SSAB

SOUTHAMPTON SAFEGUARDING ADULTS BOARD

Southampton Safeguarding Adults Board

Annual Report 2020 – 2021

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Independent Chair Foreword

It gives me great pride to share the Southampton Adult Safeguarding Board's Annual Review for 2020-2021.

Having joined the Board as Independent Chair in January 2020, our Safeguarding Adult Partnership has been on quite a journey, having encountered numerous unprecedented challenges, posed by the shared pressures of the Covid-19 pandemic and assuring that we still delivered to those in most need. As a result of those pressures, you will find less reporting herein, on the achievements of our Partnership. This is simply because of the remaining and current demands on our teams, and the capacity of our staff.

We all have our Covid story of loss, death, tragedy, isolation, poor health, financial difficulty - and trying to keep our services going, where-ever possible and no matter what. The journey that our partnership has shared – is exactly that - it was totally shared. We have worked very closely, as one team, with a connected spirit, and managed to maintain a high degree of safeguarding assurance, aware at times that this been affected in some ways, by a lack of capacity, however this is perhaps the biggest achievement, that I as Chair, could have hoped for.

In April 2020 we issued a Safeguarding Assurance Framework to all statutory partners and on its completion, just a matter of weeks later, partners were able to provide our Board with the insight of what was being achieved – for example, Hampshire Constabulary deploying a robust police response to Covid, dealing with increased domestic abuse, and sometimes at the acknowledged expense of other safeguarding issues; our orchestrated and shared local resilience planning, assisting with homelessness; Adult and Children's Social Care retaining front line services and triage, whilst protecting many, with early intervention; our Clinical Commissioning Group creating designated bed spaces for Covid patients, in various landscapes; our Fire and Rescue Service continuing to provide a service and going the extra mile, to produce a local Fire Safety Framework – for all practitioners, now having gained national access and acclaim; the dedication of our NHS and Care Home staff, working many long, difficult and selfless hours, to save lives, and last but never least, the huge efforts of our voluntary sector; of Healthwatch; of Faith groups and of our City Council. All of this work was underpinned by very regular, increased levels of connectivity across the statutory arrangements; increased contact and planning, and very regular safeguarding and Covid assurance 'check-in' governance.

I could go on, as this is by no means an exhaustive list of the unsung achievements, that this year has seen - and it is this - and the sheer dedication of so many, that makes me proud to be part of Southampton's Safeguarding Partnership efforts - which this year have focused on the preservation of life.

In this Report you will find some reference to the aforesaid – but nothing that will serve justice on the Partner's efforts. You will also be able to access information about our progress, our forward planning (Appendix 2) and our annual statistics in relation to safeguarding activity, as well as the outcomes from a Safeguarding Adult Review and a serious case review.

You will denote, our ongoing theme at Board level of 'local solutions for local needs'- with a contextual approach to adult safeguarding in our City. You will also note that we still retain strong partnership connections with our three partner Boards: Hampshire; Isle of Wight and Portsmouth – but going forward, there will be a revised and more focused brief.

We are, despite the negative impact of Covid, now in a very positive position, to embed our agreed, strategic aims, of Prevention, Quality and Learning - as following a very successful partner consultation in 2020-21, our statutory partners agreed to create financial sustainability for Southampton's Safeguarding Adults Board. This will now, enable us to focus on delivery planning and widen the learning and development lens, allowing us to have the capacity to create partner wide, accessible learning; deliver on lessons learned from Southampton (and national) Safeguarding Adult Reviews, and continue to deploy the outcomes from the contribution we made, to the National SAR Analysis research, and embed the recommendations made for all Boards across England.

The dedication of our Board Members and Partners; the excellent practice within our Case Review Group and the support given to our City by this safeguarding partnership is second to none.

Thank you will never be enough.

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

What is the role of Southampton Safeguarding Adults Board?

The Southampton Safeguarding Adults Board (SSAB) is a statutory partnership, working together to prevent both the risks and experience of abuse or neglect, for people with care and support needs. The SSAB is not involved in operational practice, the main functions of the SSAB are to:

- Provide strategic oversight of safeguarding activity in Southampton
- Fulfil the statutory functions as outlined in The Care Act 2014 and the related Statutory Guidance
- Help to protect the rights of people who live in Southampton, to live a life free from harm, abuse and neglect.

The SSAB follows and endorses the six safeguarding principles outlined in the Care Act 2014, Care and Support Guidance, which are:

Empowerment - People are supported and encouraged to make their own decisions and informed consent:

"I am asked what I want as the outcomes from the safeguarding process, and this directly inform what happens."

Prevention - It is better to take action before harm occurs:

"I receive clear and simple information about what abuse is. I know how to recognise the signs, and I know what I can do to seek help."

Proportionality - The least intrusive response appropriate to the risk presented:

"I am sure that the professionals will work in my interest, and they will only get involved as much as is necessary."

Protection - Support and representation for those in greatest need:

"I get help and support to report abuse and neglect. I get help so that I am able to take part in the safeguarding process to the extent to which I want."

Partnership - Services offer local solutions through working closely with their communities. Communities have a part to play in preventing, detecting, and reporting neglect and abuse:

"I know that staff treat any personal and sensitive information in confidence, only sharing what is helpful and necessary. I am confident that professionals will work together and with me to get the best result for me."

Accountability - Accountability and transparency in delivering safeguarding:

"I understand the role of everyone involved in my life and so do they."

The SSAB has three core duties, and must:

- Develop and publish a strategic plan setting out our safeguarding priorities, and how we will meet our objectives
- Publish an annual report reflecting how effective work has been
- Commission Safeguarding Adult Reviews (SARs) for any cases which meet the legal criteria.

The SSAB has key responsibilities, which are to:

- Provide strategic direction for safeguarding adults at risk across our partnership
- Develop and review multi-agency safeguarding policy, procedures and guidance
- Monitor and review the implementation and impact of both strategy and policy

- Promote multi-agency safeguarding adults training
- Undertake Safeguarding Adult Reviews, share the lessons learned from their outcome and develop appropriate action plans for improvement
- Hold partners to account and gain assurance of effectiveness of safeguarding arrangements.

The SSAB is chaired by Deborah Stuart-Angus, the Independent Chair. The SSAB is supported by the Safeguarding Partnerships Team, which also supports the work of Southampton Safeguarding Children's Partnership. The team consists of a Partnership Manager, two Safeguarding Partnership Co-ordinators and two Safeguarding Partnership Assistants.

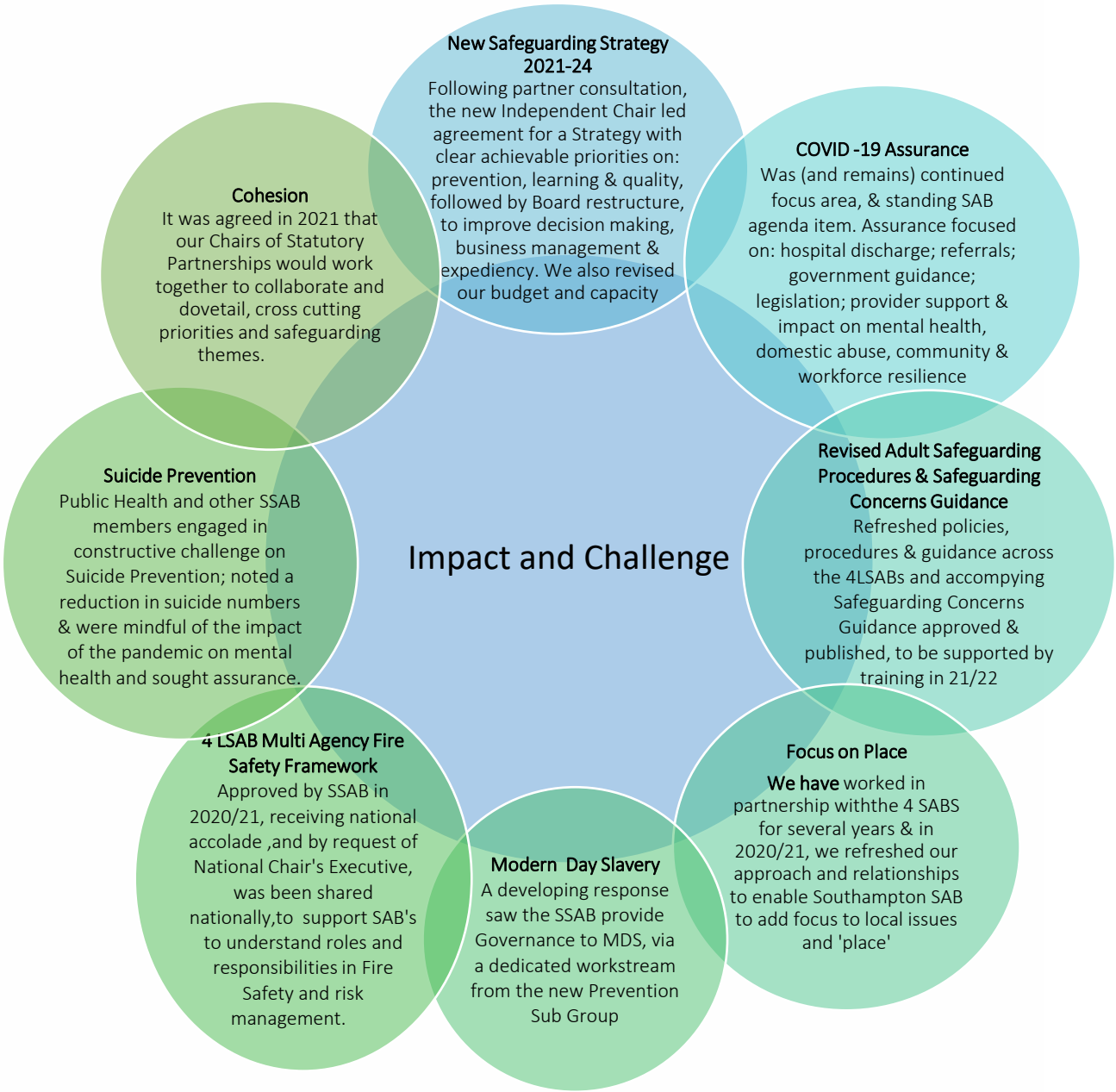
This report details:

- Impact and challenge
- Safeguarding Adults at Risk information
- The structure of the SSAB and the activity completed through subgroups of the SSAB and 4LSAB arrangements
- The findings of Safeguarding Adult Reviews and Learning Reviews which have concluded in the reporting year; implementation of lessons learned, and ongoing reviews
- National Safeguarding Adult's Week
- The SSAB's income and expenditure
- The SSAB strategic priorities for 2021-2024

Impact and Challenge

"it is important that SSAB partners feel able to challenge each other and other organisations where it believes that their actions or inactions are increasing the risk of abuse or neglect. This will include commissioners, as well as providers of services." (Care and Support Statutory Guidance)[1]

The SSAB has been able to demonstrate impact and challenge in several areas:



[1] Care and support statutory guidance - GOV.UK (www.gov.uk)

COVID-19 Assurance

The COVID-19 pandemic impacted all of our lives in different and significant ways. As attention turned to managing the resultant operational pressures, Safeguarding Adult Review work was paused for a number of months, although referrals continued to be received. Some safeguarding adult training was postponed and restarted online. Considerable and creative efforts were made to ensure adults with care and support needs were safe. Contingency planning was put in place for services and for the work of the SSAB.

It is testament to the commitment of partner agencies and the Chair, that the work of the SSAB largely continued. The Independent Chair and all statutory partners met regularly safeguarding assurance meetings during the first lockdown to consider the impact on adults at risk and the supporting services. Agencies involved in safeguarding adults were invited to a safeguarding adults' network meeting monthly as a collaborative, problem solving space, this continued during 2020/21.Participants found this useful and informative as a mechanism to touch base and share.

Agencies provided assurance updates in relation to the impact of the pandemic at all SSAB meetings, enabling partners to share context and system pressures whilst exploring shared emerging issues, and able to identify mitigation of risk. Monitoring of referrals to the Safeguarding Adult Case Review Group identified referrals where COVID-19 was identified as a contributing factor

Learning during this time has developed real partnership in Southampton; and a spirit of working together with increased mutual respect for each partner's challenges. Virtual meetings proved very successful.

SSAB Strategic Partners

The Southampton SAB brings together partner agencies with responsibility for adult safeguarding, such as Hampshire Constabulary, Southampton City Council, and the Clinical Commissioning Group, to work together, in order to:

- assure that local safeguarding arrangements are in place and work effectively
- prevent abuse and neglect from happening
  support people who have experienced neglect or abuse to recover
- raise awareness of safeguarding adults at risk and how communities can help

We also work closely with other SABs and partnerships including, the Southampton Safeguarding Children's Partnership, the Safe City Partnership and the Health and Wellbeing Board, to share priorities, prevent duplication and are working to address cross cutting themes.

Developing Southampton Safeguarding Adults Board Safeguarding Strategy

This was a year of transition for the SSAB, developing and strengthening local safeguarding arrangements and activity, and managing the impacts of the pandemic. Appendix 1 provides a 'Red, Amber, Green' rated overview, of the original 2019-2021 strategic plan, from which outstanding priorities areas were brought into the new strategic plan for 2021-2024, (attached at Appendix 2). The new strategy was built by consulting with all partners in relation their safeguarding priorities and concerns for our City, and how, as a Board we could help, and be as constructive as possible, with tight resources. A wealth of evidence from our partners was shared, which following analysis by the Independent Chair, resulted in the development of clear themes, now translated into our Adult Safeguarding priorities. The Southampton Safeguarding Adult Board Strategy 2021-24 was thus developed, approved and supported by our partners, and can be found here.

Our Priorities

Priority 1 – Prevention

We will work together, in partnership, to prevent abuse and neglect, fully deploying our statutory responsibilities to protect the most vulnerable in our City. We will raise awareness; promote multi-agency risk management, and early intervention and detection to enable the people of Southampton to live safer lives.

Priority 2 – Quality

We will assure our work; we will learn from local experience and that of others, and we ensure our processes aim to continuously improve safeguarding practice. We will seek to assure that safeguarding arrangements are lawfully compliant and meet the statutory obligations set out within the 4LSAB Multi-Agency Adult Safeguarding Policies and Procedures.

Priority 3 – Learning

We will share lessons learned from safeguarding practice and Safeguarding Adult Reviews with transparency, across our partnership, and we will proactively promote the need for a modern, competent, skilled, and shared workforce. We will enable access to learning, for our partners, deploying local, regional, and national experience to improve our safeguarding practice.

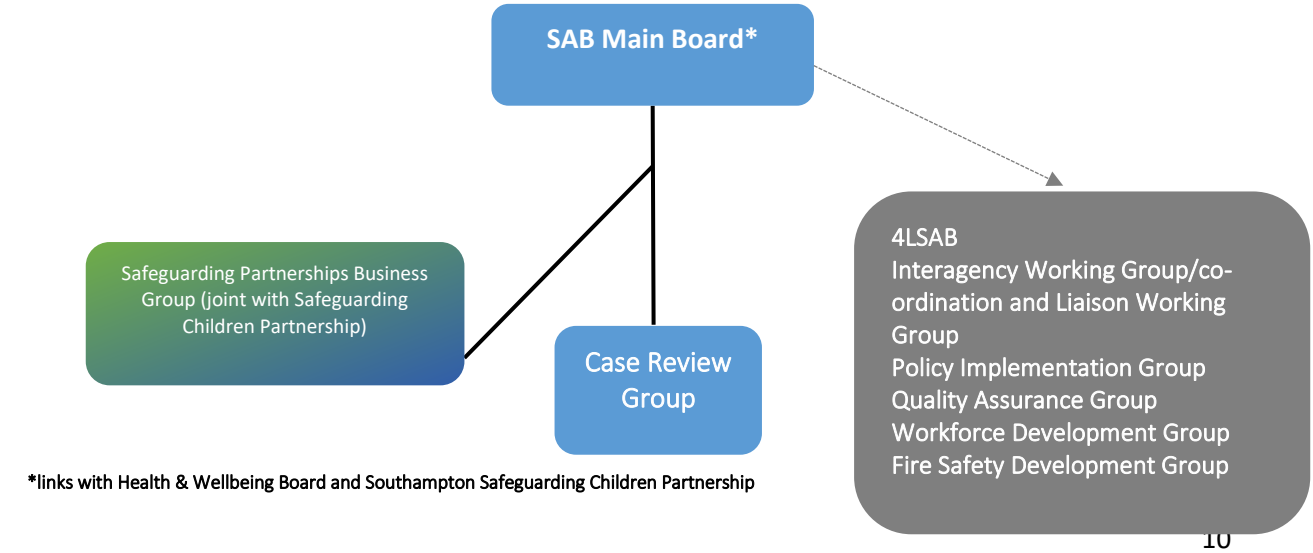
The Safeguarding Adult Partnership Strategy is also supported by a comprehensive **Business Plan,** which can be found at Appendix 2. The Business Plan has formulated the basis of our future delivery.

The SSAB arrangements and structure

During 2020/2021 the SSAB met 4 times. During the year the SSAB:

- monitored the work of the Case Review Group for Safeguarding Adult Reviews
- approved Safeguarding Adult Review Overview Reports and SAR Learning reviews
- set strategic priorities for 2021-24
- confirmed board arrangements to support the strategic priorities
- approved relevant work of the 4LSAB groups
- confirmed 4LSAB arrangements for 2021 onwards

Southampton Safeguarding Adult Board Structure 2020



*links with Health & Wellbeing Board and Southampton Safeguarding Children Partnership

Southampton LSAB Functions -2020

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, supported by a Constitution detailing their responsibilities. The Business Group incorporates members of Children's & Adults Boards, attended by senior representatives from the three statutory safeguarding partners (Police, Health and Local Authority) plus Independent Chairs from both Boards. The Business Group plans for Main Board meetings, receives reports on progress from each of the Subgroup Chairs; monitors progress and controls the budgets for each Board. The Case Review Group receives referrals for Safeguarding Adult Reviews (SARs)and determines whether they meet criteria for a SAR, and initiates and monitors other types of review. The group ensures that resultant learning is shared with partners and action plans for improvement, are deployed to hold partners to account, to try and prevent the circumstances occurring again, and to embed improvement in practice.

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

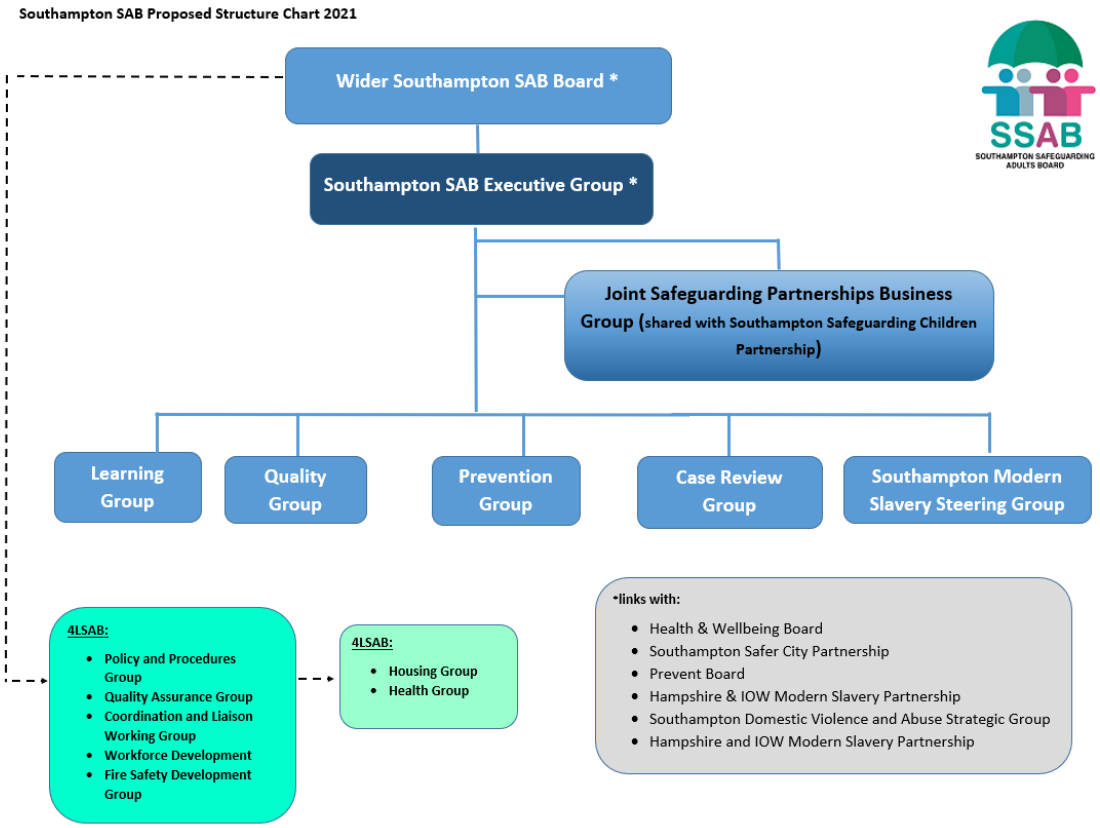
Board Structure, Business and Delivery Review

The structure of the Board was reviewed during 2020, to develop a local focus on Southampton, its specific profile and demography. This approach was very well supported by partners, led by the Independent Chair. As a consequence, an Executive Team was set up, made up of the Independent Chair, the three Statutory Partners and The Partnership's Manager. This team was set up to enhance decision making and develop expedient routes for recommendations to be made to the full Board Membership. In order to ensure that local delivery meets the Safeguarding Adult Strategic objectives, and to increase local focus on local need, three new sub-groups were proposed and agreed by members:

- Prevention Sub Group
- Quality Assurance Sub Group
- Learning and Development Sub Group

(in addition to The Case Review Group which was already in place). Future work will focus on the population of these groups with multi-agency staff, agreed Terms of Reference and local delivery planning. The following diagram demonstrates the changes made:

Southampton Safeguarding Adults Board Structure 2021/22



Contributions to the Annual Report

We have invited agencies across SSAB to contribute to the Annual Report and the following are some representative examples, given that this has been exceptional year, in terms of partner's facing unprecedented challenge, due to the pandemic:

Department of Work and Pensions (DWP)

During 2020, DWP introduced teams to lead work on its approach to supporting vulnerable customers. As part of this, a network of over 30 Advanced Customer Support Senior Leaders (ACSSLs) were appointed, providing an escalation route for all DWP colleagues to refer to when a customer requires some form of advanced support, ensuring that these customers are signposted or referred to the support that they need. The ACSSLs work with a range of external partners within their own geographical area, aligning support for vulnerable customers wherever possible. The DWP recognise the positive impact that a collaborative approach can have when supporting vulnerable customers. DWP will continue to work across all internal teams and with our external partners to help to provide the support that customers require.

Hampshire Constabulary

Hampshire Constabulary have made use of the Police Surge Fund 2020-2021, as an £830,000 Home Office Grant to maintain four police officers in Southampton, focussing on serious violence, drug related harm and related crime. A significant proportion of funding was granted to Southampton District to ensure continued support of this work and the Constabulary continued to work with Violence Reduction Units, Public Health Services, and other key agencies. There has also been a

revision of the National Referral Mechanism (NRM) to improve the quality of safeguarding to vulnerable and exploited adults.

Domestic Abuse has been raised as a strategic priority, with several initiatives created to improve the quality of life of those affected and Operation Fortress continues, where activity focuses on solving drug related harm with both victims and offenders. In terms of data and performance information that demonstrates how Hampshire Constabulary has improved adult safeguarding outcomes in Southampton during 2020 – 2021, the following examples were shared:

- Increase in the total number of Police Safeguarding Notification referrals to Adult Social Care in Southampton
- Increase in the number of Right to Know and Right to Ask Requests, under Clare's Law, referencing Domestic Abuse
- Increase in the number of ancillary orders, e.g., Domestic Violence Protection Notices (DVPN) and Domestic Violence Protection Orders (DVPO)
- Increase in the focus on both targeted and supportive action regarding victims of drug related harm

Hampshire Constabulary have identified key areas of concern with regards to safeguarding adults in Southampton:

- Reduced focus on adults at risk, through a combination of factors, such as prioritising children during the pandemic and the need to provide a COVID-19 policing response
- Austerity and associated impacts
- Police Force and Violence Reduction Unit (VRU) locality reports - now being used to identify Wards that experience social inequality, affecting crime and other high harm factors, within the population
- Targeted support, required through commissioning services and national support
- Increase in neighbourhood officers
- Modern Day Slavery (MDS), substance misuse, mental health, serious violence (including domestic abuse) and neglect - all high concern areas for Southampton, and some issues competing for resources in the face of other demands and pressures.
- Review of outside pressures will be required to support further targeted work, however District priorities are set to incorporate risks, linking into the Safer City Partnership Strategy.
- Transitional safeguarding group (18-24 year olds) is often placed at heightened harm, and a 4LSAB Task and Finish group is currently working on bridging gaps.

Southampton Voluntary Services (SVS)

In response to the pandemic SVS commissioned the compilation of bereavement support information and provided an online course for frontline staff and volunteers, who have to deal with the impact of bereavement in their jobs, frequently inclusive of death and the restrictions on family interactions, during the early stages of the COVID-19 pandemic. This resource has been shared nationally. SVS also commissioned the development of an online video based on safeguarding awareness for informal volunteers and mutual aid groups. SVS identified the cumulative impact of lockdown, financial concerns, and debt, on local people - leading to a steep increase in mental health issues, as well as seeing a profoundly negative impact on carers - during the initial COVID emergency.
SVS also ran 3 safeguarding awareness sessions for trustees and staff from organisations with Black and Minority Ethnic (BME) leaders, as part of capacity building courses and in response to Black Lives Matter.

Safeguarding Adults at Risk in Southampton

It is important to understand the data in relation to Safeguarding Adults at Risk in Southampton, which exists as a foundation to enable the SSAB to measure effective safeguarding outcomes. The SSAB receives this information annually and 2021/22 will see the establishment of a SSAB Quality Group, (as previously mentioned), where this data will be further utilised in relation to the planned SSAB quality assurance mechanisms.

Safeguarding Concerns

In 2020/21 5092 safeguarding concerns were triaged by Adult Social Care (ASC), showing a 30.8% increase from the 3894 reported in 2019/20. The increase is primarily due to (a) changes in practice introduced following the 2018 Local Government Association Peer Review and (b) continued increase in referrals to Adult Social Care: largely from increased referrals from Police, the South Central Ambulance Service and the NHS; as well as a reflection of demographic and social welfare trends in the City. (It is worth advising that, the majority of these referrals do not meet the Care Act s42 criteria for a full Safeguarding Enquiry to be required, and whilst many are directed to other actions/organisations, a large number of the referrals may not have needed to have been referred for Safeguarding consideration).

In 2018 Practice was changed to ensure that all relevant referrals were triaged, decision making was documented and automatic assumptions that a referral did not constitute a safeguarding concern, were not made.

The following table shows the number of safeguarding concerns in the South East region in 2019/20 (this is currently the last year for which national and regional comparisons will be available).

Nationally, the average number of concerns per 100,000 population was 1070 compared to the regional average of 1041. The increase in safeguarding concerns in 2019/20 resulted in Southampton having 1937 concerns per 100,000 population:

Table 1. Benchmarking 2019/20 Concerns

Population	no. of concerns	no. of concerns per 100,000 pop
England	475560	1070
Buckinghamshire County Council	9140	2185
Southampton City Council	3895	1937
Slough Borough Council	1985	1865
Isle of Wight Council	1975	1688
Brighton & Hove City Council	4010	1667
Milton Keynes Council (Unitary)	2920	1455
Royal Borough of Windsor & Maidenhead	1535	1315
Portsmouth City Council	2225	1300
West Sussex County Council	8265	1202
Surrey County Council	10425	1118
East Sussex County Council	4465	990
Wokingham Borough Council	**1280**	**979**
Oxfordshire County Council	5115	938
Kent County Council	10450	844
Reading Borough Council	960	769
West Berkshire District Council	925	753

Bracknell Forest Borough Council	700	743
Medway Council	1565	733
Hampshire County Council	3230	294

*Please note that published figures are rounded to the nearest 5 so will differ to actual submissions[2]

Action taken

- The process of triage and safeguarding recording will be reviewed by Adult Social Care (ASC) to ensure that it follows best practice and appropriate information is recorded and further analysis will be required to identify the sources of increase in concerns . Additional guidance will be provided to staff in ASC to support the triage process.
- The Brief Guide to Making Safeguarding Referrals was developed and published by SSAB
- Work completed in 2020 by SSAB, producing to develop the '***Brief Guide to Safeguarding Concerns'***, providing clear advice to partners about referral criteria.

Enquiries

In 2020/21 there were **821** safeguarding enquiries**, 619 Section 42 enquiries** and 202 other /discretionary enquiries. This is a 12.0% increase from 2019/2020 (733 total enquiries). The proportion of section 42 enquiries as a total of all enquiries is 75.4% which is a decrease from 79.4% in 2019/20. (It has been identified by Adult Social Care that internal recording errors caused of a number Enquiries not to be recorded as full S42 Enquiries; this practice has been corrected).

Due to changes in the recording of the safeguarding concerns, there has been an impact on the conversion rate from concern to enquiry. The conversion rate has reduced from 18.8% in 2019/20 to 16.1% in 2020/21.

Table 2 shows the South East region 2019/20 conversion rates. There is large variability depending on how local areas interpret and apply legislation and guidance. The comparative data for 2019/20 shows significant changes in practice in three of the Councils listed below, where the rate of recording concerns increased greatly, so that their conversion rate also fell greatly.

Action taken

Adult Social Care reviewed local practice in assessing the need to carry out full S42 enquiries. In the first four months of 2021/22 this resulted in in the number of recorded concerns remaining static when compared to 2020/21. However, the number of enquiries has risen to 445 in this period, an average of 111 per month. If this improvement continues throughout 2021/22, the conversion rate will rise to 27%.

Table 2 2019/20 Concerns to Enquiry Conversion Benchmarking

Population	conversion rate from concern to enquiry
England	37%
Surrey County Council	71%
Kent County Council	63%
West Berkshire District Council	58%
Reading Borough Council	57%
Medway Council	54%
Isle of Wight Council	49%

[2] Source: https://digital.nhs.uk/data-and-information/publications/statistical/safeguarding-adults/2019-20

East Sussex County Council	45%
West Sussex County Council	44%
Wokingham Borough Council	38%
Royal Borough of Windsor & Maidenhead	38%
Hampshire County Council	29%
Oxfordshire County Council	24%
Brighton & Hove City Council	20%
Milton Keynes Council (Unitary)	20%
Southampton City Council	19%
Bracknell Forest Borough Council	16%
Slough Borough Council	14%
Portsmouth City Council	14%
Buckinghamshire County Council	7%

In England the average is 37% compared to an average of 39% in the South East.

Section 42 Enquiries

In 2020/21 there were 619 Section 42 Enquiries and 202 discretionary enquiries, an increase of 12% compared with 2019/20. Table 3 shows Section 42 benchmarking for the South East:

Table 3 Section 42 Enquiry Benchmarking 2019/20

Council	no. of section 42 enquiries per 100,000 pop	proportion of Sec 42 enquiries
England	364	91%
West Berkshire District Council	440	100%
Reading Borough Council	435	100%
Royal Borough of Windsor & Maidenhead	494	100%
Brighton & Hove City Council	336	100%
Oxfordshire County Council	224	100%
Surrey County Council	790	99%
Milton Keynes Council (Unitary)	285	100%
Wokingham Borough Council	360	98%
Isle of Wight Council	793	97%
West Sussex County Council	507	97%
Hampshire County Council	84	97%
Portsmouth City Council	172	94%
Bracknell Forest Borough Council	107	91%
Buckinghamshire County Council	140	90%
East Sussex County Council	397	89%
Medway Council	340	86%
Slough Borough Council	218	84%
Kent County Council	416	79%
Southampton City Council	289	79%

Counts of Individuals involved in Section 42 Enquiries by Gender and Ethnicity

Demographics - Gender	2016-17	2017-18	2018-19	2019-20	2020-21
Male	146	163	147	226	242
Female	202	225	187	253	306
Unknown	0	0	0	0	0

Demographics - Ethnicity	2016-17	2017-18	2018-19	2019-20	2020-21
White	307	315	294	393	442
Mixed / Multiple	2	1	1	5	3
Asian / Asian British	9	10	8	25	17
Black African / Caribbean / British	3	3	6	7	8
Other ethnic group	2	2	4	3	12
Refused	1	1	0	0	2
Undeclared / Not Known / Unable to respond	24	56	21	46	64

Count of Concluded S42 Enquiries by Location and Source of Risk

Location of Concern	2016-17	2017-18	2018-19	2019-20	2020-21
Own Home	218	291	237	271	341
Care Home - residential	117	93	94	98	91
Hospital - acute	1	8	26	62	64
Care Home - nursing	2	71	26	48	47
In the community (excluding community services)	10	17	34	70	47
Other	11	14	17	34	20
In a community service	4	18	7	16	16
Hospital - mental health	1	1	0	4	4
Hospital - community	7	4	1	1	0
Total number of concerns	371	517	442	604	630
Source of Risk					
Service Provider / Social Care Support	178	265	244	223	230
Other - known to individual	175	221	161	298	319
Other - unknown to individual	18	31	37	83	81
Total number of concerns	371	517	442	604	630

Notes – These figures count cases not people. Locations can be double counted if there is more than one source of risk. The 2016/17 submission counted most nursing home locations as care home locations, this has been rectified in subsequent submissions.

Counts of Concluded Section 42 Enquiries where a Risk was Identified, What Was the Outcome

Where Risk Identified What Was The Outcome	2016-17	2017-18	2018-19	2019-20	2020-21
Risk Remained	15	29	47	65	64
Risk Reduced	201	246	240	321	323
Risk Removed	92	143	64	100	108
Total number of concerns	308	418	351	486	495

Other Enquiries

In 2020/21 there were 202 'Other Enquiries' which is an increase of 33.8% from 2019/2020 (151 enquiries). These enquiries are frequently about adults at risk who have mental capacity but whose needs/risks are the result of addiction/homelessness/and or mental health and or may experience coercion. Recording 'other' enquiries is being developed more in 2021/22. This is significant in the City, as it reflects broader needs and local demography. Compared to the South East region Southampton undertakes the highest proportion of Other Enquiries per 100,000 population (see Table 4).

Table 4 2020/21 S42 and discretionary enquiries by type of abuse.

Type of Abuse	Number	Proportion
Neglect and Acts of Omission	309	36%
Finance or Material	153	18%
Physical Abuse	104	12%
Self-neglect	84	9.5%
Domestic Abuse	75	8.7%
Psychological Abuse	73	8.5%
Organisational Abuse	23	3%
Sexual Abuse	23	3%
Sexual Exploitation	10	1%
Discriminatory Abuse	4	<0.5%
Modern Slavery	3	<0.5%
Total	861	

Data Quality Issues

Work has continued, both in the ways noted above and within data analysis and checking to best ensure accurate and complete recording of all Safeguarding Adults Collection fields. Manual checks continue to be carried out. This also is being carried out to best ensure full and accurate records will be transferred to the Council new recording system, Care Director, which is to come into use later in 2021. A number of updates were made to the Southampton City Council (SCC) data recording fields, to improve recording of the Mental Capacity of Adults.

Safeguarding Adult Case Examples

John

John is a 65-year-old male resident of Southampton, who lives in a private owned semi-detached property and had a previous career in finance.

John is an individual who was presenting risks for self-neglect including the neglect of his home environment. There were multiple burn marks in carpets, furniture, bedding and John's clothing from discarded cigarettes. Due to John's alcohol consumption and poor mobility, there were concerns for his ability to react to a potential fire situation and to evacuate in the event of a fire. John's nutrition and health were poor due to only eating convenience "snack foods".

John was known to SCC Adult Services, various Care Provider agencies, Hampshire & IOW Fire and Rescue Service, Hampshire Constabulary and South Central Ambulance Service.

As a result of multi-agency involvement, John had smoke detection installed throughout his property, fire retardant bedding and sofa coverings were provided, and telecare was installed which was interlinked to the smoke detection. Carers were also provided to support John with his personal care and meal provisions.

In 2020, unfortunately, a discarded cigarette caused a pile of paperwork to catch alight. Hampshire and IOW Fire and Rescue Service were alerted to the fire by the Telecare company after they received notification that the smoke detector had activated. Due to concerns for John's escalating fire risks; his lack of ability to safely respond to a fire situation, and the ongoing concerns for self-neglect, a Section 42 Safeguarding Enquiry was initiated.

As part of the safeguarding enquiry, a capacity assessment in regard to fire safety was conducted jointly between SCC Adult Services and Hampshire and IOW Fire and Rescue Service. John was assessed to have capacity with his understanding and decision making for fire safety. John informed all agencies that he wished to continue smoking, however wanted to do so in a safer manner. John also wanted to reduce his alcohol intake as he was aware of the health and fire risk implications this was presenting.

The Safeguarding enquiry also resulted in; fire buckets and sand being obtained and provided to enable John to discard of his cigarettes safely; replacement fire retardant bedding and throws provided; and Fire Suppression systems explored for John's property. Care assessments and plans were updated to incorporate fire risks and the ongoing control measures required in order to suitably reduce the fire risks.

The safeguarding enquiry was closed after a few months due to a successful reduction in risk and improved safety, whilst at the same time ensuring the primary focus of the enquiry centred on John's wishes and decisions regarding how he wanted to live his life.

Ms T

The Hospital Discharge Team (HDT) received a referral from Ward Staff for a female patient, Ms T, who had herself identified that she was self-neglecting. This was to such a degree that she was unable to use her home effectively and carry out everyday personal care activities.

The extend of the hoarding in her home was extreme. She was unable to wash and dress, couldn't get to her kitchen and had to climb over belongings. She would sleep on the top of her hoarded possessions, curling up on top of belongings to sleep. When her home was deep cleaned, the cleaning company found that the bottom of the pile of belongings was "mush". So the impact on her health and wellbeing was clear and risks were high. She was said to have "significant muscle wastage."

The HDT engaged with a provider to deep clean the home, the initial cost estimate was in over £10,000. A smaller cost was negotiated, by taking a gradual approach to first tackle key areas of Ms T's home. However, this cost could not be negotiated to a lower level and the social worker and her manager redeveloped the approach in discussions with Ms T, developing a targeted, gradual approach, focussing on a step-by-step approach where short term goals were put in place and gradually achieved.

Ms T had a rehabilitation placement followed by a short stay in a care home, both to enable her to build up her health and to allow time for the clean-up to begin. Contact was made with a specialist Charity, Dehoarding South West, who carried out further deep-cleaning and decluttering. They will continue to work closely with Ms T to support her to move forward and address her hoarding behaviours. This continues to be a positive and successful support intervention and it is anticipated that Ms T will have regained much of her independence, both physically and psychologically.

The charity described the property as being an "Extreme hoard". They were concerned that the effective approach needed to be twofold, to sort out the hoard, and to support Ms T to move forward and sustain the changes. The cost from cleaning charity was £3500.

The HDT are looking into further use of this organisation, given the success of their support for Ms T.

David

David is a 41-year-old male resident of Southampton, who lives in flat provided by a Housing Association and has a diagnosis of Post-Traumatic Stress Disorder, Psychosis, anxiety and depression.

David's first interaction with Hampshire Police was in 2006 and was linked to 19 reports until December 2020. In the following four months he was linked to 40 incidents including assault, public order, threats to life, weapons offences, harassment and antisocial behaviour. This caused considerable concern and disruption to neighbours and following allegations, David was arrested on 8 separate occasions and received HDLS assessments. Officers raised concerns for David's mental health and on occasions he was sectioned under the Mental Health Act for assessment and returned to the community shortly afterwards.

The first Multi-Agency Risk Management (MARM) meeting was held at the end of January and was attended by the Adult Mental Health Team, Community Mental Health Team, Housing Associations, Southern Health, NHS Mental Health nurse, and Hampshire police and an initial Risk Management (protection) plan was agreed. He was described as an impending risk to himself and others with a Doctor stating he had serious concerns if professionals did not act. Professionals worked closely for a

further four months to address the risks. Housing sought an injunction to address David's behaviours that were impacting neighbours which was granted in June 2021 lasting 12 months. Police completed engagements with neighbours through regular patrols and dealt robustly with criminal matters.

From a police perspective, the MARM process and professional network around it facilitated timely and productive information sharing to ensure changes in risk were identified and addressed by the appropriate agency. After assessment in the late spring David was detained under Section 3 of the Mental Health Act, where professionals reported good progress after his presentation was stabilised. During this period Police and Housing engaged with residents and reassurance provided.

David returned to his home address later in the summer. Professionals had implemented a number of mechanisms and supports around David and in the subsequent seven months, no incidents have been reported to police. The active police management was closed in September 2021 and an agreed police response plan is in place should there be incidents in the future.

Safeguarding Adult Reviews

The Care Act 2014 requires Safeguarding Adults Boards to conduct Safeguarding Adult Reviews (SARs) when an adult with care and support needs it the area dies or experiences serious abuse or neglect (whether known or suspected), and there is concern that partner agencies could have worked more effectively to protect the adult. However, the SAB can also conduct a SAR on a discretionary basis, where it is believed either learning or good practice can be gained.

The purpose of a Safeguarding Adult Review is to learn lessons and for the SSAB to gain assurance from partner agencies that organisational learning and improvement is consequently put into place to prevent similar harm occurring in the future. Organisations are held to account by the SSAB via evidence-based action planning and ongoing assurance monitoring. The Independent Chair developed a Safeguarding Adult Review Quality Assurance Framework, which following review, was agreed and adopted by the SAB Membership and the Case Review Group for piloting. This provided a comprehensive structure to ensure that the Case Review Group and our Independent Reviewers can follow a robust structure, set out with quality assurance standards. The National SCIE Quality Markers were taken into account in the development of the framework.

During the year, the Case Review Group:

- Met 5 times
- Commenced one SAR
- Completed one SAR and one Learning Review

SAR 'Brenda'

The full overview report for this case has been published on the Southampton LSAB website along a 6-step briefing designed to summarise the review.

Learning Report 'Adult W'

A learning briefing has been published.

Moving forward the Case Review Group will:

- Pilot the new SAR quality framework
- Monitor SAR action plans
- Explore different ways of sharing learning from SARs

Additional Learning

Learning from Reviews 2020 - 2021 is also available on the SSAB website. This combines key learning and messages for practitioners from the work of the Case Review Group, who also published a one-minute guide to Professional curiosity due to learning from reviews, where professional curiosity is described as:

*"the need for practitioners to practice **'respectful uncertainty'** through enquiring deeper using proactive questioning and challenge to understand one's own responsibility, to know when to act, not to make assumptions or take things at face value."*

4LSABs, Portsmouth, Hampshire, Isle of Wight, and Southampton SABs

The SSAB works collaboratively with other Safeguarding Boards locally in a 4LSAB arrangement. This includes Hampshire, Portsmouth, Isle of Wight and Southampton SABs.

4LSAB Inter-Authority Working Group/Inter Authority Co-ordination and Liaison Working Group.
The terms of reference for this group were reviewed during this year. This group comprises of the Chairs of the SABs, plus statutory partners and Board Managers. The group confirms priorities for collaborative working across the 4LSAB, either through established subgroups or task and finish groups.

4LSAB Safeguarding Adults Policy & Procedure Subgroup
This group produced a refreshed 4LSAB Safeguarding Adults Policy & Procedure which was approved by Southampton SSAB in June 2020. The 4LSAB Policy & Procedure document is separated into four sections:

- Policy & Procedures – sets out the lawful legal responsibilities of practitioners under the Care Act 2014, including key legislation for safeguarding adults at risk.
- Adult Safeguarding Practice – advises on how agencies should work with an adult at risk in order to support their best interests, as well as managing adult safeguarding enquiries and concerns, whilst managing other statutory duties
- Adult Safeguarding Process – sets out detailed guidance from early recognition of abuse, through to concluding a safeguarding enquiries, and post-abuse support. It includes issues relating to section 42 enquiry decisions and working to reduce the risk of abuse and neglect.
- Glossary of Terms – Explanation of terminologies used in Adult Safeguarding

The group also reviewed and updated the Multi-Agency Risk Management (MARM) Framework in June 2020. This is where the criteria for an adult safeguarding enquiry (section 42) are not met. The guidance is designed to support professionals working to safeguard adults at risk of harm, but not experiencing abuse and neglect.

In February 2021, Portsmouth Safeguarding Adults Board published a podcast as part of the Multi-Agency Risk Management framework. Work also began in relation to developing a Safeguarding in Transitions Framework, for young people aged over 18 - where concerns remain and there is no existing transition pathway into support from adult services. This will be completed in 2021/22

4LSAB Workforce Development Group
The 4LSAB Workforce Development sub-group have been meeting regularly and have revised and refreshed the 4LSAB Workforce Development Strategy. In addition, they have produced and published a Self-Neglect Learning Briefing. This was designed to provide greater awareness to practitioners about identifying self-neglect. Self-neglect has been a common theme in Southampton's recent Safeguarding Adult Reviews.

Self-neglect *"covers a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding. It should be noted that self-neglect may not prompt a section 42 enquiry. An assessment should be made on a case-by-case basis. A decision on whether a response is required under safeguarding will depend on the adult's ability to protect themselves by controlling their own behaviour. There may come a point where they are no longer able to do this, without external support."* [3]

4LSAB Fire Safety Development Group (FSDG)
The role of the FSDG is to co-ordinate work across the 4LSAB area. The group aims to ensure fire safety and risk management is embedded into the day-to-day work of partners. The group also

[3] Care & Support Statutory Guidance, Care Act 2014

maintains oversight of fire incidents and deaths involving adults with care and support needs. Partner agencies are required to review the identified learning, consider their own agency procedures, ensure this learning is fully embedded within their organisations and develop internal mechanisms to identify, support and effectively manage fire risks for all individuals across the 4LSAB areas. The FSDG have focused on defining best practice and developing a Multi-Agency Fire Safety Framework, where it is defined as:

'Think…Person, Behaviour and Environment'

SSAB is advised that the most effective way to assess a person's vulnerability to fire is to identify the individual risk factors which impact upon their health, safety and wellbeing. This includes: the person, physical or cognitive impairments; behaviours (such as unsafe cooking practices or carelessness with smoking materials) and their environmental considerations (such as hoarding, trip hazards or blocked escape routes). The more risk factors identified the greater their vulnerability.

Care Plans and Person-Centred Risk Assessments

The group advises that where individuals are in receipt of a social care service, the management of their fire safety should be risk assessed and embedded within their individual care plans. Ensuring an individual is kept safe from the risk of fire must be a key consideration in their overall care provision. Ensuring smoke detection systems are tested weekly, fire retardant bedding is in use or the individual has an ability to summon assistance in case of an emergency are simple steps that will greatly increase a person's safety if a fire should occur in the home. As with all care plans, an individual's vulnerability to fire should regularly be reviewed and documented. Should the vulnerability increase, so too should the fire safety control measures in place, to appropriately manage and mitigate the risk.

Risk Management

The group also advises that there are situations where an individual may be presenting 'significant' fire risks to themselves and others, but they choose not to engage with support services or adhere to the fire safety advice provided. In such cases, and where the concern does not engage a statutory safeguarding framework (e.g. a Section 42 Enquiry), it is essential that agencies work together and consider the Multi Agency Risk Management Framework (MARM) as a method of fully understanding the risks being presented. This will ensure that an effective, co-ordinated, and multi-agency response can be provided to these 'critical few' cases and assist in the development of an action plan to mitigate the impact of the individual's actions of which may be compromising their safety and the wellbeing of others.

2020/21 saw the development of the 4LSAB Multi Agency Fire Safety Framework which will be formally launched in 2021/22. This is accompanied by a helpful video guide.

Financial Contributions to the SSAB

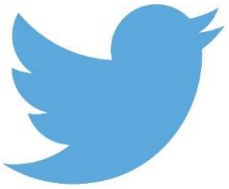
Partner Contributions	19/20	20/21
Southampton City Council	37,086	51,586
Clinical Commissioning Group	29,013	29,605
Hampshire Constabulary	11,072	11,298
Total	**77,171**	**92,489**

The majority of this funding supports, costs arising from statutory obligations such as Safeguarding Adult Reviews, staffing and learning

Following a very successful partner consultation, led by the Chair, in relation to developing a sustainable and developmental future, 2021/22 will now see a significant increase in the funding made by all three statutory partners. This will not only enable sustainability but increase the SSAB capacity to provide learning and development and to strengthen Southampton's local safeguarding adult board arrangements, and consequent delivery. It also very much supports the 2021-24 SAB Safeguarding Adults Strategy.

National Safeguarding Adults Week 2020

The partnership is active on social media, both through SSCP and SSAB, and via a Twitter account: @SPSouthampton – managed by the Safeguarding Partnerships team. In partnership with the SABs in Portsmouth, Hampshire and Isle of Wight and with local safeguarding agencies, National Safeguarding Adult Week was held, focusing on themes highlighted by the impact of COVID-19 to include:



- Mental health
- Loneliness and social isolation
- Fraud, scams and cybercrime
- Family approach
- Homelessness

The 4LSAB Co-ordination and Liaison Working Group were able to access reporting, evidencing the reach and effectiveness of the campaign.

Appendix 1 - Southampton Safeguarding Adult Board Strategy.

Appendix 2

Southampton Safeguarding Adults Board – Business Plan 2021-24

The SSAB Business Plan for 2021/24 provides information on actions and target timescales required to deliver the SSAB's priorities. Progress in relation to the plan will be reviewed at each SSAB meeting with updates from Subgroups. A Blue/ Red/Amber/Green rating is used to assess progress in relation to each action.

BRAG index

Blue action- complete

Green – Action on track and progressing to plan

Amber- Some problems or delays with the action but expected to recover

Red – Major problems and issues threatening the action, behind schedule and not expected to recover

Priority 1: Prevention and Awareness

We will work together, in partnership, to prevent abuse and neglect, fully deploying our statutory responsibilities to protect the most vulnerable in our City. We will raise awareness; promote multi-agency risk management, and early intervention and detection to enable the people of Southampton to live safer lives.

"I want to live safely; I know what abuse is and I know how to get help"

What	How	Who	Success metrics	When	RAG status and comments
1.1 Agencies with safeguarding obligations have clear processes in place to deliver the 4LSAB Multi- Agency Adult Safeguarding Policy & Procedures, and safeguarding activity is effective to prevent abuse, crime, neglect, self-neglect, modern slavery and exploitation.	Work collaboratively with 4LSAB arrangements and deliver the outcomes from the Self-Assessment, Framework Audit to review safeguarding systems and practice; information sharing; safeguarding training & MCA and DoLS practice and activity.	SSAB Quality Subgroup	90% of partners will complete the audit Analysis, outcomes learning, and recommendations will be reported to the March 2022 SSAB Partners will achieve an overall compliance score of 80% A SMARTER Action plan will be in place in each agency to aim for 100% compliance.	Oct 21 Organisational Self-Assessment Audit Tool to partners Feb 22 Analysis of outcomes March 22 Findings Report to SSAB with recommendations May 22 Agency action plans in place June 22 Random agency sample (30% of cohort) to assure RAG rated action plans	

1.2 We will work together and collaborate, to maximise multi-agency risk management and improve the lives of the people of our City.	The Modern Slavery Task and Finish Group will ensure that 4LSAB aims are implemented locally and that a clear view of MDS in Southampton is available, with recommendations for strategic and operational improvement, and will report into the SSAB Prevention Subgroup	Prevention Subgroup	Awareness is raised about MDS Development and publication of SSAB MDS Guidance for Practitioners. MDS Training offer & attendance is increased Where an MDS concern exists, safeguarding activity is monitored in relation to care and support needs.	March 2022 Quarter 1, 2022 Quarter 2, 2022 Quarterly reporting	
	Promote use of Multi Agency Risk Assessment Framework & Learning from SARS (e-learning resource)	Subgroups for Quality Assurance & Learning & Development	Tracked agency use with outcomes from Integrated Score Card Accessible multi-agency on-line training provided on learning from SARS	Dec 21 March 2022	
	Work jointly with 4LSAB partners and Southampton's Children's	4LSAB Policy and			

	Arrangements to develop a Safeguarding in Transition Framework.	Procedures Group	Agreed framework and SSAB dissemination in place.	March 2022	
1.3. We will raise organisational and public awareness about abuse, neglect and self-neglect; what can be done to help and demonstrate how and where we seek assurance and accountability.	Work collaboratively with 4LSAB partners to promote and activate the National Safeguarding Adults Awareness Week Campaign 2021. Arrange and implement Awareness Raising actions e.g. by partners holding a free awareness conference; by partners hosting pop up stands in supermarkets; by working with banks; by trying to create City safe places businesses. Quarterly SSAB Newsletter providing updates on SSAB activities & regional & national updates Use of social media to raise awareness	SSAB Prevention Group Safeguarding Partnership Team, Independent Chair & Prevention Sub Group Safeguarding Partnerships Team & Prevention Subgroup	A working Impact Report to be developed and shared with SSAB and 4LSAB Co-ordination and Liaison Working Group Increase and evidence reach, compared to 2020 efforts. Quarterly SSAB newsletters will be in operation A Social Media comms plan will be in place	Campaign - Nov, 21 Report – Feb 2022 Reach – Dec,2021 January 2021 December 2021	

1.4 We will ensure that the voices of adults at risk are sought, heard, listened to and acted upon, and that we engage with our local communities.	Establish a system to ensure adults at risk and or their lived experience influences SSAB Policy, Procedure and business.	Prevention Subgroup, Southampton Healthwatch, Southampton Connect, Independent Chair	System established and agreed across stakeholders	July 2022	
	Set out a delivery plan in accordance with the TOR and the Board Business Plan	All Sub-Groups	All Delivery plans will be in place for all Subgroups	December 2021	
	Engage with local communities through community leaders e.g. City Church; Southampton University; Southampton Connect		The Prevention Sub Group Delivery Plan will reflect actions that address how views of safeguarding and awareness raising in local communities will be addressed.	December 2021	

Priority 2 – Learning

We will share lessons learned from safeguarding practice and Safeguarding Adult Reviews with transparency across our partnership, and will proactively promote the need for a modern, competent, skilled and shared workforce. We will enable access to learning for our partners, deploying local, regional and national experience to improve our safeguarding practice.

'I am confident in the people who help me and they will be confident in how to effectively safeguard'

What	How	Who	Success Metrics	When	RAG status and comments
2.1 We will seek assurance that all statutory agencies have training in place to deliver their adult safeguarding obligations to prevent abuse, crime, neglect, self-neglect, exploitation and modern slavery.	See 1.1	L&D Sub-Group Partnerships Team			
2.2 We will seek assurance that agency training is aligned with the 4LSAB Multi-Agency Adult Safeguarding Policy & Procedures; local and national learning.	See 1.1	L&D Sub-Group Partnerships Team			
2.3 We will ensure that, having sought evidence from those	Conduct a Training Needs Analysis across the partnership.	L&D Subgroup	SSAB Training Strategy & Training Plan	April 2022	

with lived experience, that this makes a positive impact on learning and development.	Develop a SSAB Training Strategy and associated Training Plan, ensuring that learning reflects research outcomes; the voice of the adult & family feedback from SARs. Ensure the SSAB Training Strategy matches the current safeguarding priorities such as: MCA LPS Legal Literacy Modern Day Slavery Self-Neglect Mental Health Suicide Awareness Transitional Safeguarding		overseen and agreed by agreed by SSAB		
2.4 We will share lessons learned from Safeguarding Adult Reviews, hold agencies accountable and seek evidence that organisational improvements are made, where necessary.	See 1.2 Develop e-learning and additional resources about learning from SARs. (OMG/6 Step Briefings)	Case Review Group L& D Subgroup Independent Chair Partnerships Team	Procurement of E-learning authoring tool Plan for modular development Prioritisation of training needs Resources developed to promote learning from SARs	Dec 21 Dec 21 February 2022 March 2022	

			Feedback mechanisms built into on-line learning systems to assure future proofing Numbers of staff trained will increase and be evidenced by the authoring tool that is procured and the supportive Local Management System.	March 2022 December 2022	

Priority 3

We will assure our work; learn from local experience and that of others and ensure that our processes aim to continuously improve safeguarding practice. We will seek to assure that safeguarding arrangements are lawfully compliant and meet our statutory obligations, set within the 4LSAB Multi-Agency Adult Safeguarding Policies and Procedures.

'I am confident that the people who work with me and with each other, help me to achieve my outcomes in the best possible way'

What	How	Who	Success Metrics	Timescale	RAG status and comments
3.1 We will ensure that agencies are held accountable for their quality outcomes in relation to safeguarding	SSAB will seek assurance from commissioners and regulators about the safety and quality of care provision in Southampton by:	SSAB Quality Subgroup	Integrated score card in operation and inclusive of data as described	QTR 4 2021, 22 and 23	

activity; and request assurance that partners evaluate outcomes & share with SSAB.	analysing quarterly data from Integrated Scorecard bi-annual updates and assurance from all statutory services annual update and assurance from Care Quality Commission and see 2.1		Bi -annual reports from statutory partners Annual CQC update Outcomes from Self-Assessment QA Framework and random evidence selection	Quarters 2 and 4, 21, 22 and 23 Quarter 4 ,21, 22 and 23	
3.2 We will ensure that our own performance is reviewed and evaluated.	Annual report demonstrates assurance against statutory functions and effectiveness of SSAB SAR Quality Assurance Framework established	Safeguarding Partnership Team Independent Chair Case Review Group	Annual report scrutinised and challenged by SSAB Membership; Healthwatch; SCC Health & Scrutiny Committee and the Health & Wellbeing Board SAR QA Framework piloted SAR QA Framework established	Dec-21, 22 and 23 Quarter 4, 21 Quarter 1, 22	
3.3 We will ask agencies to gain feedback those with lived	Established consistent approach to seek adult's views at the end of s.42	SSAB Quality Assurance Subgroup	Research effective practice and learning from other areas and deploy where appropriate.	Dec-21	

experience and seek evidence that learning is put into practice to improve safeguarding outcomes for our population.	enquires to test Making Safeguarding Personal See 1.4				
3.4 We will work to ensure that safeguarding practice is lawfully compliant, and practice is made personal at every opportunity.	We will continue to commission Safeguarding Adult Reviews and each SAR will deploy MSP principles and ensure families views are reflected and where possible, that the voice and views of the adult at risk is heard. We will share the learning from SARs as widely as possible and note learning from other SARS in other areas. See 2.3 and 3.3 We will assure lawful compliance of practice from the organisational Safeguarding Self - Assessment Framework and SAR outcomes	Case Review Group Partnerships Team	Quarterly Reports to SSAB Self-Assessment Framework & Audit SAR Action Plans and their outcomes	QTRLY	

Key to abbreviations:

Board / LSAB:	The full board of the Local Safeguarding Adult Board
LSB	Collective name for Local Safeguarding Board / team in Southampton – working across the adults and children's safeguarding boards
Exec	The joint business group for LSCB and LSAB in Southampton
QA:	Quality Assurance
WFD:	Workforce Development
4LSAB:	Hampshire, Isle of Wight, Portsmouth & Southampton Local Safeguarding Adults Boards
HWBB:	Health & Wellbeing Board
DVA:	Domestic Violence and Abuse
HBV:	'Honour' Based Violence
FGM:	Female Genital Mutilation
FM:	Forced Marriage
MSP:	Making Safeguarding Personal