SSAB
SOUTHAMPTON SAFEGUARDING ADULTS BOARD

Annual Report
2019-20

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Chair's Foreword

Thank you for your interest in the work of Southampton's Safeguarding Adult Partnership and its Statutory Board. I was appointed as Independent Chair in January 2020 and it gives me great pleasure to introduce our 2019- 20 Annual Report.

Here you will find accounts of previous achievements from 2019, along with our annual statistics in relation to safeguarding activity and detailed outcomes from Safeguarding Adult Reviews, as well as a brief thematic analysis, about lessons learned.

Between January and March 2020, our partnership quickly got to work and identified the need for clear strategic aims; a safeguarding adult strategy refresh; a new business plan and a keen desire to act and work locally. This has set future priorities of prevention, learning and quality and the foundations for Southampton Safeguarding Adult's Board to focus on local need and local safety.

We will still work collaboratively with the Isle of Wight, Hampshire and Portsmouth Boards, but we will also adopt a very local focus on the needs of our particular population, with the backdrop of our unique demographic picture, and our very specific safeguarding adult at risk profile. I hope to be able to report more on this in our 2020-21 Annual Report.

Going forward this report will reflect more on its partnership achievements, and addresses the huge range of activity and continued endeavor, clearly demonstrated in combined efforts to enable the people of Southampton City to live safe lives.

My intention has been, and will continue to be, to work very closely and collaboratively, with this committed partnership, moving us forward to our next natural stage of development. We will take forward the lessons learned from both Southampton and national Safeguarding Adult Reviews, and in February this year we engaged with the Department of Health and Social Care Research Project regarding the national thematic analysis from Safeguarding Adult Reviews and the associated learning.

I am proud to say that from our very close working during the COVID-19 pandemic, true partnership with Southampton CCG, Hampshire Constabulary and Southampton City Adult Social Care, and other partners, really came into its own and I will work to embed that spirit in all that we do.

Our new approach will lead to a more robust Board decision making, stronger, more connected governance, make safeguarding more personal, make quality outcomes focus on local outcomes, and in future, we will set out a Board structure, that is fit for purpose to deliver well on our shared partner safeguarding priorities.

So far, I have been more than impressed by the dedication of many of our Board Members; the excellent practice in our Case Review Group, the supportive approach for Board management and the forging of ideas across the four Boards. All of our partners have faced significant challenge and had to practice in unprecedented circumstances, yet they have continued to deliver well, and have shown great commitment to both continuous improvement; strategic alignment and producing quality outcomes for people at risk. My personal thanks go to these people.

Deborah Stuart-Angus, BSc(Hons) CQSW Cert.Ed. Dip.App.SS
The Independent Chair, Southampton Safeguarding Adults Board

1. Introduction

What does Safeguarding Mean?

"Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the 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)

Who are we and what are our lawful responsibilities?

Southampton Safeguarding Adults Board (SSAB) is group of partners who come together to co-ordinate work to safeguard and promote the welfare of adults in Southampton city. The main objective of the SSAB is to assure itself that local safeguarding arrangements and partners help and protect adults at risk of harm in Southampton. It also aims to ensure that safeguarding activities are of a high quality and in line with the Care Act 2014. The Board is a statutory partnership, which includes, Southampton City Council, Hampshire Constabulary, Southampton City Clinical Commissioning Group (CCG) and other agencies that work with adults with care and support needs. It is important that SSAB partners are able to challenge each other and other organisations where it is deemed that their actions or inaction, increase the risk of abuse or neglect. This will include commissioners, as well as providers of services.

Southampton Safeguarding Adults Board has 3 core duties:

- *'it must publish a strategic plan for each financial year that sets how it will meet its main objective and what the members will do to achieve this. The plan must be developed with local community involvement, and the SSAB must consult the local Healthwatch organisation. The plan should be evidence based and make use of all available evidence and intelligence from partners to form and develop its plan.*
- *it must publish an annual report detailing what the SSAB has done during the year to achieve its main objective and implement its strategic plan, and what each member has done to implement the strategy as well as detailing the findings of any safeguarding adults reviews and subsequent action.*
- *it must conduct any safeguarding adults review in accordance with Section 44 of the Act.'*

(Section 14.136 Care and Support Guidance, The Care Act 2014)

Southampton SAB also works within the '4LSAB' area of Southampton, Portsmouth, Hampshire and Isle of Wight. The 4 areas share common safeguarding policies, procedures and guidance for staff to work to. Southampton SAB participates in several cross area groups as represented in the diagram at the end of this document and going forward Southampton from 2020 will be developing a City-wide local focus.

Demographics and Population

The current population of Southampton is 252,800[1], with:

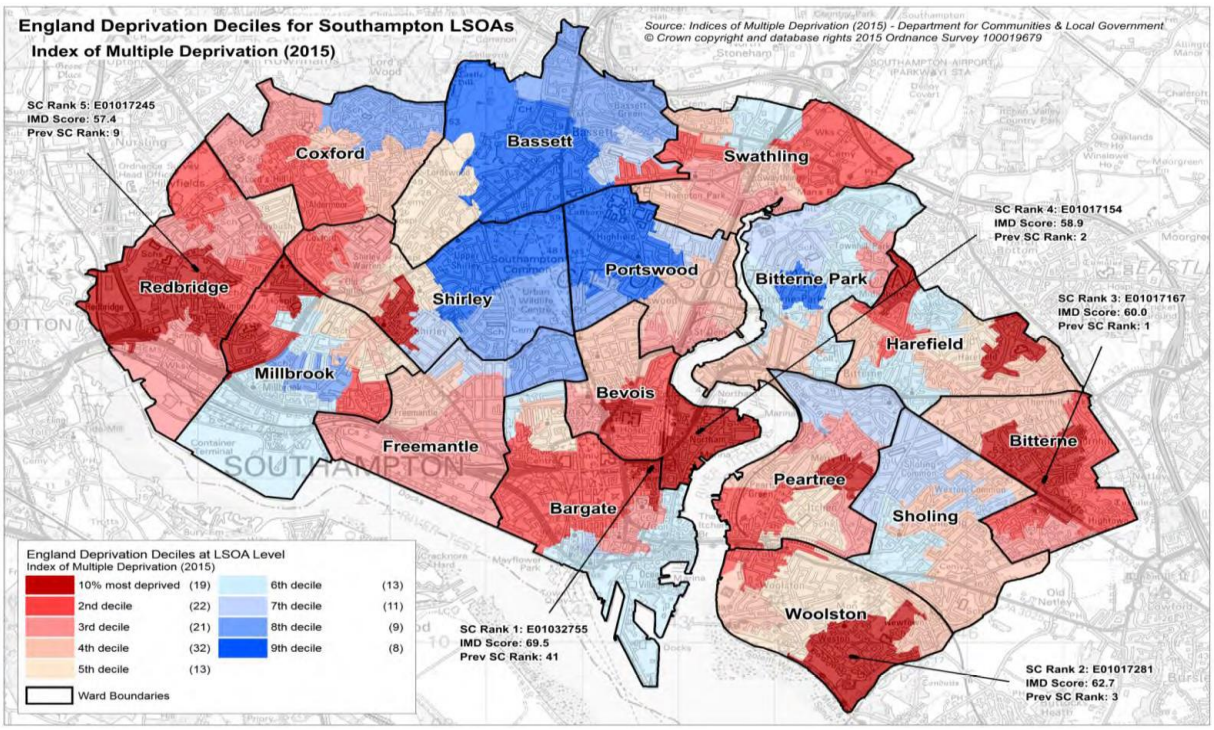
- 53,000 residents who are not white British (22.3%)
- 43,000 students
- Approximately 22% of Southampton residents are non-white British, of which 14% are Black and Minority Ethnic (BAME).

[1] Source: LG Inform, 2019

Whilst Southampton has achieved significant economic growth in the last few years in line with the South East region, the city's characteristics relating to poverty and deprivation present challenges, more in common with other urban areas across the country that have high levels of deprivation. In 2017 it was estimated that 34,781 of Southampton residents were over the age of 65 and people living in the most deprived areas in Southampton are almost twice as likely to die prematurely (under 75 years old), than those in the most affluent. In Southampton, as nationally, life expectancy is increasing and more people are living longer. The older population is projected to grow proportionately more than any other group in Southampton, over the next few years.

Health and Equalities

More adults in Southampton live in poverty than the national average (19.7% for Southampton, compared to 12.5% for the surrounding Hampshire area, and 16.8% as the national average). Since 2010 Southampton has become more deprived and in 2015 it was ranked 67th out of 326 Local Authorities in England, with 1 being the most deprived. The City is a patchwork of deprivation and pockets of affluence. It has 19 neighbourhood areas (known as Lower Super Output Areas) which are within the 10% most deprived in England and none in the least deprived. The map below shows the most (red) and least (blue) deprived areas in the city:



The health of people in Southampton is generally worse than the England average. 20.1% (8,905) of children live in low-income families. Life expectancy for both men and women is lower than the England average. Life expectancy is 8.7 years lower for men and 4.8 years lower for women in the most deprived areas of Southampton than in the least deprived areas.[2]

The rate for alcohol-related harm hospital admissions is 719[3], worse than the average for England. This represents 1,550 admissions per year. The rate for self-harm hospital admissions is 323*, worse than the average for England. This represents 876 admissions per year. The rates of new sexually transmitted infections, killed and seriously injured on roads and new cases of tuberculosis are worse than the England average. The rates of violent crime (hospital admissions for violence), under 75 mortality rates from cardiovascular diseases and under 75 mortality rates from cancer are worse than the England average[4].

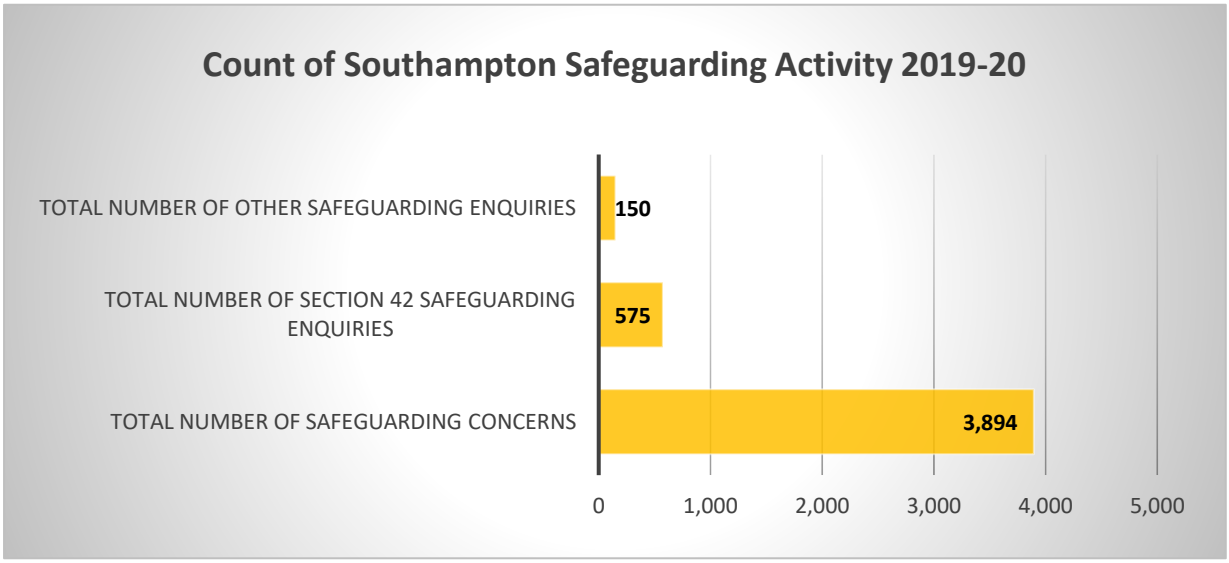
[2] Public Health England – Local Authority Health Profile 2019

[3] Rate per 100,000 population

[4] Public Health England – Local Authority Health Profile 2019

2. Safeguarding Adults Data

The following data is taken from the Safeguarding Adults Collection for the year 2019-20. In some cases, comparing Southampton's 2018/19, 2017/18, 2016/17 and 2019-20 data with the national data available at the time of completion. This data is submitted to the Department of Health and Social Care on an annual basis.



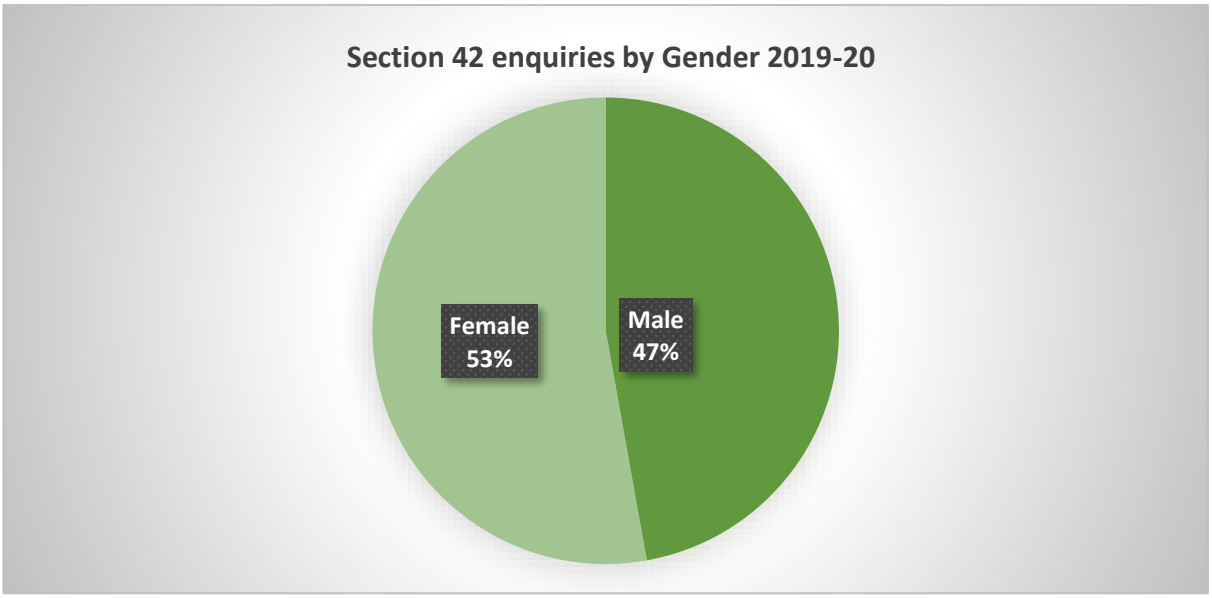
In 2019/20 there were 3894 concerns which is a 67.5% increase from the 2325 reported in 2018/19. This increase is due to changes in practice introduced following the 2019 Local Government Association Peer Review. Practice was changed to ensure that all relevant referrals were triaged, and decision making documented.

The average no. of concerns per 100,000 population in the South East Region is 888.55 compared to the national average of 942.8. The increase in safeguarding concerns in 2019/20 will result in Southampton having 1900 concerns per 100,000 population.

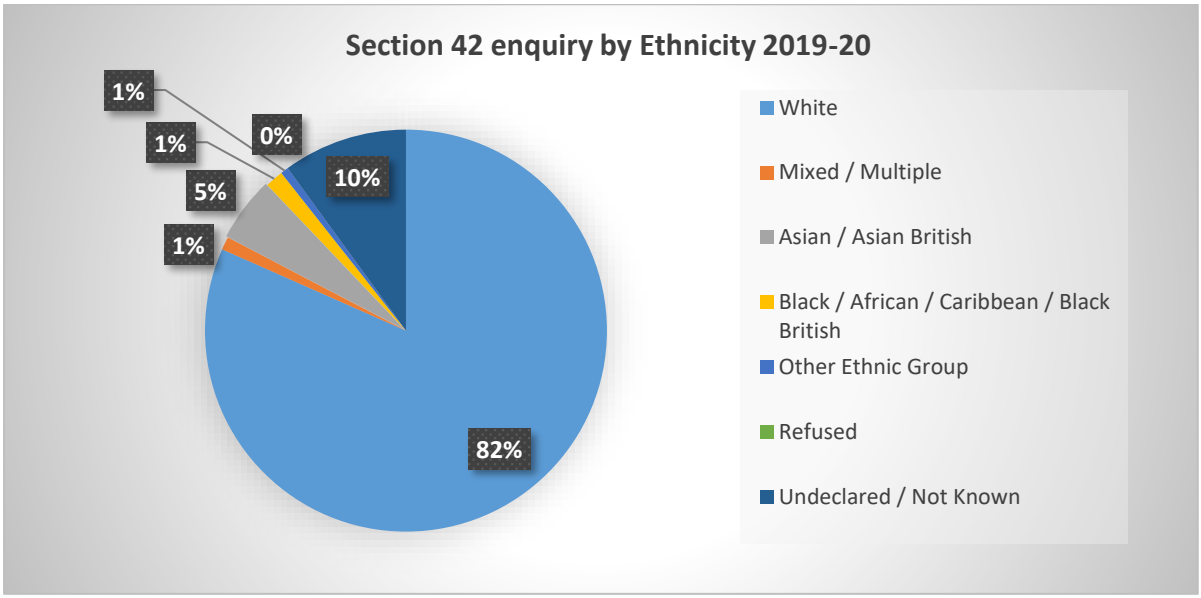
Counts of Safeguarding Activity	2019-20	2018-19	2017-18
Total Number of Safeguarding Concerns	3,894	2,325	1,695
Total Number of Section 42 Safeguarding Enquiries	582	387	442
Total Number of Other Safeguarding Enquiries	151	181	326

Section 42 Enquiries (Care Act 2014) a local authority has a duty to make enquiries or cause others to make enquiries in cases where it has reasonable cause to suspect:

- 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.



Of the individuals involved in Section 42 Safeguarding Enquiries in 2019-20, 47% were for men and 53% were for women. This is an increase of 3% for males compared to the reported figures last year, which were 44% male, 56% female. Southampton's gender profile is also broadly in line with the national gender profile of 40:60 men to women and Southampton population profile of 51% male and 49% female.



As the chart above shows, the majority of individuals involved in Section 42 Safeguarding Enquiries were raised for adults of White ethnicity, at 82%, this compares to 88% last year, and a national average of 82.7%. There is an increase in Section 42 Enquiries raised for adults of Asian/Asian British ethnicity from 2% last year to 5%. The category of 'undeclared/unknown' has also increased this year from 6% last year to 10%.

In 2019/20 there were 733 safeguarding enquiries, 582 section 42 enquiries and 151 other/discretionary enquiries. This is a 29.0 % increase from 2018/19 (568 enquiries). The proportion of section 42 enquiries as a total of all enquiries is 79% which is an increase from 68% in 2018/19.

Due to the changes in the recording safeguarding concerns, there has been an impact on the conversion rate from concern to enquiry. The conversion rate has reduced from 24.4% in 2018/19 to 18.8% in 2019/20. The table below shows the South East region (2018/19) conversion rates:

2018/19 Concern to Enquiry Conversion Benchmarking

population	conversion rate from concern to enquiry
Brighton & Hove City Council	100.0%
West Berkshire District Council	76.8%
Kent County Council	60.3%
Surrey County Council	59.3%
Buckinghamshire County Council	53.8%
Medway Council	50.5%
Reading Borough Council	50.5%
Isle of Wight Council	47.4%
Wokingham Borough Council	39.3%
Hampshire County Council	37.1%
Royal Borough of Windsor & Maidenhead	36.6%
West Sussex County Council	33.3%
Bracknell Forest Borough Council	32.6%
Southampton City Council	24.4%
Oxfordshire County Council	24.1%
East Sussex County Council	23.2%
Milton Keynes Council (Unitary)	18.9%
Slough Borough Council	15.5%
Portsmouth City Council	12.8%

In England the average conversion rate from Concern to Enquiry is 39% compared to an average of 45.8% in the South East.

Section 42 Enquiries

In 2019/20 there were 582 section 42 enquiries which is a 50.4 % increase compared to 2018/19 (387 section 42 enquiries). The proportion of section 42 enquiries as a proportion of the total enquiries has increased to 79% compared with 68% in 2018/19. The table on the next page shows the section 42 benchmarking for the South East region.

2018/19 Section 42 Enquiry Benchmarking

population	no. of section 42 enquiries per 100,000 pop
Isle of Wight Council	722.02
West Sussex County Council	498.64
West Berkshire District Council	443.61
Reading Borough Council	440.81
Surrey County Council	434.33
Kent County Council	402.76
Royal Borough of Windsor & Maidenhead	372.77
Brighton & Hove City Council	371.96
Wokingham Borough Council	313.69
Medway Council	292.63
Milton Keynes Council (Unitary)	244.20
Oxfordshire County Council	219.96

East Sussex County Council	200.71
Southampton City Council	191.31
Slough Borough Council	183.22
Portsmouth City Council	151.91
Bracknell Forest Borough Council	143.37
Buckinghamshire County Council	94.44
Hampshire County Council	88.33

Other Enquiries

In 2019/20 there were 151 Other Enquiries which is a 16.6 % decrease from 2018/19 (181 enquiries). These enquiries are for adults at risk who have mental capacity but whose needs/risks are the result of addiction/homelessness/mental health and experience coercion and control etc.

Compared to the South East region Southampton undertakes the highest proportion of Other Enquiries per 100,000 population.

2018/19 Other/Discretionary Enquiry Benchmarking

population	no. of other enquiries	no. of other enquiries per 100,000 pop
Southampton City Council	181	89.44
Kent County Council	840	67.87
Medway Council	75	35.12
Slough Borough Council	35	32.89
East Sussex County Council	135	29.94
Milton Keynes Council (Unitary)	35	17.44
Buckinghamshire County Council	60	14.35
West Sussex County Council	95	13.81
Isle of Wight Council	15	12.82
Reading Borough Council	10	8.01
Bracknell Forest Borough Council	5	5.31
Surrey County Council	40	4.29
Wokingham Borough Council	5	3.83
Hampshire County Council	40	3.64
Portsmouth City Council	5	2.92
Oxfordshire County Council	0	0.00
West Berkshire District Council	0	0.00
Royal Borough of Windsor & Maidenhead	0	0.00
Brighton & Hove City Council	0	0.00

Data Quality Issues

There were 48 individuals involved in both s42 and discretionary enquiries that did not have ethnicity recorded and for 19 individuals, a Primary Support Reason was not recorded. Each of these cases have been manually checked on the Service User Database, to identify if relevant information was stored elsewhere and work has been completed in 2020 to improve recording.

Type of Abuse and Location

The most prevalent categories of abuse in Southampton, based on concluded Section 42 Enquiries are neglect and acts of omission which reflects the national picture. This is followed by financial, physical, and organisational abuse.

Location of risk	Concluded Section 42 Enquiries 2019-20	Concluded Section 42 Enquiries 2018-19
Own Home	271	237
In the community (excluding community services)	**70**	**34**
In a community service	16	7
Care Home - Nursing	48	26
Care Home - Residential	98	94
Hospital - Acute	**62**	**26**
Hospital - Mental Health	4	0
Hospital - Community	1	1
Other	34	13

The table above indicates that the most common location for concern was the adults' own home, followed by Care Home – Nursing and Residential and again this reflects the national picture and recent years data for the City. This year there has been an increase in numbers of location of risk recorded in the community (excluding community services and within acute hospital setting).

Risk Outcomes

The table below shows the outcomes for individuals who were faced with risk, (taken from concluded S42 enquiries):

Outcome	2019-20	2018-19	2017-18
Risk Remained	13.4 %	13.4%	6.9%
Risk Reduced	66.0%	68.4%	58.9%
Risks Removed	20.6 %	18.2%	34.2%

3. Engagement with practitioners and communities

The SSAB engages with the public, professionals and families throughout the year in various ways, to ensure our work is focused on placing people who are at risk, at the centre of our decision making and safeguarding activity.

Public awareness raising takes place through public facing events and activities, including road shows, training events and exhibitions as well as direct messaging through social media. During the year the SSAB delivered activities and awareness raising to mark the following events:

- White Ribbon Day
- Maternal Mental Health Month
- Hampshire Police Never Choose Knives campaign
- Safer Internet Day
- FGM Zero Tolerance Day
- Scams Awareness

Safeguarding Partnerships Conference – Adopting a Family Approach

In June 2019 over 150 of our practitioners attended a conference to launch the Pan-Hampshire Family Approach Protocol. Speakers included Ryan Hart from the charity CoCo Awareness talking about his family's experience of coercive control, and Detective Superintendent Rachel Farrell from Hampshire Constabulary, presented on Adverse Childhood Experiences and Trauma Informed Practice. Practitioner Workshops were:

- Adult mental health and impact on children
- Domestic abuse: working with perpetrators
- Restorative Practice and Adverse Childhood Experiences
- Impact of substance misuse and alcohol on children and families

The conference brought together local practitioners from practice with adults, children and families and an evaluation of the day evidenced that those who attended felt more confident to consider a family approach to safeguarding in daily practice.

Safeguarding Adults Week 2019

In November 2019 Southampton, Portsmouth, Isle of Wight and Hampshire SAB's collaborated on a campaign for national Safeguarding Adults Week. The beginning of the week saw the publication and launch event of 4LSAB Multi Agency Hoarding Protocol which was developed jointly with Radian (Local Housing Association). The protocol details local and national guidance for practitioners including a clutter rating scale.

Locally Southampton SAB launched the '*Spot the Signs and Speak Out'* campaign highlighting different types of abuse and neglect, throughout the week. The campaign was designed and supported by Southampton City Council and Southampton City Clinical Commissioning Group Communication's Teams in response to the SAB's strategic plan to work in partnership to raise awareness of adult safeguarding and build on our community resilience. A resource pack was created for SSAB partners to use and to promote to communities and practitioners. Southampton SAB also visited University Hospital Southampton to take part in a week long programme of engagement events, providing signposting and resources, to staff and community members.

4LSAB Animated Scribe Project

The 4LSAB animated scribe Safeguarding Adults Video was promoted by the 4LSAB's during the week across social media platforms and circulated to partners. The video was designed to engage members of the public, practitioners and volunteers to promote safeguarding adults, and increase confidence and knowledge of how and when to report concerns. Southampton SAB consulted with Choices Advocacy Busy People User Group on the format, content and structure as reported in the Annual Report 2018-19. The video is available on You Tube and the Southampton SAB website.

Southampton Safeguarding Partnerships Training Programme

The SSAB works closely with the Southampton Safeguarding Children Partnership to provide a coordinated, joint training offer. This enables a family approach to be taken via the training, and offers networking opportunities across both he disciplines. It includes 2-hour 'weekly Wednesday workshops', covering:

- County Lines
- Trafficking
- Mental Health
- Fire Safety

There is good attendance averaging 25 attendees for each session and regular half-day sessions are held on topics of local and national interest which have included:

- Learning from Safeguarding Adult Reviews and Serious Case Reviews
- Harmful Cultural Practice; Female Genital Mutilation, Forced Marriage and Honour Based Violence
- An Introduction to Neglect
- Child Sexual Exploitation and Criminal Exploitation

Weekly workshops and half day sessions had to be unfortunately reduced owing to a lack of administrative capacity in the Safeguarding Partnerships Team. Attendance was also affected by the Covid-19 pandemic, however there is a history of good attendance and positive feedback and going forward the new Adult Safeguarding Strategy will be taking into consideration the value of e-learning and technology to increase access to training.

4. Priority Issues for Southampton SAB 2019-20

The SAB set the following key priorities for 2019-20: **Mental Capacity Act and Multi Agency Risk Management; Self-Neglect and the interface with Homelessness; Alcohol and Substance misuse; A Family Approach to Safeguarding,** and **Making Safeguarding Personal**. Below is a summary of the service assurance provided by partners and what the SSAB partnership have delivered in relation to these themes:

Mental Capacity Act (MCA) and Multiagency Risk Management

- The 4LSAB Workforce Development Group agreed the Multiagency Risk Management Framework (and associated tools) and Mental Capacity Act (MCA) as a priority area to focus on for 2020.

- The 4LSAB Quality Assurance Group completed an audit of local and pan Hampshire responses to organisational audits which included a separate report on applying MCA in practice. The audit returns identified that further work and training is required in terms of deploying the MCA; it's understanding, and compliance with the Act, along with a need to implement the MCA toolkit across agencies.

- The Multi Agency Risk Management tools have been redeveloped, which includes proforma documentation regarding format and structure, along with guidance on chairing a multi-agency risk management meeting. (This protocol has been included as an appendix in the revised 4LSAB Multiagency Safeguarding Adults Policy, launched in June 2020).

- Southampton SAB is aware of the new Liberty Protection Safeguards, soon to replace the Deprivation of Liberty Safeguards (DoLS), a previous Amend to the Mental Capacity Act 2005. This is in relation to the prevention of depriving a person of their liberty and what safeguards must go into place when a deprivation has to occur for the person's own safety, if they cannot make their own capacitated decision. The recent Mental Capacity Amendment Bill, was launched in early 2019 and LPS were due from October 2020. However due to the COVID-19 pandemic this is delayed until October 2022. The main changes will be:

  - ✓ LPS will apply to everyone from the age of 16 upwards (DoLS applies from the age of 18)
  - ✓ LPS will apply in all settings including a person's own home
  - ✓ Under LPS everybody has the right to an advocate
  - ✓ To simplify the legal framework
  - ✓ To improves outcomes for service users
  - ✓ To enable a consistent authorisation process across settings
  - ✓ To implement good MCA practice as intended at ground level

  There is a shared responsibility for LPS between Local Authorities, Clinical Commissioning Groups and hospitals and a Hampshire and Isle of Wight LPS steering group has been working on joint publicity material.

- Southampton City Council Adult Social Care commissioned new safeguarding adults and MCA training from Making Connections. The training has received positive feedback and has been offered to providers and volunteers. Southampton SAB is looking to offer this training as part of its joint multiagency training offer in the future.

Making Safeguarding Personal

- By means of a quick reminder, Making Safeguarding Personal is an initiative which aims to develop an 'outcome focus' to safeguarding activity, as well as a range of responses to support people to improve or resolve their circumstances. It is a personalised approach that enables safeguarding to be done 'with', and not 'to, people. It is a personalised approach that considers what the person wants as an outcome from safeguarding intervention and should consider the person's strengths and their networks. It's about involvement and participation, and seeing the person, not the process.

- The 4LSAB Workforce Development Group agreed Family Approach to Safeguarding, Risk Management Framework, Mental Capacity Act and Self-Neglect in terms of multi-agency safeguarding training needs across the 4LSAB area. It was agreed that Making Safeguarding Personal would run as a golden thread through all these topics and any priority areas agreed in the future.

- The 4LSAB Quality Assurance Group delivered a survey to practitioners regarding Making Safeguarding Personal to gain a base line understanding of practitioner confidence and how this is integrated in to their practice. The Isle of Wight Safeguarding Adult Board facilitated an MSP workshop in 2019 which reported on responses and findings and produced an action plan, actions from which have been fed in to the 4LSAB subgroups and the 4 Safeguarding Adult Boards to progress priorities. One of the actions agreed, was to promote the Local Government Association Making Safeguarding Personal Toolkit.

- A peer review of Southampton Adult Social Care recognised a priority area for development was embedding personalisation and strengths-based practice across the service. Whilst many practitioners are proactive and the is awareness of good practice examples, the need to embed strengths based approaches consistently into practice, remains.

Family Approach to Safeguarding

- Southampton Safeguarding Partnerships – the Safeguarding Adult Board and Safeguarding Children Partnership held a joint conference in June 2019 titled 'Adopting a Family Approach'. The Family Approach Toolkit was launched and promoted to Southampton practitioner and there has been continued promotion of the toolkit in training and resources by the partnerships.

- Across the Pan Hampshire Safeguarding Adult Board's and Safeguarding Children Partnerships One Minute Guide's for all aspects of safeguarding, have been produced and published.

- The 4LSAB Workforce Development Group agreed the Family Approach to Safeguarding as a priority area for focus in 2020.

- An audit of Transition from Children's Mental Health Services to Adult Mental Health Services was commissioned by the Southampton Safeguarding Partnerships and the report was presented to the SAB in October 2019. The audit sought to evaluate how case information for those requiring mental health support is passed from a child service to an adult service, as young people had highlighted that their transition from children's to adult services had not always gone smoothly, particularly for those who needed to access mental health services. Information was requested from agencies to assess the creation of transition plans, along with the level and

quality of engagement and participation with the young person. Questionnaires were sent out, and responses were analysed. The audit identified some good practice within services in creating transition and discharge plans, however, there was limited evidence of multi-agency working in such circumstances, and it appears that the multiple recording systems limited access to care plans by professionals. Recommendations have been made to raise awareness of the importance of effective transition planning, improved multi-agency working, and how to address problems with communication and record keeping. Both the SSAB and the Safeguarding Children's Arrangements remain committed to continuous improvement in relation to the audit outcomes.

Self-Neglect and interface with homelessness, alcohol and substance misuse

- The 4LSAB Policy Implementation Group started work to revise the Multi-agency Safeguarding Adult's Policy in Summer 2019. As part of this work the current 4LSAB Self Neglect policy is also being updated considering current research, case law and legislative interpretation of the Care Act and Mental Capacity Act. Southampton took the lead to complete work on the policy, but due to capacity issues across the partnerships, during COVID-19, production of a draft revised version was delayed, but due in Autumn 2020.

- In November 2019 Southampton SAB took part in National Safeguarding Adults week with a range of community engagement and safeguarding adult awareness raising activities. During the week the 4LSAB Fire Safety Development Group held a launch in partnership with Radian Housing, called 'Taking the heat out of hoarding', helping to recognise the links between hoarding and fire safety. The group identified the key agencies to target through a fire death analysis carried out over 3 years. There was a high proportion where hoarding was identified as a significant risk factor and people presenting with poor mental health. Among others the campaign is targeted mental health practitioners, housing, and public health. The launch event culminated in the publication of the 4LSAB Multiagency Hoarding Guidance.

- Southampton SAB have promoted the use of the Escalation Policy for proactive challenge within the partnership. The policy should be used for safeguarding partner practice issues, not for other matters (individual practitioner performance is not part of the scope of this document).

5. Learning from Reviews

When there is a failure to safeguard people, results can be severe and tragic. In order to learn lessons and prevent future similar tragedies from occurring, SABs have a statutory duty to host a Safeguarding Adult Review, in order to assess how agencies worked together. The Statutory guidance dictates that a SAB must decide when a case review needs to be commissioned so that all organisations involved can contribute and build on their development to improve, through action planning. It is also the duty of the SSAB to hold partners to account in relation to achieving the aforesaid associated outcomes. In accordance with the Care Act 2014 a Safeguarding Adult Review (SAR) must be commissioned if:

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 the statutory SAR criteria, it may still be considered as a different type of review such as a multi-agency partnership review or a single agency review. The Southampton SAB Case Review Group has a key part in overseeing this activity and decision making and ensuring that learning is gathered and disseminated widely amongst professionals. All final decisions however rest with the Independent Chair.

In 2019-20 the SAB received 11 case referrals for Safeguarding Adult Review; 2 cases have been progressed to Statutory Safeguarding Adult Review and 3 cases were progressed for a discretionary review. Unfortunately, due to the COVID-19 pandemic and in line with guidance received by NHS England, all safeguarding adult review work was suspended at the end of March 2020 and therefore progression and delivery of review reports will be delayed. An update on the learning and improvement from these reviews will be detailed in the 2020-21 SAB annual report.

We reported on 1 review that took place during 2019-20 in the Safeguarding Adult Collection (SAC) for the Department of Health and Social Care.

SSAB concluded 2 learning reviews in 2019-20. Learning from the reviews is disseminated to the local partnership and to practitioners, in various ways, as summarised below:

Adult P - Safeguarding Adult Review

The SAR for 'Adult P' was commissioned after an incident in 2014, where tragically Adult P died from injuries following a serious sexual assault. Adult P was known to services and had a history of alcohol dependency, homelessness, and substantial self-neglect. There was also some concern about financial and sexual exploitation, by others toward Adult P. The full overview report for this case was published on the Southampton LSAB website, alongside a 6 Step summary briefing to aid in dissemination of the learning.

Marie - Multiagency Review

In 2017, the Southampton LSAB considered the case of 'Marie' (pseudonym) and determined that the Statutory Criteria for Safeguarding Adult Review (Section 44, Care Act 2014) was not met but that significant learning may be gained from carrying out a multi-agency review. Marie had complex needs; she had learning disabilities and a mental health diagnosis. The decision not to publish the full report was taken by SSAB, in order to protect Marie as a surviving victim. A 6 Step Summary briefing of the case is available on the LSAB website.

Follow up and Learning

All recommendations and actions from Case Reviews are transferred into actions for the services to deploy via planning. Their progress in implementing plans is monitored by the SSAB's Case Review Group. The SSAB seek to ensure that all staff are aware of the shared learning and managers are responsible for disseminating this in supervision, to prevent similar outcomes for adults at risk of harm, abuse or neglect.

Learning identified throughout the case review process is disseminated to relevant organisations as soon as it becomes available. This is to ensure lessons learned are acted upon as soon as possible to improve practice, policies and systems management and to reduce the risk of similar tragedies occurring again. In addition, the SSAB collates learning according to identified themes, which is cascaded to board members and wider audiences, as appropriate.

The themes identified this year through case reviews and audit work are summarised below. They influence regular 'Learning from Case Reviews' briefings and workshops hosted by SSAB. Themes so far have been:

The need for effective communication between agencies and with service users

- The lead professional for an individual should establish the roles and responsibilities of each professional and family member involved, to ensure common goals in decision making and care planning. Effective communication and healthy working relationships are an important part of good multiagency practice.
- Practitioners need to remember that safeguarding/adult protection overrides data protection legislation

Listening to the voice of the adult and making safeguarding personal

- Practitioners need to see the adult at risk and consider the context of any exploitation and abuse and to effectively consider the daily, lived experience of the adult at risk i.e. impact of abuse and neglect and the potential long term significant harm it can cause.
- There is a need to ensure that non-verbal communication from an adult at risk are integral to assessing responses in safeguarding interventions.
- It is important for adults at risk to know about and access local advocacy services so that people's decisions are clear in relation to planning for their health, care and wellbeing.
- Accessing Local Government Association Making Safeguarding Toolkit supports practitioners to adopt a strength based approach when working within Safeguarding Adults and is vital to safeguarding work

Taking a family approach - *Including risks from 'Trigger Trio' of domestic violence, substance misuse, alcohol and mental health issues.*

- Commonality of the combination of 'trigger trio' issues in families, and increased risk of significant harm
- High risks posed to others as well as 'subject' of the safeguarding work, including wider family members and children

- Early identification and intervention can reduce the risk of harm
- Risk can escalate quickly, particularly where there is a combination of domestic abuse with mental health issue or substance misuse
- There is a need for further understanding of the impact of coercive control on families.

Escalation

- Underpins the principle that Safeguarding is everyone's business 'until the individual is safe' which is a key factor in promoting the welfare of our adults at risk
- Practitioners and families need to constructively challenge, if a response is received to concerns, which is inadequate.
- There is a need to raise awareness of the 4LSAB Escalation procedures.

Disguised Compliance & Hostile families

- Importance of professional curiosity – encouraging professionals to act on this and triangulate findings to test a methodology or hypothesis.
- Cases show that intentional deception and control of professionals exists with carers /parents, minimising or denying abuse and neglect.
- Practitioners can become over optimistic about progress being achieved, again delaying timely interventions for individuals and families.
- Aggressive/intimidating individuals and family members can influence personal responses.

Impact of self -neglect

- Adults can spend long periods of time subject to interventions from services with limited impact.
- Early intervention is a key factor in reducing harm and the long term impact on an individual who self-neglects can consequently mean they are at a higher risk of harm.
- Housing issues such as rent arrears, lack of property maintenance and anti-social behaviour is apparent in many self-neglect cases.
- There is a link between experience of neglect as a child and in adolescence, and then self-neglect as an adult.
- Practitioners need to apply the 4LSAB Multi Agency Risk Management Framework in self-neglect cases, where the Section 42 threshold is not met.

Using history to inform current practice

- Existence of quality chronologies with clearly identified risk factors improves outcomes for child and adults
- These need to be more than a simple timeline – include qualitative information, analysis and narrative
- Should be made available to multi-agency professionals to review them at all levels of intervention and assessment
- Need to include patterns or trends noticed for the family/individual and patterns of behaviour, crisis times and 'peaks' of risk, in order to help predict and prevent future harm
- Consideration should be given to include previous generational case/family history to form a holistic view.

Regular and Effective supervision

- Area of repeat concern across agencies in our case reviews

Each agency should have:

- A written policy for the supervision of staff
- A process for handling complaints and disagreements with regards to safeguarding supervision.

- Safeguarding supervision provided by an appropriately experienced supervisor that is regular, planned with protected time & one-to-one or group basis.
- A written agreement that explains the purpose, value and importance, the roles of the supervisor and supervisee, a record should be kept of each session in line with the specific organisation's own supervision policy and/or agreed processes.
- Decisions should be recorded (or cross-referenced) case file or record. There is a duty to escalate the following concerns should they arise within safeguarding supervision discussion:
    - Individuals or family members who may be at risk of significant harm.
    - There is unsafe practice placing people at risk.
    - There is illegal activity.

Application of Mental Capacity Act

- The over reliance upon the assumption of mental capacity and the limits of understanding mental capacity in more complex cases.
- This includes where mental capacity may fluctuate due to, for example, substance misuse.
- Fluctuating capacity impact upon the professional's assessment of risk and what legal framework may be available to protect the individual.
- Assumption of capacity around the adult understanding the risk from safeguarding concerns arising from their current situation.
- Recording and evidencing mental capacity assessments and using the formal legal tests for assessing decisions provides a sound structure.
- Acknowledgement that Mental Capacity assessments for more complex individuals present a real challenge across agencies.
- Practitioners need to be aware of how factors such as duress or coercion can affect a person's mental capacity and that further expertise and/or legal advice may need to be sought.

Case Review Action Plans

The SAB translates recommendations from reviews to detailed improvement and action plans that the partnership and individual organisations monitor and take action in response to the findings of the reviews. The SAB Case Review Group has oversight of these plans and reviews them regularly.

6. Next Steps and Priorities for 2020-21

Southampton SAB have had a productive and challenging year co-ordinating quality assurance of adult safeguarding activity and promoting the welfare of adults at risk of harm, in the City.

Following the appointment of the new SSAB Independent Chair, Deborah Stuart-Angus, in January 2020 work was initiated work on developing partner safeguarding adult priorities and reviewing the strategic plan. This review and subsequent discussions held with partners, identified an appetite for Board development, for strengthening its position and the need for strategic safeguarding improvement. The SSAB is working towards improving the local focus for Southampton City's safeguarding, and its particular local needs such as homelessness; the high number of care homes; a large student population; sex working and the risk of exploitation and the requirement for closer scrutiny of local safeguarding data.

By the end of March 2020, we had identified our future priorities as **Prevention, Quality and Learning**, and following partnership consultation and analysis, we are now set to:

- Set out 21-24 Strategy with shared aims, objectives and a supporting business plan
- Set out a Board Team workplan
- Set out a Board structure which is fit for purpose
- Increase our connectivity with other Boards
- Revise our Constitution
- Set up a Risk Register
- Achieve service user feedback and representation
- Set out a Coroner's Protocol
- Review our SAR methodology, business process and quality system

COVID-19 Response

On 11th March 2020 the World Health Organisation declared the outbreak of COVID-19 as a pandemic. During these unprecedented times safeguarding our most vulnerable and at risk adults in Southampton has never been more important. The Southampton Safeguarding Adults Board is continuing to work in partnership to ensure an effective and timely response to safeguarding issues, and have ensured that assurance exists for continuing to deploy Section 42 Care Act duties.

The SSAB set out its Board Assurance Safeguarding Framework to help monitor the ongoing challenge during the COVID-19 pandemic, and partners worked relentlessly, with very high levels of co-operation and co-ordination in order to collaborate planning and deploy their safeguarding duties. This ensured a robust safeguarding response for people in our communities who may not have normally sought support from agencies but who, due to the impact of social distancing and self-isolation measures, were more at risk, due to life circumstances, for example homeless and rough sleepers; asylum seeker; those with no recourse to public funds; those who had no local connection to the area; people with specific disabilities (including mental illness, those using drugs and alcohol); those who were socially isolated, and those experiencing domestic abuse, and for adults and children, the family approach being of more importance than ever.

It is important to capture the essence of the very real partnership and collaboration that has been witnessed and experienced through integrated working, during Southampton's shared response to managing the pandemic and protecting its most at-risk residents.

At this this juncture, it will give us a timely opportunity to review our strategic plan, the SSAB structure and membership, SSAB governance and Constitution, and to ascertain how Southampton SAB is assured that safeguarding adults at risk is effective, and, in order for us to deploy our lawful and statutory obligations.

As a result, a new strategic plan will be developed and will take effect from Spring 2021.

7. Reporting Adult Safeguarding Concerns

If you are worried that an adult may be at risk of abuse or harm please contact Southampton Adult Social Care on:

Email: adultsocialcareconnect@southampton.gov.uk

Telephone: 023 8083 3003

Address: Adult Social Care, Southampton City Council, Civic Centre, Southampton, SO14 7LY

If an adult at risk 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.

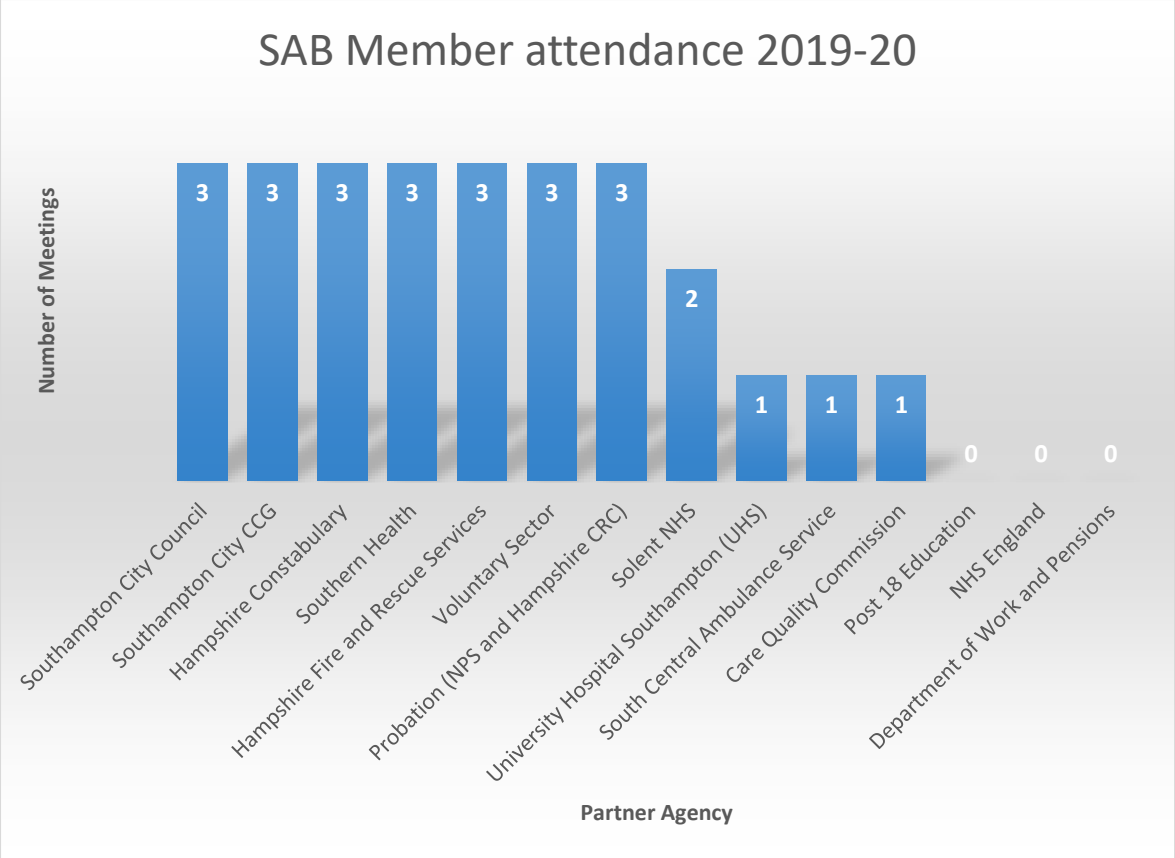
Appendices

Appendix 1 SAB Finance

SAB partners agreed to the following contributions to cover 2019-20

Board Partner Agency	Contribution 2019 - 20
Southampton City Council	**£37,086**
Southampton City CCG	**£29,013**
Hampshire Constabulary	**£11,072**
Total contributions	**£77,171.00**

Appendix 2 Board Members Attendance

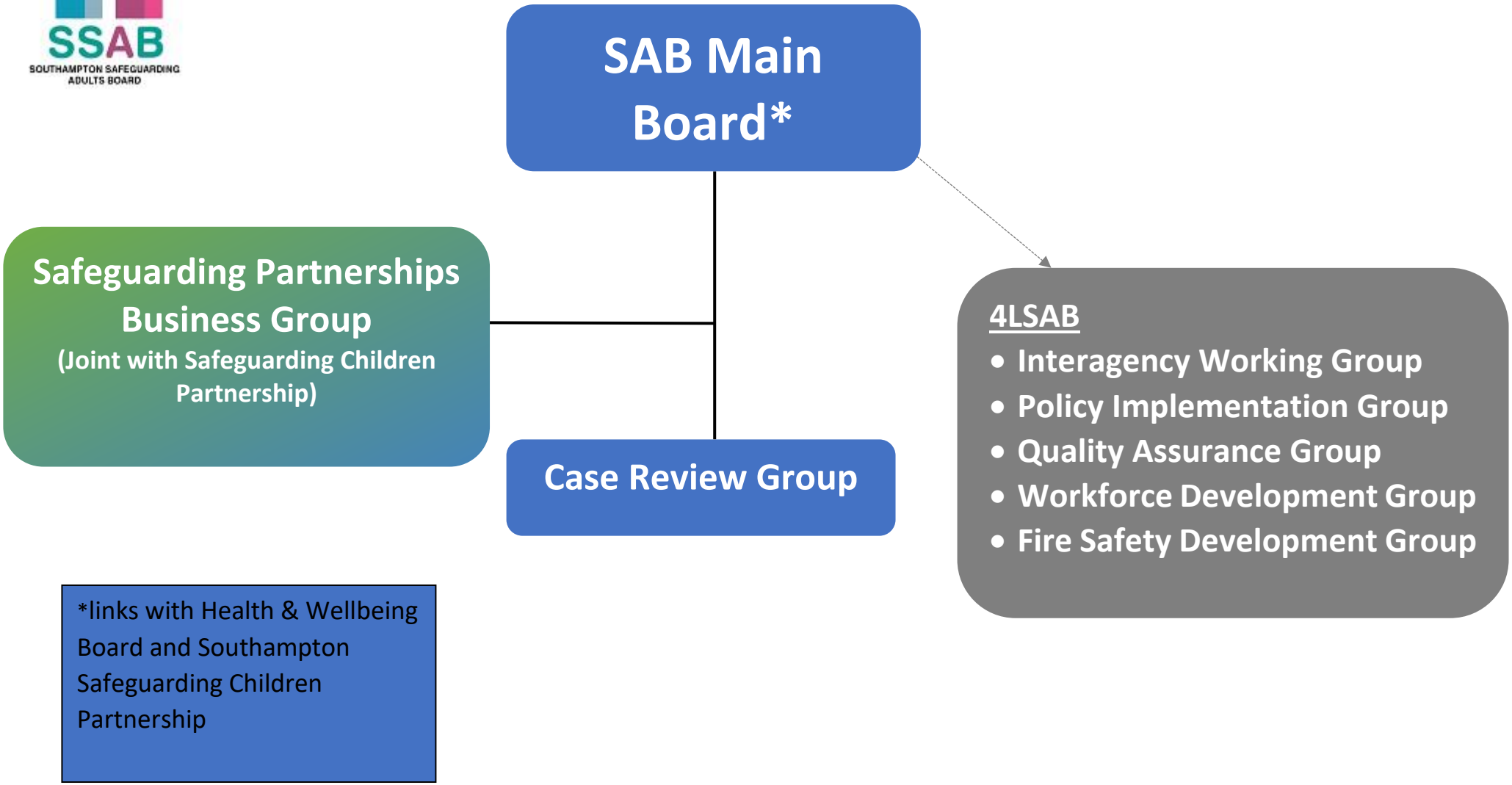


The above graph shows that the majority of agencies had 100% to 75% attendance at SAB meetings. Only 3 meetings took place in 2019-20; the SAB meeting which took place in March 2020 was attended by funding partner agencies only to discuss strategic response to COVID-19 pandemic. Partners such as NHS England, CQC and DWP are not noted as essential partners at every meeting.

Appendix 3 Glossary

4LSAB	Joint collective of the SABs from Hampshire, Isle of Wight, Southampton, Portsmouth
CAMHS	Child and Adolescent Mental Health Services
CSE	Child Sexual Exploitation
DoLS	Deprivation of Liberty Safeguards
ED	Emergency Department
GP	General Practitioner
Hampshire CRC	Hampshire Crime Rehabilitation Company
HCC	Hampshire County Council
HFRS	Hampshire Fire and Rescue Service
HMPPS	Her Majesty's Prison and Probation Services
MARAC	Multi Agency Risk Assessment Conference
MASH	Multiagency Safeguarding Hub
MET	Missing, Exploited and Trafficked
MSP	Making Safeguarding Personal
NPS	National Probation Service
RSH	Royal South Hants Hospital
SAR	Safeguarding Adult Review
SCAS	South Central Ambulance Service
SCC Adult Social Care	Southampton City Council Adult Social Care
SHFT	Southern Health NHS Foundation Trust
Southampton City CCG	Southampton City clinical Commissioning Group
Southampton SAB	Southampton Safeguarding Adults Board
Southampton SCP	Southampton Safeguarding Children Partnership
UHS	University Hospital Southampton NHS Foundation Trust
YOS	Youth Offending Services

Appendix 4 - Southampton SAB Structure Chart 2019-20



Southampton LSAB Functions

The **Main Board** is attended by panel of senior officers from all safeguarding partners in the city. Together they form the core decision making body for the partnership and have a constitution which details their responsibilities.

The **Business Group** incorporates Children's & Adults Boards. It is attended by senior representatives from the three key safeguarding partners (Police, Health & Council) plus the Independent Chairs of both Boards. The Business Group plans for Main Board meetings, receives reports on progress from each of the Sub Group Chairs to monitor progress and also controls the budgets for each Board.

The **Case Review Group** receives referrals for reviews and determines whether they meet criteria for a Case Review and initiates and monitors Reviews. The group ensures that resultant learning is shared with partners to help prevent the circumstances occurring again.

The **4LSAB** coordinated work includes: a merged Chair/Strategy Group, a Quality Assurance Group which is closely aligned to other 4LSAB sub groups, a Policy Implementation Group and a Workforce Development Group, which is looking at merging adults' workforce development.