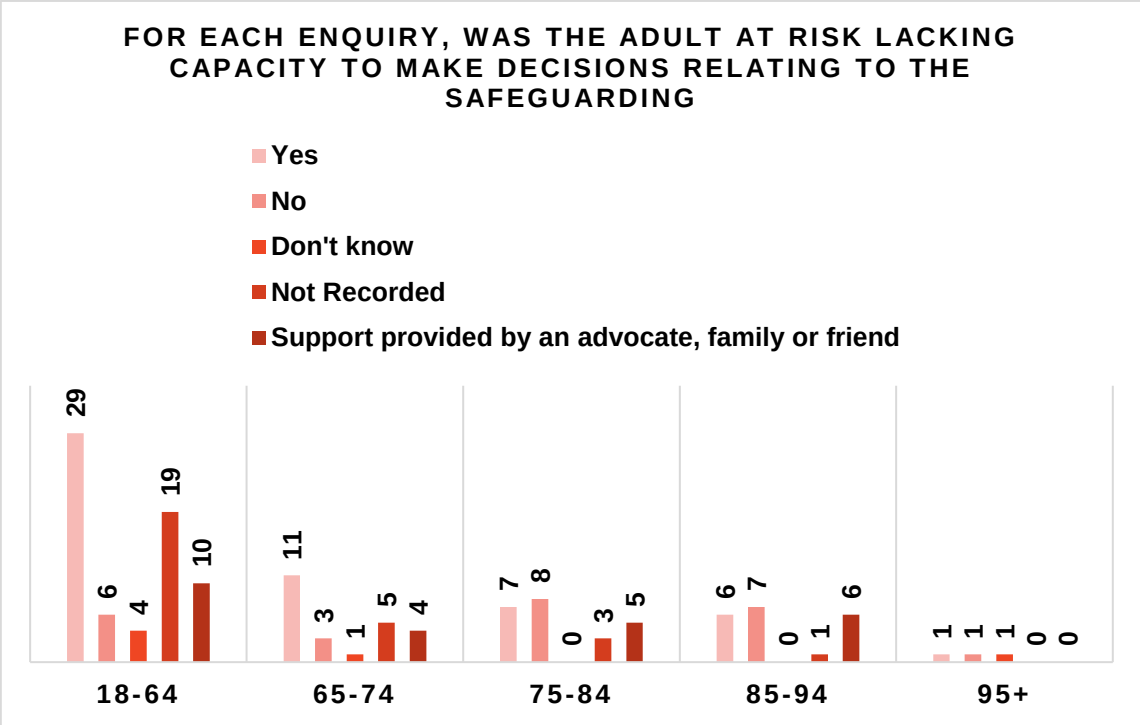
From SAC 2016, as reported by Adult Social Care, the data shows that the location of abuse is most often in the individual's own home. Once again the source of risk is predominantly someone known to the individual. This is similar to the pattern of abuse that is reported nationally, but it is noticeable that there is very little abuse reported in Care Homes and Hospitals within Southampton compared with what is reported nationally.

Concluded case enquiring by action taken and risk remaining



From SAC 2016, as reported by Adult Social Care, most concluded Section 42 Enquiries had action taken and either a reduced or removed risk. Both categories have 39 concluded enquiries each.

Mental capacity for concluded case enquiries



It is of concern that this data demonstrates there are still a high number of cases where the adults mental capacity is either not recorded or unknown at the conclusion of the case. It is also of concern that the data also suggests a large proportion of individuals who do not have capacity remain unsupported during a safeguarding enquiry despite this being a statutory obligations under s.68 Care Act 2014.

Following the finding of the House of Lords Inquiry into the Mental Capacity Act 2005 that showed the legislation was not well understood nor implemented, training was provided on behalf of the Southampton CCG to improve compliance. A series of workshops took place over a three month period in 2015. Staff from the NHS, Social Care, Police and the Ambulance Service and other partners attended the workshops. The workshops were focused on the practical application of MCA and DoLS within health care settings. The workshops were used to improve organisational and individual knowledge about legal responsibilities and accountability of the Mental Capacity Act whilst ensuring patients and users of services receive an effective service and safe care with minimal restraints.

How did the LSAB support adults at risk in Southampton 2015-2016?

The role of the Safeguarding Adults Board is governed by the Care Act 2014, Department of Health Guidance advises that Boards should:

- **Gather data so strategies are informed by an accurate picture of current risks faced by adults in need of care and support in Southampton.**

Gathering data on safeguarding activity undertaken by all partners has always proved challenging, but in 2015-16 partners appointed an analyst to the safeguarding boards' team to collate multi-agency data, analyse this and report any trends and key findings. In addition, the LSAB held a workshop with partners to review our Quality Assurance framework and agreed on key performance data that would be delivered by each partner to enable the LSAB's Monitoring and Evaluation group to start to build up an understanding of the picture of need within the city.

The data reports and performance reports from partners delivering frontline responsibilities were also reported directly to the full board throughout the year and have been summarised within this report. This should enable us to determine whether policy work, training and campaigns are having a practical impact on safeguarding interventions.

However, the Board recognises we still have notable gaps as key strategic partners continue to have difficulties in reporting certain data requested. In part this is due to amendments needed to IT systems to reflect the new Care Act duties and to meet different expectations for national data collections. The changes to national data requirements also make it difficult to compare data from year to year or form a true picture of progress made by partners. We continue to seek to address these challenges with all our

partners, but remain clear that our role requires this information and as such it is necessary for members to provide this in line with s.45 of the Care Act.

The Board has offered to assist partners improve record keeping and data collection so that a clearer profile of risk can emerge in the coming year. It is reassuring that senior managers within the partnership share an understanding that these data reports not only offer transparency and accountability but ensure operational practice accords with the statutory duties and that there is a clear evidence on which to base joint strategic decisions.

- **Seek assurance from partners that they are meeting core standards in safeguarding practice**

Within the 2015-16 Strategic plan we identified a need to obtain assurance that agencies understood pathways for referring safeguarding concerns. The LSAB also reviewed SCC operational guidance on the thresholds for s.42 safeguarding enquiries and were satisfied this complied with the obligations set out in the Care Act 2014 and the pan Hampshire safeguarding policy. The data, reported in previous pages, does identify areas for continued improvement. This information has informed our strategic plan and priority actions for 2016-17.

SCC and the CCG's Integrated Commissioning Unit provided bi-annual joint reports with the Care Quality Commission ['CQC'] on inspections and monitoring visits undertaken within residential, nursing home and domiciliary 'home care' services. In August 2015 they were able to report that the standards of care within the sector were improving in response to a more collaborative approach of working with providers to agree robust improvement programmes and firmer monitoring arrangements. For the second year running there has been no reports of any organisational abuse,

in addition the numbers of allegations made against social care staff and in care settings has reduced. CQC reported that their inspection regime had changed and was more challenging, particularly in respect of safeguarding. They confirmed 36% of providers in the city were rated good. However, as 54% of services inspected required improvement and 5% were inadequate, work will continue to raise standards of care to ensure adults in need receive a good quality of care and support which not only meets their day to day needs, but does so in a way that respects their choices, reflects their individual needs and upholds their dignity.

The Board received reports on emerging areas of risk, including work undertaken by Hampshire Constabulary to raise awareness and address national challenges such as honour based violence. The Police and the LSAB have provided 11 training opportunities for practitioners across statutory and voluntary services to learn more about their new duties in relation to Female Genital Mutilation and to assist frontline staff respond effectively to Forced Marriage and Human Trafficking. In 2015-16 the police obtained consent from twelve Southampton residents to refer them for support as victims of trafficking. This is a type of abuse is extremely difficult to identify so these figures likely represent only a fraction of the risk in the city. Currently partnership work on Human Trafficking is led by the Police and Crime Commissioner and, in Southampton, the Safer City Partnership [‘SCP’]. The safeguarding board’s joint Learning and Development sub group are working alongside the SCP to develop a programme of multi-agency training that supports those already offered by Hampshire Constabulary, aimed at raising awareness. We will continue to participate in the steering group set up to meet the local challenges to implement guidance (expected in the Autumn of 2016) on the new obligations for us all to recognise, report and respond effectively when adults at risk are exploited for domestic or commercial use.

The Police also reported on the success of pilot initiatives to address a rise in reports of missing people. This includes the use of new technologies to support people with dementia or other cognitive impairments and their carers who value their independence, but may require reassurance that they could easily, or if certain circumstances automatically, notify their carer if they were to find themselves in an unfamiliar area or in any difficulty. The police recognise that frontline officers play an important part in helping to locate and return missing people. However, we know from poor outcomes in the past, that anyone with caring responsibilities recognises the risk for any adult they care for and works to reduce that risk. Furthermore, when an 'adult at risk' does go missing carers must ensure they assist the police, providing all relevant information e.g. accurate description, usual routines, level and type of risk they may face and anything that might increase that risk (e.g. prolonged delay in accessing medication) as well as access to the person's home so that thorough investigations can progress quickly.

Southampton City Council reported on changes made to drug and alcohol services with increased focus on structured intervention services working in partnership with the voluntary sector. Public Health services and Hampshire Constabulary also reported on work undertaken to minimise drug activity and the harm that this causes to residents in the city. The Council report on plans to integrate MARAC responsibilities into the Multi Agency Safeguarding Hub ['MASH'] so as to build on the improvements to practice already starting to have an impact on responses to domestic abuse.

The Police also reported on the challenges they face addressing a significant rise in reported incidents of rape and serious sexual offences. The LSAB have long been concerned that this type of abuse is underreported, particularly when the victim has additional vulnerabilities. The tragic death of a Southampton resident served to reinforce our resolve to push for continued improvement in recognising such risks. We know

residents in Southampton share a common belief that, whatever our frailties, we are all entitled to live our lives free from abuse. These values underpin safeguarding practice and cores duties. The LSAB is working with all agencies to review this case and understand what lessons could be learnt. The findings and recommendations will be reported to the Board in due course. In 2016-17 the board will also undertake a thematic review to better understand how well partners work together to identify risks of sexual harm, protect those most at risk and successfully prosecute those responsible.

In addition, during the course of the year two key themes emerged from the performance reports and work of the sub groups which received significant attention from the Board.

Mental wellbeing

Representatives of member agencies play an active role in the development of the Mental Health Crisis Concordat action plan. During the course of 2015-16 partners regularly reported on the implementation of this plan and the impact for adults at risk. For example, training across agencies on Mental Health First Aid should increase support and reduce stigma for those affected by mental ill-health. Representatives from SHFT and the police reported an increase in joint working on ‘operation serenity’. This was a programme of joint training and practical improvements in service provision. Front line police officers were supported with direct access to mental health staff based in the police control room, SHFT staffing within the emergency mental health assessment unit and increased access for temporary assessment places for young people in the city. Also more flexible commissioning arrangements has enabled ambulance staff responsible for transporting those subject to s136 MHA to support a least restrictive response. All of this has seen a dramatically reduction in the use police powers under s.136 of the Mental Health Act to temporarily detain those at risk due to mental ill health.

Southampton University Hospital Trust ['SUHT'] and CQC reported they had undertaken a mental health thematic review detailing national and local issues. The report identified a number of areas of good practice in Southampton, but suggested that Improved out of hours access to Approved Mental health Professionals and s.12 Doctors particularly outside of normal working hours, would reduce delays for those requiring initial mental health assessments and decrease pressure on A&E services.

The way in which individuals experiencing mental ill health has been substantially redesigned over 2015-16. The LSAB were also consulted as part of the mental health matters consultation on the service redesign and will continue to seek assurance from commissioners and providers that these changes are effectively meet local people's needs.

Mortality review

Referrals received in 2014-15 under the LSAB's Learning Review Framework had identified a need to improve practice in mortality reviews and serious incident reporting.

Over the course of 2015-16 the LSAB received a number of reports from partners on research or learning reviews following the deaths of those in need of care and support. The Director of Public Health reported on work his team had undertaken reviewing drug related deaths and provided a separate report on research into risk factors for suicides in the city. It was noteworthy that 62% of those who sadly go on to commit suicide were not known to services set up to offer support. Following on from this, in August 2015, representatives from Southern Health Foundation Trust summarized key findings from a review they had undertaken in response to deaths by suicide and serious episodes of self harm of their service users that occurred over a 12 month period from April 2014 to March 2015. The review also included benchmarking against the National Confidential Inquiry into

suicide and homicide and other local reports and information relating to suicide and self-harm. Recommendations from these reviews form the basis of SHFT's improvement plan. They continue to report on the implementation of this and have agreed to submit key performance data to the LSAB so that the impact of practice and policy improvements can be monitored. The Board also agreed, as a result of this work, to seek to engage more closely with the work of the Director of Public health and the Health and Wellbeing Board to develop a local Suicide Prevention Strategy.

In December 2015 the release of the MAZARs report into SHFT's processes for undertaking mortality reviews brought this work to the attention of the public. Partners, including commissioners and SHFT, worked with adult safeguarding boards to acknowledge that processes for investigating and reporting a patient death, whilst improving, needed to be better. The LSAB acknowledged work already undertaken locally in Southampton had started to address many of the concerns raised within this report. The Chair of the LSAB's case review group confirmed they were receiving referrals, in line with what they would expect from SHFT, suggesting that practitioners were proactively engaging with the s.44 safeguarding adults review process. It also received confirmation that Southampton City Council will review the s.75 partnership agreement to ensure this complied with the safeguarding duties under the Care Act.

The LSAB is actively involved in multi-agency work to design a comprehensive process for learning from mortality reviews. This is a complex because it will need to take into account work already undertaken in line with the NHS's Serious Incident Reporting Framework, the role of the Coroners and partnership duties to conduct serious case reviews, safeguarding adults review, domestic homicides, MAPPA and mental health homicide reviews. It will also need to account for the changes anticipated to the Child Death Overview Panel's processes.

Lead on policy and strategy development for protecting adults

Operational staff from Southampton's LSAB partners played an active role in the development of the Pan Hampshire Safeguarding Policy and guidance. The draft document was then fully considered by the strategic leads at the Board. Suggestions made by Board partners were incorporated into the final version which was ratified by the Board in June 2015.

Another key action required within the 2015-16 strategic plan was to seek assurance that the local authority and relevant partners were using risk assessment and risk management process effectively. The high level of repeat concerns, reported over a number of years, raised questions over whether there was a well understood process for multi-agency assessment and management of risk including for concerns reported outside of normal office hours. In order to support practice improvement the operational and strategic members of the LSAB worked with colleagues across Hampshire, Portsmouth and the Isle of Wight to agree a joint framework for multi-agency risk assessment. This is due to be ratified by the Southampton LSAB in July 2016.

Work with other key partnerships to coordinate activity to meet common objectives across the partnerships

The Board continues to strengthen links between key partnerships in the city and with safeguarding boards across the region. In 2015-16 we continued to coordinate regular meetings with the 4 LSAB in Hampshire and the Isle of Wight and relevant partners to share learning, ideas and coordinate policy developments. During 2015 the board received reports from MAPPA, the LSCB and SCP on key data and strategic plans going forward. In addition, the Chairs of the Health and Wellbeing Board, LSAB, LSCB, SCP and Southampton Connects agreed a quarterly programme of

meetings to discuss issues affecting the city and look to coordinate activity. We have also worked with the LSCB and SCP in delivering joint awareness programmes on lessons learnt from case reviews and continued the practice of sharing annual reports so that our work could inform decisions where there are synergies.

In 2015-16 the LSAB Chair also attended meetings with Police and Crime Commissioner, Health Watch, the Health and Wellbeing Board and SCC's Overview and Scrutiny Committee to present the annual report and consult on our key priorities.

Audit organisations' safeguarding practice

In 2015-16 the LSAB launched its Quality Assurance framework and Organisational Audit Tool. This tool enables organisations to review the effectiveness of their internal safeguarding arrangements and to identify and prioritise any areas needing further development. The tool requires organisations evidence that the safeguarding responsibilities are embedded throughout the organization by looking at how it influences the leadership, policy and procedures, commissioning and contract obligations, workforce development and practice.

This is a self-evaluation, but on completion the report is scrutinised by the LSAB's Monitoring and evaluation subgroup who are encouraged to challenge if information is incomplete or there is insufficient evidence to support their self-evaluation. During the year audits were undertaken by Hampshire Community Rehabilitation Company, Southern Health Foundation Trust, Hampshire Constabulary, Hampshire Fire and Rescue Service, University Hospital Southampton, Solent NHS Trust, SCAS, SCC Licensing and SCC Regulatory Services. The Monitoring and Evaluation group made suggestions to a number of those agencies about how they may want to evidence improvements in future years. Each partner is

expected to feedback, according to their own internal governance arrangements, the advice given by the LSAB and use this when determining improvement plans or strategic priorities.

The process is a collaborative one, aimed at supporting organisations to improve with the support of the LSAB members. Many agencies reported they found the process of undertaking the audit very helpful to assist them in focusing on meeting the new statutory duties associated with safeguarding work. Common areas for improvement emerging from the audits included difficulties in collating data and staff knowledge of new legal obligations and practice standards.

Reviewing cases with poor outcomes: what we did, what we learnt and how we know this has improved practice

During 2015-16 the LSAB supported a MAPPA Review, through participation by the Safeguarding Board manager and SCC's Director of Social Care, a review into the death of a Southampton resident. That report has not yet been completed or the findings and recommendations finalised. The LSAB have agreed to undertake further work to look at whether services could have worked more effectively together to protect the victim from abuse.

The Board received a partnership review report following the death of an adult who was known to multiple services. Previously the Coroner had confirmed that the cause of death was not linked to abuse or neglect and as such there was no requirement to undertake a Safeguarding Adult Review. However, given the nature of the adult's needs and circumstances surrounding their death, the LSAB believed there were opportunities to learn lessons from this case. Each agency involved in the provision of care reviewed their practice and contributed to the review. The report found that many opportunities to proactively support the adult may have been missed,

because professionals were not working together to form a picture of the adult's needs, nor did they recognise the long-term impact of persistent low level health concerns. The review acknowledged practitioners from different disciplines often lacked detailed understanding of the roles of other professionals, be that police powers in missing persons enquiries, GPs involvement in monitoring mental and physical health or the role of a specialist health and social care professionals. They also found there was overreliance on lead professionals to undertake tasks to address needs that lay outside of their legal powers. Organisational change and the inevitable instability that brought to a workforce impacted on relationships of trust between staff and the adult at risk and between professionals, contributing to poor multi-agency risk management.

Out of respect for the wishes of the adult's family this review has not been published, but the key findings have been used to:

- Help shape service redesign.
- Reinforce the benefits of early intervention and preventative work that is 'person centred'.
- Encourage staff to implement the 'making safeguarding principles' of engaging adults and their wider community to agree ways of addressing safeguarding risks that lifestyle or deteriorating health may expose.
- Shape the content of specific training and briefing sessions with staff across the partnership
- Shape the self-organizational audit tool under the quality framework, specifically in respect availability of supervision and professional challenge.

The full board also received a report on a case reviewed by the LSCB where there were opportunities to improve responses to risks posed by adults in need of care and support. The shared safeguarding Board team

Keeping people safe is everybody's business……..

If you are concerned that someone you know is being abused or harmed please call Southampton City Council Single Point of Access for Adult Social Care on 02380 833003 or visit the website here.

If the person has been seriously hurt or a crime has been committed please call 999.

and Chairing arrangements for the LSCB's Case Review subgroup continued during 2015-16. This provided opportunities to discuss the needs of adults within the context of safeguarding children and young people to ensure that agencies consider a 'whole family' approach to safeguarding risks.

Engaging with communities and raising awareness

In 2015 the CEA sub group reviewed and refreshed its membership and agreed a new plan focusing on strategic development so that any awareness raising activity by the safeguarding boards more closely linked with partners' existing plans for community involvement across the city. The LSAB has continued to consult regularly with voluntary sector groups through SVS, attending a number of meetings to discuss their experiences of the safeguarding process, report on the annual report and consult on the strategic plan. As one supported housing provider stated, "I find working together with the safeguarding team to protect our clients is a very collaborative, positive process".

We recognise, however, that we need to continue to reach out to communities and raise awareness within the public if we are to reverse the reduction in concerns being raised by them. This is important because nationally in cases where the adult was not previously known to services, 82% of alleged abuse took place in the adult's home. It is therefore vital that family, friends and neighbours recognise if a person they know is experiencing or at risk of abuse or neglect and are confident that reporting their suspicions or concerns will result in safe, effective protection. A key action within the strategic plan for 2016-18 is to deliver a robust plan for better community engagement and the safeguarding boards held a week of awareness raising events in June 2016.

Providing training opportunities across partnership

The LSAB has provided training to a range of professionals across a wide variety of subjects to assist practitioner recognise types of abuse such as self-neglect and hoard, physical abuse and financial exploitation. Advisory sessions on substance misuse, adult mental health first aid, welfare benefit changes, debt management etc. also ensure that practitioners were better able to support vulnerable clients. In addition, the Board has run a number of awareness raising events on key topics such as learning from case reviews, 'making safeguarding personal' and equality and diversity issues. The Board has also provided briefing sessions to Southampton City Councilors in order that they are aware of the duties owed to adults at risk of neglect, abuse and exploitation and how the adults safeguarding corporate responsibilities affect their decision making.

The Board commended the work of Dr Ali Robbins and GP's from across the City who engaged in training on new responsibilities. This included the role of GPs in safeguarding adult's reviews and the preparation of individual management reports, Mental Capacity training, Clinical supervision standards and recording concerns on medical records (read codes/flagging systems). Future work programmes will build in this. The board were advised of established links with NHS England who were responsible for overseeing performance of GP's. It is noteworthy that during 2015-16 7 GP practices had received CQC Inspection and safeguarding had not been raised as a concern in any one of the inspections. The LSAB will look to work with the CCG and NHSE who have recently appointed a strategic lead for safeguarding adults to build on this work. We know, from the learning reviews undertaken in 2015-16, just how vital GP and primary health care services are to identifying safeguarding risks and to provide (as part of a multi-disciplinary team) support, which is person specific, for adults who are experiencing, or at risk of, abuse and neglect.

Board partners have also responded to the threat posed by extremism, partly in relation to preventing groups targeting adults at risk. As a result of the implementation of the Counter Terrorism Act the Local Authority are now responsible for the strategic lead role in implementing a 'PREVENT' strategy. The LSAB received an update on mechanisms for multi-agency coordination of any interventions needed to protect those vulnerable to exploitation by extremists. Further work is needed to raise awareness of how partners and communities should respond effectively to meet safeguarding duties to adults at risk across all agencies,

Mental Capacity and Deprivation of Liberty Safeguards ['DoLS']

SCC report continued pressure to meet the huge rise in requests for authorisations under the DoLS procedure. The Council, as reported in last year's annual report, act as Supervisory Body under this process. The law requires that if someone does not have capacity to agree to care arrangements, but requires constant supervision or would not be free to leave their care arrangements, the Supervisory body must commission an independent assessment to determine whether it is in that person's best interests to be subject to those care arrangements. The Supervisory Body cannot authorise the arrangements if there is a more proportionate way to meet the person's care needs. This applies whether the care is provided in a residential or nursing home setting or hospital. However, anyone providing care to a person which deprives them of their liberty, even within a family home, must obtain lawful authority to do so as our right to liberty is protected by article 5 of the European Convention of Human Rights.

It is important that staff from across health, social care and supported living sectors recognise when measures taken to provide protective care impose restrictions which amount to a deprivation of liberty. They must also know when and how to apply for authorisation, as without this those they care for can't benefit from the scrutiny such independent assessments provide. In

June 2015 the CCG reported they have provided a comprehensive programme of training for staff from NHS, Social Care as well as other partners of the local authority and clinical commissioning group, for example, police and ambulance service.
This was well attended and feedback from the events was very positive.

Southampton City Council's Adult social care department have also confirmed they have now provided training for 10 'Best Interest Assessors" (who qualified in 2015/16) so that more assessments can be undertaken within timescales. Despite this pressure remains acute as the legal, financial and reputational risk of non-compliance is high. Conversely the cost to the Local Authority of commissioning external experts to undertake the assessments within the timescales places significant impact on other operational duties and priorities. It is therefore disappointing that the Department of Health has refused to recognise the financial impact of this legal obligation.

The Board also received reports from partners responsible for providing care and treatment within in-patient settings identifying concerns regarding the impact that securing authorisation had in respect of palliative care provision. Recent guidance has meant that Coroners were now required to consider those who had died whilst subject to a DoLS authorisation as a 'death in state custody'. This is reported to have caused significant distress to many family members, especially where there isn't a dispute that the care provided to loved ones was necessary and proportionate in the circumstances.

The adverse impact on resources, staff and families is the subject of national concern and currently being considered as part of a Law Commission's consultation on the matter. The LSAB recognises the importance of the legal principles protected by the procedures, but is working to secure more effective means to implement these in practice. The Board was well represented by operational and strategic leads at the Law Commission's consultation event in Hampshire, we have also had discussions with the Coroner locally and provided extensive and detailed

responses to the questions and proposals contained within the Law Commission's consultation document. The LSAB will continue to monitor the how well the DoLS procedure operates locally and work with our partners to support effective, safe care. But equally we will work with national bodies to highlight concerns until a practical solution which respects individual's rights can be implemented.

Glossary

CCG	Clinical Commissioning Group
CQC	Care Quality Commission
DoLS	Deprivation of Liberty Safeguards
HFRS	Hampshire Fire and Rescue Services
LSAB	Local Safeguarding Adults Board
LSCB	Local Safeguarding Children Board
MAPPA	Multi Agency Public Protection Arrangements
MSP	Making Safeguarding Personal
SCAS	South Central Ambulance Service
SCC	Southampton City Council
SCP	Safe City Partnership
SHFT	Southern Health Foundation Trust
SVS	Southampton Voluntary Services
UHS	University Hospital Trust