Southampton Safeguarding Adults Board Annual Report 2016 - 2017

Annual Report
2016 - 2017

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Southampton Safeguarding Adults Board Annual Report

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1. Statement by the Chair:

I am very pleased to introduce this Annual Report from the Southampton Adults Board (SLSAB).

The Annual Report shows how the SLSAB has delivered on the areas of work previously identified as priorities for 2016/17. This is important because it shows what the Board aimed to achieve and what was actually done both as a partnership and through the work of participating partners. The report aims to provide a picture of who is safeguarded in Southampton, in what circumstances and why.

I am very mindful of pressures on partners in terms of resources and time and am grateful to all those who have engaged in the work of the SLSAB. I would like to acknowledge all the hard work that takes place on the frontline, and across the partnerships every day and you should feel proud of the contribution you make.

I would also like to take this opportunity to thank Fiona Bateman who stepped down as Board Chair in August of this year. Fiona Chaired the Board with considerable knowledge and I know all board members will join me in thanking her for her support, guidance and dedication. Fiona leaves the Board much stronger and more effective than when she arrived in 2014.

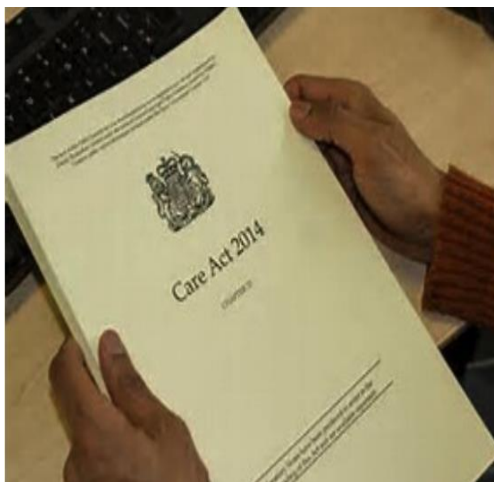
Robert Templeton
Independent Chair of Southampton Safeguarding Adults Board

2. Introduction

Welcome to Southampton Local Safeguarding Adults Board (SLSAB) annual report. This report describes the work that has been undertaken locally to protect adults at risk in Southampton. The purpose of the report is to share information on our achievements and future plans with our partners, those who use services and residents of Southampton. We are very proud of our achievements but know there is still a lot to do and we are committed to continuing our work to deliver great adult safeguarding services across Southampton.

The SLSAB's main objective is to ensure that local safeguarding arrangements are in place and partners act to safeguard adults at risk. The Board has strategic oversight of adult safeguarding across the locality. 'Making Safeguarding Personal' is at the heart of the Southampton Safeguarding Adults Board, working with adults at risk of abuse, neglect or exploitation to ensure they are as safe as they want to be and are helped to make their own decisions.

3. What is Safeguarding?



'Safeguarding is defined as 'protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult's wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action'

Care Act 2014

4. What is Abuse and Neglect?

The Department of Health gives the following as examples of abuse and neglect. However, as abuse and neglect can take many forms, local authorities should not be constrained in their view of what constitutes abuse or neglect, and should always consider the circumstances of the individual case.

Physical

- including hitting, slapping, pushing, misuse of medication, restraint or inappropriate physical sanctions;

Sexual

- including rape and sexual assault or sexual acts to which the adult has not consented or was pressured into consenting;

Psychological

- including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, isolation or unreasonable and unjustified withdrawal of services or supportive networks;

Exploitation

- either opportunistically or premeditated, unfairly manipulating someone for profit or personal gain;

Financial or material

- including theft, fraud, exploitation, coercion in relation to an adult's financial affairs or arrangements, including in connection with wills, property , inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits;

Neglect and Acts of Omission

- including ignoring medical or physical care needs, failure to provide access to appropriate health, care and support or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating;

Discriminatory

- including discrimination on grounds of race, gender and gender identity, disability, sexual orientation, religion, and other forms of harassment, slurs or similar treatment; and

Institutional (or organisational)

- including neglect and poor care practice within an institution or specific care setting like a hospital or care home, for example. This may range from isolated incidents to continuing ill-treatment.

5. About the Southampton Safeguarding Adults Board

The SLSAB is a partnership of key organisations across Southampton who work together to keep adults safe from abuse and neglect. These include:

- Adult social care
- Health
- Emergency services
- Prison and probation services
- Housing
- Community organisations

The Board has an independent Chair that can provide some independence from the local authority and other partners. This is especially important in terms of:

- Offering constructive challenge
- Holding member agencies to account
- Acting as a spokesperson for the SAB

The Board is a statutory body that works to make sure that all agencies are working together to help keep adults in Southampton safe from harm and to protect the rights of citizens to be safeguarded under the Care Act 2014, Mental Capacity Act 2005 and the Human Rights Act 1998.

The overarching purpose of SLSAB is to help and safeguard adults with care and support needs. It does this by:

- Assuring itself that local safeguarding arrangements are in place, as defined by the Care Act 2014 and statutory guidance;
- Assuring itself that safeguarding practice is person-centered and outcome-focused;
- Working collaboratively to prevent abuse and neglect where possible;

- Ensuring agencies and individuals give timely and proportionate responses when abuse or neglect have occurred; and assuring itself that safeguarding practice is continuously improving the quality of life of adults in its area.

6. Vision

The work of the Board is driven by its vision that we all work together to improve the safety and wellbeing of Adults at risk of harm in Southampton and that we:

- **Have a culture that does not tolerate abuse**
- **Work together to prevent abuse**
- **Know what to do when abuse happens**

The SLSAB leads adult safeguarding arrangements across its locality and oversees and coordinates the effectiveness of the safeguarding work of its member and partner agencies. The Care Act (2014) gives SABs three specific duties it must:

1. Publish a strategic plan for each financial year that sets out how it will meet its main objective and what each member will do to implement that strategy. In developing the plan it must consult the Local Healthwatch organisation and involve the community.

2. Publish an annual report detailing what the SAB has done during the year to achieve its objective and what it and each member has done to implement its strategy as well as reporting the findings of any Safeguarding Adults Reviews (SAR) including any ongoing reviews.

3. Decide when a SAR is necessary, arrange for its conduct and if it so decides, to implement the findings. Where the SAB decides not to implement an action from the findings it must state the reason for that decision in the Annual Report.

16 - 25?
FIRE & RESCUE

7. Principles

Southampton Safeguarding Adults Board believes that:

- People have the right to live their lives free from neglect and abuse
- Safeguarding adults is the shared responsibility of all organisations and agencies commit to holding each other to account
- The individual, family and community should be at the heart of safeguarding practice
- High quality multi-agency working is essential to good safeguarding
- Adults have a right to take risks and that this will sometimes restrict our ability to act
- There should be transparency in delivering safeguarding
- There must be a commitment to continuous improvement and learning across the partnership

The work of the Board is underpinned by the following principles:

Empowerment

- Presumption of person led decisions and informed consent.

Protection

- Support and representation for those in greatest need.

Prevention

- It is better to take action before harm occurs.

Proportionality

- Proportionate and least intrusive response appropriate to the risk presented.

Partnership

- Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.

Accountability

- Accountability and transparency in delivering safeguarding.

8. Governance

Southampton Safeguarding Adults Board is Chaired by its Independent Chair and meets four times a year bringing partners together from: Southampton Council, Hampshire Police, Hampshire Fire Services, the Ambulance Service, Southampton Clinical Commissioning Group, health trusts, probation services, the voluntary sector and other members representing health, care and support providers and the people who use those services across Southampton. The SAB has a number of subgroups Chaired by senior members from across the partner agencies. During the year the structure of the Board changed to reflect priorities and efficiencies.

The Chair of SLSAB reports to the Health and Well-Being Board and meets regularly with the Chief Executive, the Director of Adult Services, the Lead Member for adult safeguarding, the Leader of the Council, and the Chair of the Safeguarding Children Board. The Chair also meets annually with the Council's Scrutiny Committee. Links are maintained through representation on key strategic partnerships:

- Community Safety Partnership
- The Health & Wellbeing Board
- The Safeguarding Children Board

The work of the Board is financed by contributions from partner agencies, of which currently the majority comes from the council. In addition to financial contributions, partner agencies contribute significant amounts of staff time to support the delivery of the Board's work programme, and to support training delivery.

9. Progress Against Priorities 2016 - 17

The Board identified a number of key themes required scrutiny at greater depth to enable the Board to understand the nature of the issues and ascertain how the partnership could work more effectively to address these issues when undertaking their core business functions. The Board identified the following 5 key actions:

1. **Evaluate the local knowledge of and compliance with the Mental Capacity Act and 'Making safeguarding personal' approach in Southampton.**

2. **Deliver a programme of multi-agency audits to provide more detailed picture of services ability to identify and respond to safeguarding risks within specific areas of concern.**

3. **Deliver thematic meetings focused on key areas of concern identified through case reviews, audits or local and national events to obtain assurances that partner agencies are working together to meet key safeguarding challenges.**

4. **Deliver a revised Community Engagement Plan: What have we done this year and how do we demonstrate we are shaping practice through listening to adults at risk, carers and partners?**

5. **Learning and Development sub group to carry out audit of safeguarding training to seek assurance that providers are compliant with Care Act responsibilities and devise programme of workshops linked to priorities**

Priority one: Evaluate the local knowledge of and compliance with the Mental Capacity Act and 'Making safeguarding personal' approach in Southampton

In October 2016, the Board agreed to commission an independent review to fully evaluate compliance and understand how those experiencing safeguarding interventions view the system in Southampton. This was led by an author of the national 'making safeguarding personal' programme. The report collated information from safeguarding data, organisations' self-assessments and an on-line and frontline staff survey. It analysed practice in case studies of early intervention and more detailed safeguarding enquiries. The authors also met with advocacy groups and with representatives of providers of services, carers and with adults who have experience of safeguarding processes.

The partners' shared aspiration is to create a culture of proactive risk assessment, where risk management plans are co-produced with the adult at risk and those caring for them, where people can say when things aren't quite right and providers/ carers ask for support. The report recognised that to achieve this, staff across organisations

require further support working with risk, cooperating and communicating effectively across agencies. The Board must provide leadership on these core principles.

The report advised that the Board carries out a number of actions including the following:

- Adopting the use of standalone chronologies for recording complex cases in order to help identify patters or escalation of concerns.
- Devise a tool to guide practitioners and support effective record keeping. This would enable the relevant professionals and the adult at risk to have a clear understanding of what actions need to be taken and this could also be used to assist reflective practice in supervisions.
- Develop a meaningful feedback process so the partnership and single agency organisations can develop from learning in the City.

The action plan produced as part of the report provides the Board with firm foundations to take this important work forward. This has already been used to update the Strategic plan for 2017-18 so that there is specific reference to the next steps agencies and the Board will take to embed MSP principles into safeguarding practice. In addition, the Monitoring and Evaluation sub-group (M&E) met in March 2017 to review the findings of the MSP audit and further develop the action plan, with specific focus on what each partner agency can do to further embed practice within their organisation.

There is now a ‘Making Safeguarding Personal’ task and finish group in Southampton. They will focus on developing an assessment tool and a chronology template as described above. This will go to Board and be shared with partners in 2017 – 18.

The LSAB has agreed a new process for disseminating learning that will take place in 2017 – 18. When an audit or a case review is complete, feedback will be shared with partners and practitioners in the following ways:

- 6-step briefing – detailing findings and recommendations.
- A 5 – 10 minute video outlining key findings and learning points.
- Learning newsletter disseminated quarterly.
- Learning points factored in to Safeguarding Training offer.
- Specific ‘learning workshops’ offered throughout the year.

Priority two: Deliver a programme of multi-agency audits to provide a more detailed picture of services ability to identify and respond to safeguarding risks within specific areas of concern.

In June 2016 the LSAB agreed to prioritise the delivery of thematic reviews, these reviews considered how well partner agencies comply with their core statutory functions, prevent needs escalating and effectively work to reduce or remove risk.

The Board commissioned an independent author to conduct a review of self-neglect. The author conducted a detailed audit of two cases where adults had suffered significant harm or died as a result of perceived ‘self-neglect’. In addition, she held face to face meetings with a range of professionals to ascertain how they feel services work together to identify risk and put in place effective protection plans. She then met with the Monitoring & Evaluation group and LSAB’s Independent Chair in November, for further discussion on how best the Board and partners could action the

recommendations. The full report and feedback from partner agencies was then considered by the Board in December 2016, a summary report is also available. The Board recognised this review provided a 'wake up call' for Southampton agencies.

Part of the LSAB action plan was to establish a specific task and finish sub group with nominated members from relevant partner agencies to drive forward this important work. The review had also identified that the Pan-Hampshire policy was inconsistent and out of date. The LSAB Chair agreed to support swift implementation by drafting a revised protocol. This group reviewed the draft protocol before it was presented to the 4LSAB Pan – Hampshire policy group in February 2017.

Presently the task and finish group's focus is on ensuring effective pathways are in place in Southampton so that staff know where to refer and how to ensure a coordinated, personalised and effective response is provided.

The task and finish group also strongly recommended the adoption of an agreed assessment tool to support early identification of issues and effective joint protection planning. A self-neglect toolkit is due to be complete and disseminated widely in Southampton during 2017 – 18.

Priority three: Deliver thematic meetings focused on key areas of concern identified through case reviews, audits or local and national events to obtain assurances that partners are working together to meet key safeguarding challenges

In July the Board considered issues affecting Carers in Southampton and whether services were meeting the expectations under the Care Act 2014. This was timed to coincide with the publication of Southampton's Strategy for Unpaid Carers and Young Carers for 2016-2020. Staff from Southampton Carers presented two case studies where carers had become involved in safeguarding enquiries. In one particular case, a carer expressed that there are many carers who are known to have learning disabilities without their own care manager. This comment prompted the Safeguarding Lead for Adult Social Care to assure the Board that although there slippages during the transformation period, this is swiftly being rectified. This will be monitored annually by the Board.

In October 2016 the Board themed their meeting to consider accommodation based issues and the impact these had on safeguarding. In part this was identified following a reported increase in the use of 'legal highs' by those using supported accommodation and emergency homeless hostel provision in the City. In addition, it was understood that the benefit cap (to be introduced in February 2017) could have a disproportionate impact on service users in supported housing, meaning that those at need of this support might be more at risk. Board members heard from Society of St James staff, who described the experience of a number of their service users who had been subject to safeguarding enquiries. The Board agreed that there needed to be more training on issues such as self-neglect. It was also agreed that self-neglect would be the theme of the Annual Conference in December 17.

December's meeting focused on making safeguarding personal. At that meeting the Board members heard directly from a service user about her experience of the safeguarding process. She reported that she hadn't been asked for her opinion and reported on how the number of people involved in her case had made it difficult for her to follow what had been decided and to be involved in those decisions. Members commented how small changes in practice could make a dramatic impact on the effectiveness for service users and how her experience highlighted the vital role played by advocacy support. Her input also positively influenced the remaining discussions when reviewing multi-agency key performance data for MSP and assurance reporting from CQC and members of the quality surveillance group. It was agreed that this issue would be reviewed again as monitored as part of the self-organisation audits.

Priority four: Deliver a revised Community Engagement Plan: What have we done this year and how do we demonstrate we are shaping practice through listening to adults at risk, carers and partners?

The LSAB has worked hard this year to improve representation on the board from the voluntary sector. We have always benefitted hugely from the input of SVS. Their representative has worked with key partners to maintain strong links across the voluntary sector and raise their concerns at the Board. However, the inclusion of members from Choices Advocacy and Southampton Carers as well as the introduction of a lay member for the first time increases the diversity within the Board and offers improved opportunities to hear the voice of those reliant on services in the City.

The Board has also looked to secure meaningful engagement with adults who have experienced safeguarding processes and are in receipt of services. To this end we have established regular input from the Busy People Group (facilitated by Choices Advocacy). This group have actively supported the Board's work by commenting on the content and layout of the 2015-16 Annual report. As a consequence of their feedback we designed a pictorial report and will this year also aim to work with them to coproduce an easy read version. In addition, they ran important workshops for us on what MSP means in practice. This was presented to professionals at the Neglect Conference in December and at the Board's own business planning day where

strategic leaders were challenged to identify whether their practice would be up to the challenge of personalising safeguarding interventions. Both delegates at the conference and Board members commented on the impact that this session had and agreed via evaluation that it would positively influence their practice.

Following on from the mortality review work undertaken in 2015-16 the Board has maintained a keen interest in the suicide prevention programme. This work is led by public health colleagues, with the Health and Wellbeing Board retaining oversight. The LSAB board team, Independent Chair and many members attended the Suicide Prevention Conference in September 2016 where we were able to make valuable contributions, link in with experts in the voluntary sector supporting those at risk and those who have been affected by suicide. We have subsequently offered to host, as part of our learning and development programme, practitioner workshops to raise awareness of risk factors. In addition, the Board is represented on the working group responsible for monitoring the implementation of the suicide prevention action plan.

In December the Safeguarding Board's Annual conference focused on neglect. The day was split into morning sessions on the impact of neglect in childhood and in the afternoon, considered how services could better respond to issues of self-neglect in adults. 193 practitioners attended from across the statutory, private and voluntary sectors. Facilitators ensured that staff were engaged in 10 very different, but equally thought-provoking workshops on a range of relevant subjects. The feedback was extremely positive and plans are afoot to build on this to provide further opportunities, particularly in relation to working with those with learning disabilities, considering the impact of poverty on neglect and on learning from safeguarding adult reviews and serious case reviews.

In June 2016 the Board team worked with partners and local media to put on a roadshow visiting three separate locations within the city over 5 days. This was to promote safeguarding week. The team was supported by volunteers from different agencies and was able to speak directly with the public, delivering key safeguarding messages. Information packs were also handed out, enabling information on keeping adults and children safe to reach new audiences. The team spoke to a total of 400 individuals/families across the week, sharing relevant resources and advice.

Priority 5: Learning and Development sub group to carry out audit of safeguarding training to seek assurance that providers are compliant with Care Act responsibilities and devise programme of workshops linked to priorities

Work undertaken by the group identified a pressing need for the local safeguarding training opportunities to more carefully reflect the national requirements for staff across health agencies. As a consequence, an offer was developed to provide staff at every level of seniority and practice. A diverse programme has been commissioned to cater for all, courses range from general awareness of safeguarding responsibilities and practical information on how to raise concerns, to in-depth face to face training on practice skills e.g. chairing or leading safeguarding meetings and investigation techniques. This is in addition to the free e-learning course and scheduled programme of half day sessions and Weekly Wednesday workshops coordinated by the LSAB team. Details of this programme is available here: http://southamptonlscb.co.uk/professionals/training/. This training is attended by a multi-agency audience and is consistently evaluated positively. Attendance and evaluation feedback is scrutinized annually by the Learning and Development group.

10. Meeting The Care Act 2014 Responsibilities

Development Policy and Strategy

One of the core functions for the LSAB is to lead on policy and strategy development for protecting adults. In accordance with this, the multi-agency safeguarding adults guidance, first published in April 2015, was revised and ratified in March 2017. This included more detailed guidance on working with those with persistent welfare concerns, including self-neglect. As reported above, Southampton LSAB had taken the lead in drafting this guidance following the self-neglect thematic review. The guidance closely followed the findings and recommendations from that review, incorporating tools for use by practitioners to identify where self-neglect or persistent concerns represent a risk to life or wellbeing.

The Board also ratified the ADASS guidance on out of area safeguarding responsibilities and reviewed local guidance offered to safeguarding staff on tri-age and case prioritisation to ensure that it met duties under the Care Act 2014.

In November 2016 the Pan Hampshire Multiagency risk management framework and allegations management framework were launched. These offer practical guidance to professionals on how to assess and managed risk and allegations against health and social care staff. They also set out the referral process in each area.

In addition to the policy work already identified within this report, Board members have been instrumental in drafting or amending the following policies, protocols or guidance for use by agencies across Hampshire in 2016-17:

- Information Sharing Agreement
- Allegations Management Framework for adults
- Female Genital Mutilation Policy and Flow Chart
- Adult Sexual Exploitation guidance

Learning from Case Review Work

In accordance with the Care Act 2014, A SAR takes places when:

There is reasonable cause for concern about how the SAB, its members or organisations worked together to safeguard the adult
AND
b) The person died and the SAB knows/suspects this resulted from abuse or neglect (whether or not it knew about this before the person died)
OR
c) The person is still alive but the Safeguarding Adults Board knows or suspects they've
experienced serious abuse/neglect, sustained potentially life threatening injury, serious sexual abuse or serious/permanent impairment of health or development.

If a case is referred but is not deemed to meet this criteria, it may still be come a different type of review such as a multi-agency partnership review or a single agency review. The Southampton Case Review Group has a key part in overseeing this

activity and ensuring that learning is gathered and disseminated widely amongst professionals.

There have been a number of reviews underway during this annual report year. This includes two SARs, three multi-agency partnership reviews, one thematic review and one single agency review.

One review is seeking to build on learning undertaken by the Safer City Partnership following the murder of an adult at risk in 2015. The LSAB were concerned that the earlier review, which rightly focused on the learning needed by criminal justice agencies, did not capture all opportunities for learning. In particular, the LSAB were keen to ascertain if more could have been done by agencies within the Safeguarding Adult's partnership to identify the risks to the victim of this appalling crime and offer more support. In November 2016 the Board commissioned the author of the Safer City Partnership's review to conduct this further work in order to ensure consistency between the two reports. A review panel was set up in February and it is anticipated that this report will be completed in 2017 with the findings and actions taken to implement learning reported in next year's annual report.

Two of these cases reached their conclusion within the year and learning is set out below:

The thematic review is based around two cases wherein people resident in Southampton City died, with self-neglect being a key feature in their circumstances. These cases involved commonalities such as; non-engagement with services, absence of effective multiagency working, complex medical needs, poor living conditions and poor self-care.

The Findings from the Self-Neglect Thematic Review:

1. **Understanding, Definitions, Knowledge and the Legal Framework** - Self-neglect is a complex issue and this complexity is compounded where there is a lack of clear, standard definition.
2. **Good practice in assessment and in respect of Mental Capacity** - Assessment is an important tool, not only for identifying the current situation, and planning around risk management but also for exploring the past and identifying the triggers, motivations and other predisposing issues behind the presenting behaviour.
3. **Mental Capacity and Risk Management** - Mental Capacity is a key element in weighing up and balancing two key moral imperatives with regard to intervening in self-neglect: respect for autonomy and self-determination versus Duty of Care and promotion of dignity
4. **Models and tools for intervention / Effective multidisciplinary working** - Agencies in themselves can be challenging for self-neglect – structure, roles, responsibilities and the culture itself can all impact on outcomes for individuals.

There were nine specific recommendations as a result of this review and these are being carried forward by a specific multi-agency task and finish group to look at the issue of self-neglect. The recommendations from this review are:

1. Southampton LSAB to adopt and promote a clear position statement in relation to self-neglect and include an explicit statement in policy and/or guidance as to

which model of self-neglect it encourages agencies to work with in order to develop consistency and enable effective joint working.
2. All partner agencies to review their policies, procedures and guidance documents concerning self-neglect and ensure these are fully compliant with the 4LSAB document.
3. LSAB to develop and share toolkits for use in cases of self-neglect.
4. Training strategy to be reviewed to consider options for multiagency training around working with self-neglect.
5. Mental Capacity Awareness to be revisited across all partner agencies.
6. LSAB to review existing guidance to include detailed reference to information concerning the legal framework and what Powers exist in statute, including coercive measures where these may be required.
7. LSAB Working Group to work with all partners to define an explicit pathway for referrals concerning self-neglect, in conjunction with use of the threshold toolkit.
8. LSAB and partner agencies to consider how they can ensure work with (high risk) self-neglect is mindful of the longitudinal nature of effective intervention and how to facilitate this in practice.
9. LSAB to consider establishing a dedicated Risk Management Panel (perhaps as a local process sitting beneath the 4LSAB Multiagency Risk Management Framework), to enable high risk complex cases of self-neglect.

The first task and finish group meeting is due to meet in May 2017, where an action plan will be put in place to respond to these recommendations. We will be in a position to update on this work in the 2017 – 18 annual report.

A SAR was also completed this year, although it was not published due to the need to ensure anonymity.

The Findings from the Adult E SAR:

1. **Human Bias** - There is a tendency to assume that clients with longer-term needs are stable, resulting in key assessment and review processes becoming a paper exercise in some cases.
2. **Longer-term Working** - The Care Programme Approach is implemented as a set of standalone processes and meetings rather than a dynamic approach that supported partnership working that was reactive and responsive to changes in needs and risks.
3. **Longer term Working** - Professional understanding, both of the Care Coordinator role and of their own responsibilities is impacting adversely upon the quality of care provided to service users whose needs are not acute.
4. **Communication and Collaboration in Response to** Incidents - Multiple Agencies involved with an individual service user working in isolation are less effective than those who work closely together; resulting in poorer outcomes in managing risks.
5. **Management Systems Clinical Supervision** - Current supervision systems are not functioning well enough to pick up vulnerabilities in practice on cases that ostensibly present no concern
6. **Communication and collaboration in longer-term work** - Communication collaboration in longer-term work: Within Southampton, partner agencies do

not work cohesively together to investigate missing vulnerable adults leading to less effective investigations.

7. **Communication and Collaboration in longer-term work** - Do 24/7 services in Southampton have a culture whereby insufficient attention is paid to the purpose and detail of information passing between teams within agencies leading to less effective joint working?

A set of recommendations were formed within this report and a multi-agency action plan is being monitored by the Case Review Group.

Actions to be taken forward as a result of this review are as follows:

- Ensure primary health care professionals are actively involved in CPA1 reviews.
- Ensure policy for GP practices to escalate concerns re non-attendance of ‘vulnerable/ at risk’ patients is operational and widely understood.
- Care planning to involve section on risk management (including information regarding potential of individual going missing if identified as being at risk of this)
- LSAB should support Hampshire Constabulary so that lessons learned from this case review inform demand maps and are embedded into the predictive analysis.
- Support the Police in the development of their ‘outcome buddy’ so that this reflects the MSP principles and properly understands the roles and responsibilities of key relevant partners within the partnership.
- Review of pan Hampshire policy and protocols to embed shared risk management and duty to cooperate.
- Adoption of the Herbert Protocol Missing Person Incident form
- Ensure a clear link between health agencies in order to identify risks, make appropriate plans, devise strategies and share information.
- Learning from reviews to be disseminated via focused workshops and newsletters.

The 2017 – 18 annual report will offer a comprehensive overview of how these actions have been achieved.

Once a case review has been written, the lead author will form recommendations. The multi-agency partnership will use these to create an action plan, in order to address these. The LSAB Case Review Group have oversight of these plans and will review them quarterly. If all are agreed that an action has been achieved, this is turned to ‘green’, signed off and removed from the plan.

The LSAB is planning to enhance the way in which it shares learning from case reviews in the future. There will be a learning package offered for each case which will include:

- Regular learning workshops
- 6-step briefing documents on each case
- A learning video recorded by the lead reviewer or a relevant professional (to be accessed via the LSAB website)

Securing Assurance on Safeguarding Practice

A cornerstone of the LSAB's Quality assurance framework is the 4LSAB organisational safeguarding audit tool. This requires agencies to reflect on core safeguarding principles and standards and evaluate how firmly embedded those are within their organisation. Those audits are reported to the Monitoring and Evaluation sub-group who scrutinise these and ensure that findings are evidence based and accurate.

During the course of 2016-17 seven agencies from across the partnership have completed the audit. In May Southern Health NHS Foundation Trust and Hampshire CRC made their submissions. In July the Southampton branch of the National Probation Service and Southampton's CCG/ICU submitted their evaluation for scrutiny. Further discussions were held at the joint LSCB/LSAB executive meeting in November 2016 and agreement reached on how the CCG could work with subgroups to gain assurance from the wider provider health economy. Prior to this, in September 2016, Care UK and over 50% of GP practices in the City completed the audit tool, the Board would like to commend those organisations for undertaking this important task and for sharing their findings, we also look forward to supporting other organisations reviewing their practices as this can only improve outcomes for their clients and enhance their reputations. In January 2017 SCC's adult social care and public health departments reported their findings.

Following these reports each agency is responsible for putting together an action plan for their organisation to tackle areas where further work would improve safeguarding outcomes.

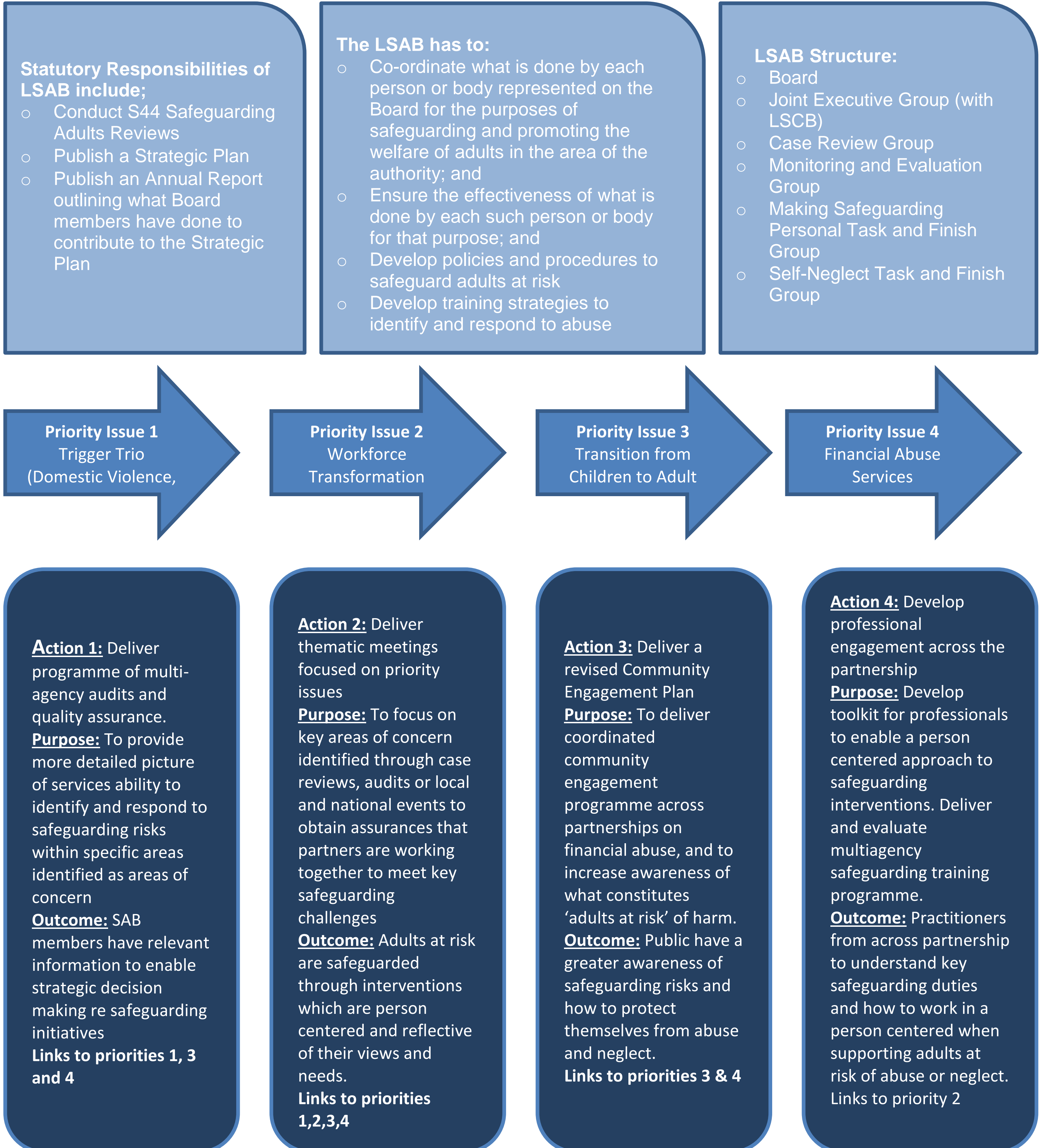
In February 2017 the audit tool was revised and the process streamlined to reduce duplication for agencies who work across the 4 LSAB Hampshire boundaries. The changes, whilst maintaining robust challenge, require agencies to report to one of the four LSAB boards, thus using less staff resource from partner agencies in this important quality assurance role.

Another key ingredient of the Quality Assurance framework is the data received from each partner. A summary of this information is set out later within this report. Partners recognised that, as resources and business needs change, the data collected may also need to change to evidence improvements. In recognition of this, Hampshire Constabulary agreed to amend the data they report from November 2016. This provides a clearer picture on activity relating to hate crime, adults reported missing and domestic abuse.

Partners have consistently informed us that one of the most important functions of the LSAB is to ensure that the duties owed to adults at risk are given the prominence needed when new initiatives or budgetary pressures require service redesign. This was especially noted within the LSAB Member Survey. Over the preceding years the Board has worked hard to review these important duties and to ensure that resources to meet those challenges are protected. This work put us in a strong position in January 2017 to advise, as a partnership, on the proposals for the transformation of Southampton City Council's Adult, Housing and Community Services, Public Health and Children and Families Services as well as a number of other key services relevant to safeguarding. This consultation was in response to significant budgetary pressures for the Council. A full response to those proposals was submitted by the LSAB Chair, identifying opportunities where greater coordination across the statutory and voluntary

sector would reduce costs and duplication without the need to cut vital services for adults at risk or those in need of care and support. Similarly, audit and case review work undertaken in 2015-16 with health commissioners and providers ensured prominence was given to safeguarding responsibilities within plans put forward under the STP and Better Care Plan. The opportunity, to address gaps previously recognised through LSAB audit and reviews, was grasped which should further improve services for adults at risk in Southampton.

11. Priorities and Action for 2017-2018



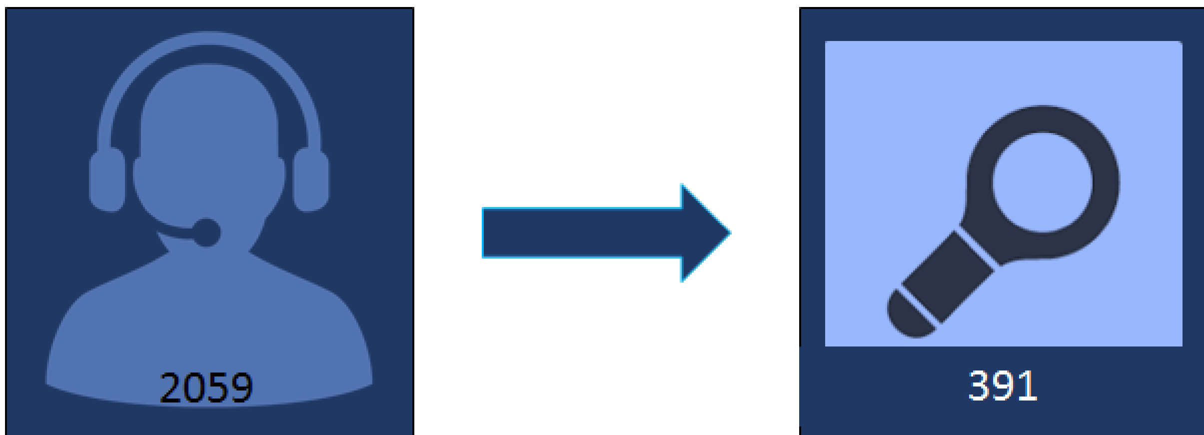
12. Safeguarding Activity 2016 - 17

Safeguarding Activity

Under Section 42 of the Care Act, a local authority has a duty to make enquiries or cause others to make enquiries in cases where it has reasonable cause to suspect:

- That an adult has needs for care and support (whether or not the local authority is meeting any of those needs) and
- Is experiencing, or at risk of, abuse or neglect and
- As a result of those care and support needs, is unable to protect themselves from either the risk of, or experience of, abuse or neglect.

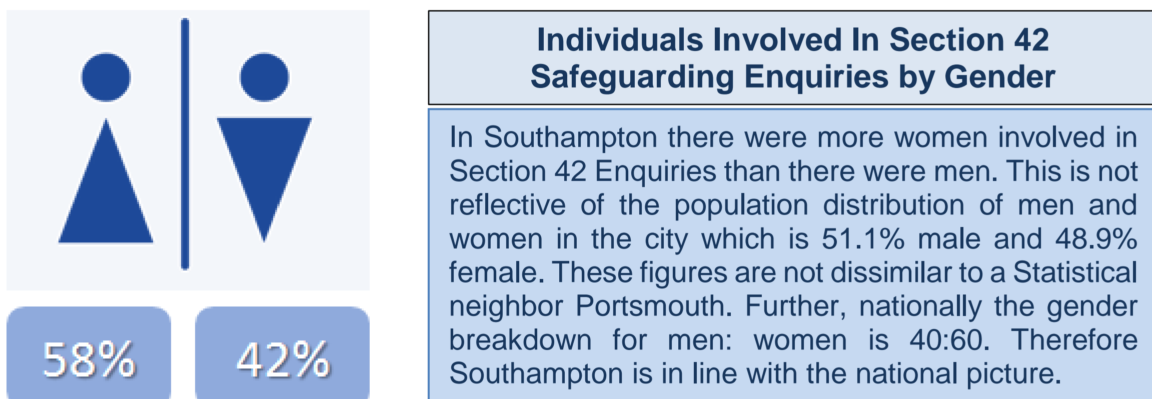
A safeguarding **concern** is a 'worry' raised regarding a person's safety. An **enquiry** is what needs to be looked at to confirm a person is safe.



There were 2059 concerns received during 2016/17. 19.0% of these concerns were taken forward as 391 Section 42 enquiries.

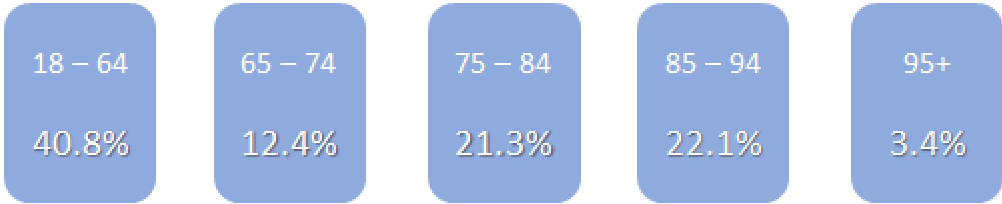
Profile of Need

Profiles of individuals involved in Section 42 Enquiries can be summarized as follows:



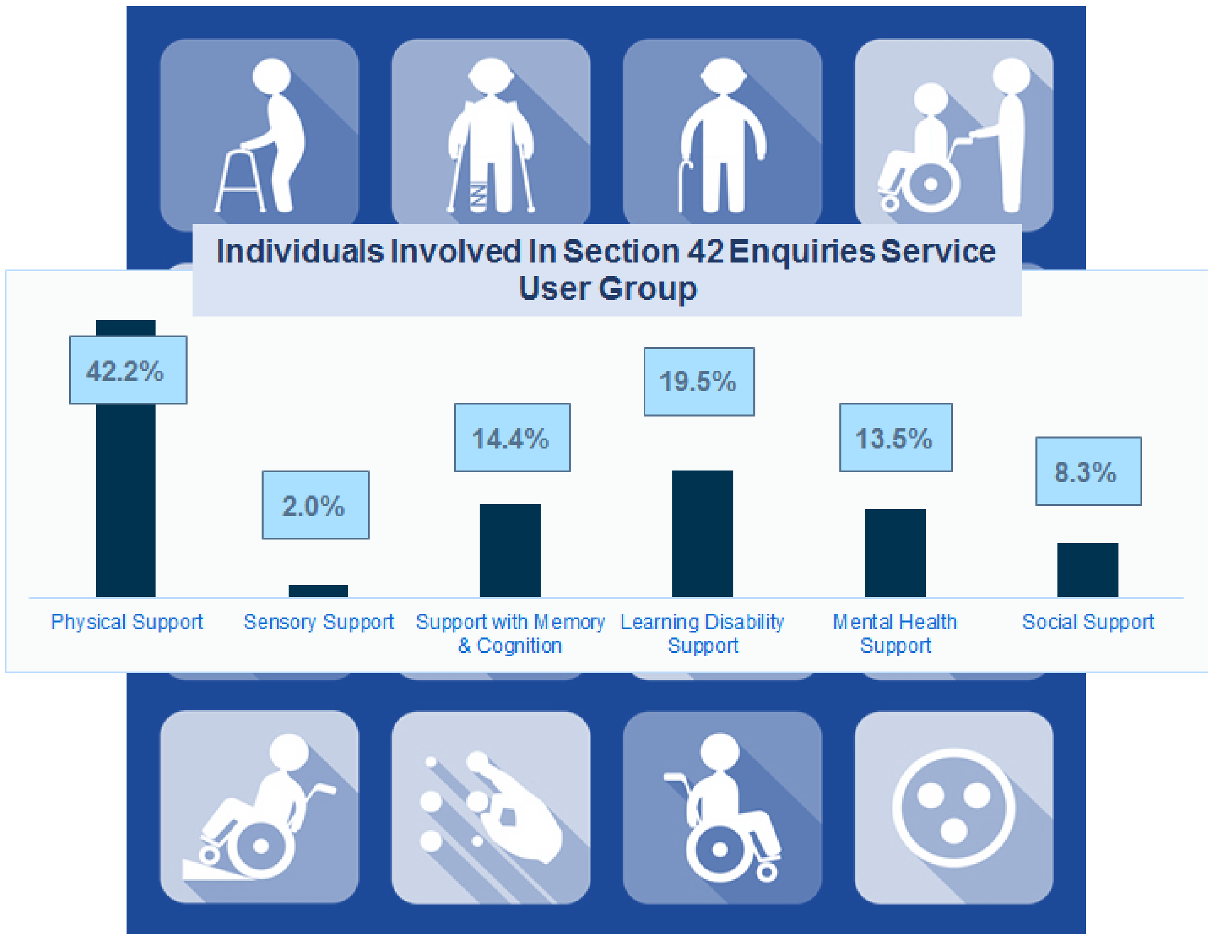
Individuals Involved In Section 42 Safeguarding Enquiries by Gender

In Southampton there were more women involved in Section 42 Enquiries than there were men. This is not reflective of the population distribution of men and women in the city which is 51.1% male and 48.9% female. These figures are not dissimilar to a Statistical neighbor Portsmouth. Further, nationally the gender breakdown for men: women is 40:60. Therefore Southampton is in line with the national picture.



18 – 64	65 – 74	75 – 84	85 – 94	95+
40.8%	12.4%	21.3%	22.1%	3.4%

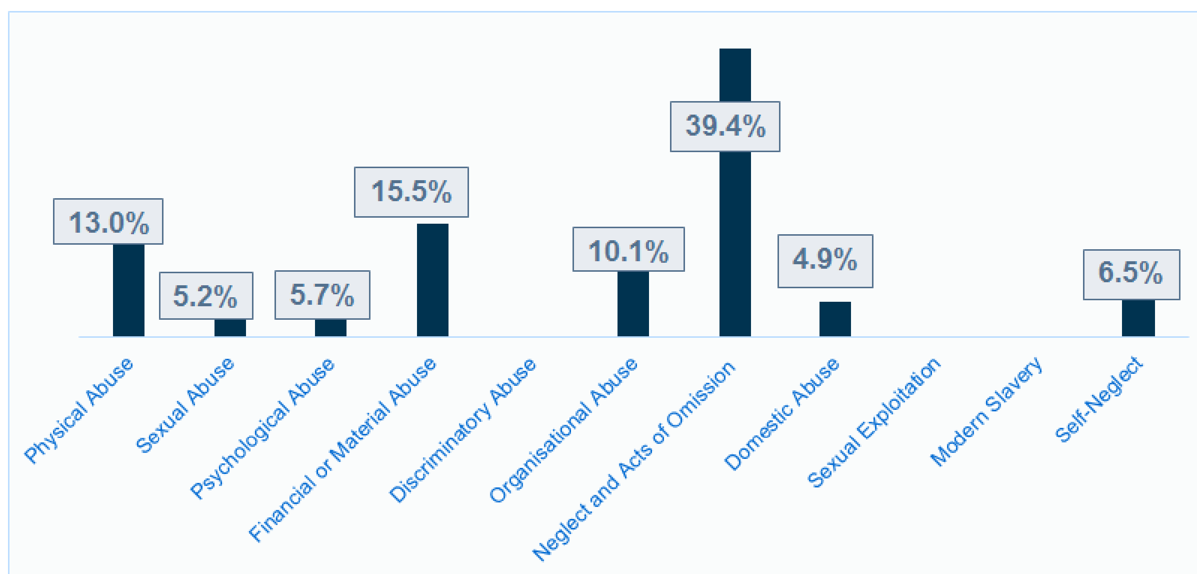
By far the largest cohort with respect to age is the 18-64s, followed by the 85-94, 75-84s, 65-74s and then the 95+ cohort.
These figures are in line with the national picture and aligned with Statistical Neighbour Portsmouth.



The greatest primary support need for individuals involved in S42 Enquiries is physical support. This is followed by support for Learning Disabilities, Memory and Cognition and Mental Health.
These trends in support needs are aligned with the national picture, where the greatest support needs are Physical Support, Learning Disability, Mental Health and then support with Memory and Cognition.

Nature of Abuse

The data below show the count of concluded enquiries by nature of abuse. The type of risk describes the nature of the allegations made, such as physical or sexual. Multiple types of risk can be recorded one count for each different type and source. For example, a concluded enquiry involved an allegation of financial abuse by a family member and an allegation of physical abuse from someone not known to the individual. This would be counted as one in the 'Financial' category and one in the 'Physical' category. Some of these categories can overlap each other, for example an incident of domestic abuse can also be physical abuse.



Of those Section 42 Enquiries that were closed in 2016/17 the majority of abuse identified was around Neglect and Acts of Omission. Financial Abuse and Physical Abuse were the next most prevalent types of abuse that emerged from the concluded S42s. These types of abuse were also the three most prevalent types in Portsmouth's findings.
Nationally Neglect and Acts of Omission is the most prevalent followed by Physical Abuse, Financial/Material Abuse and Psychological Abuse.

Location of Abuse

The charts below show the count of concluded enquiries by nature of abuse. 'Hospital' includes community hospitals, acute hospitals and mental health inpatient settings. The location of abuse describes where the alleged safeguarding incident took place. Multiple locations can be included. For example, a concluded enquiry involved an allegation, which took place in a care home, and an allegation that took place in a hospital. This would be counted as one in the 'Care Home' category and one in the 'Hospital' category.

Hospitals		Nursing Care Homes	0.5%	Own Home
Acute	0.3%	Residential Care Homes	31.5%	58.8%
Mental Health	0.3%	Community Services	1.1%	
Community	1.9%	In the Community	2.7%	Other 3.0%

Regarding Location of Risk:

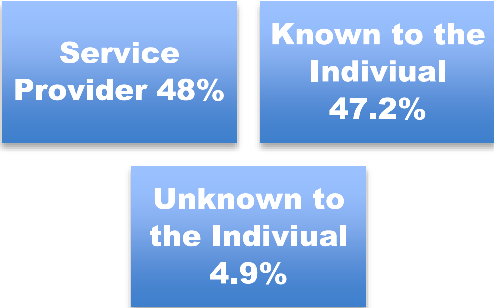
58.8% of concluded S42s had the Adult at Risk's Own Home as the Location of Risk

31.5% of S42s had the Residential Care Home as the Location of Risk.

Of the 218 concluded S42s where the Location of Risk was the Own Home, in 53.7% of cases the Source of Risk was known to the Individual. In 42.7% of cases the Source of Risk was the Service Provider.

Of the 117 concluded S42s where the Location of Risk was the Residential Care Home, in 59.0% of cases the Source of Risk was the Service Provider whilst in 36.8% of cases the Source of Risk was known to the Individual.

For S42s where Neglect and Acts of Omission is the type of abuse, in the majority of these cases the Service Provider is the Source of Risk (72.4% of S42s). With regards to Organisational Abuse the 94.9% of concluded S42s had the Service Provider as the Source of Risk.



13. How to Report Abuse

If you are worried that an adult may be at risk of abuse or harm please contact us by:

Email: singlepointofaccess@southampton.gov.uk
Tel: 023 8083 3003
Address: Adult social care, Southampton City Council Civic Centre, Southampton, SO14 7LY

If an adult is in immediate danger, contact the police by telephoning 999.

The following will help you understand how reports about safeguarding concerns for adults and vulnerable people are dealt with. Please remember that any abuse is unacceptable. If you believe a crime has been committed please contact the Police.

What you can do if you think someone is being abused

- Take action - don't assume that someone else is doing something about the situation
- If anyone is injured get a doctor or ambulance
- Make a note of your concerns, what happened and any action you take
- Let us know by either telephoning us or completing our form
- All safeguarding matters will be dealt with confidentially, though if the issues concern evidence of a crime, or unacceptable risk, this may be shared with the appropriate authorities
- If you think a criminal offence has been committed, contact the police straight away

If you think you are being abused or mistreated, contact us, either by phone or by completing the form.

What will happen next?

Adult Services work closely with other organisations and the person affected to find out as much as possible about what has happened. We will do a number of things which might include:

- Talking to you and other people involved to find out what has happened
- Planning what to do to safeguard the person being abused
- Supporting the person and their carers through the process
- Being available to offer support in the future

Perhaps you, or someone you know, is being harmed or living in fear of abuse and wants to stay safe. The Speak Out easy read leaflet gives more information on how you can get help.