Southampton Local Safeguarding Adults Board

Annual Report 2017-18

023 8083 2995

lsab@southampton.gov.uk

www.southamptonlsab.org.uk

@Sotonlsb

Contents

Chairs Foreword	**3**
1. Introduction	**4**
2. What is the impact of safeguarding partners working together in Southampton?	**6**
3. Workforce Development within the Multiagency partnership	**12**
4. Community Engagement	**15**
5. Priority Issues for Southampton LSAB 2017-18	**16**
6. Learning from Reviews	**21**
7. Next Steps and Priorities for 2018-19	**28**
8. Reporting Adult Safeguarding Concerns	**29**
Appendix 1 - LSAB Finance	**30**
Appendix 2 – Board Members Attendance	**31**
Appendix 3 - Glossary	**32**
Appendix 4 - Southampton LSAB Structure Chart 2017-18	**33**
Appendix 5 – LSAB Functions	**34**

Chairs Foreword

I am pleased to introduce this Annual Report from the Southampton Local Safeguarding Adults Board (LSAB). This Report shows how the LSAB has delivered on the areas of work previously identified as priorities for 2017/18. This is important because it shows what the Board aimed to achieve and what was actually done both as a partnership and through the work of participating partners.

In a City of 254,275 people we can never eliminate risk entirely, but we need to be satisfied as a Board that arrangements for safeguarding adults in Southampton are as effective as they can be. This report aims to provide a picture of who is safeguarded in Southampton, in what circumstances and why.

The work of the Board progressed during a period of unprecedented national uncertainty and I am well aware of the increasing demand placed on agencies both financially and physically. I am also extremely grateful for the consistent work and engagement that Southampton LSAB receives. Partnership working within Southampton has continued to be a strength evidenced regularly throughout the work of the board.

One of the highlights of this year is the progress we have made working with neighbouring LSABs. We have worked closely with Hampshire, Portsmouth and the Isle of Wight, known collectively as the 4LSAB's, in the form of an Interagency-working group to jointly support all agencies in the areas of Policy, Quality Assurance and Workforce Development.

Finally and most importantly I would like to acknowledge all the hard work that takes place on the frontline and across the partnerships every day and you should feel proud of the contribution you make. It is a privilege to Chair the Southampton Local Safeguarding Adults Board and I look forward to working with our partners in 2018-19.

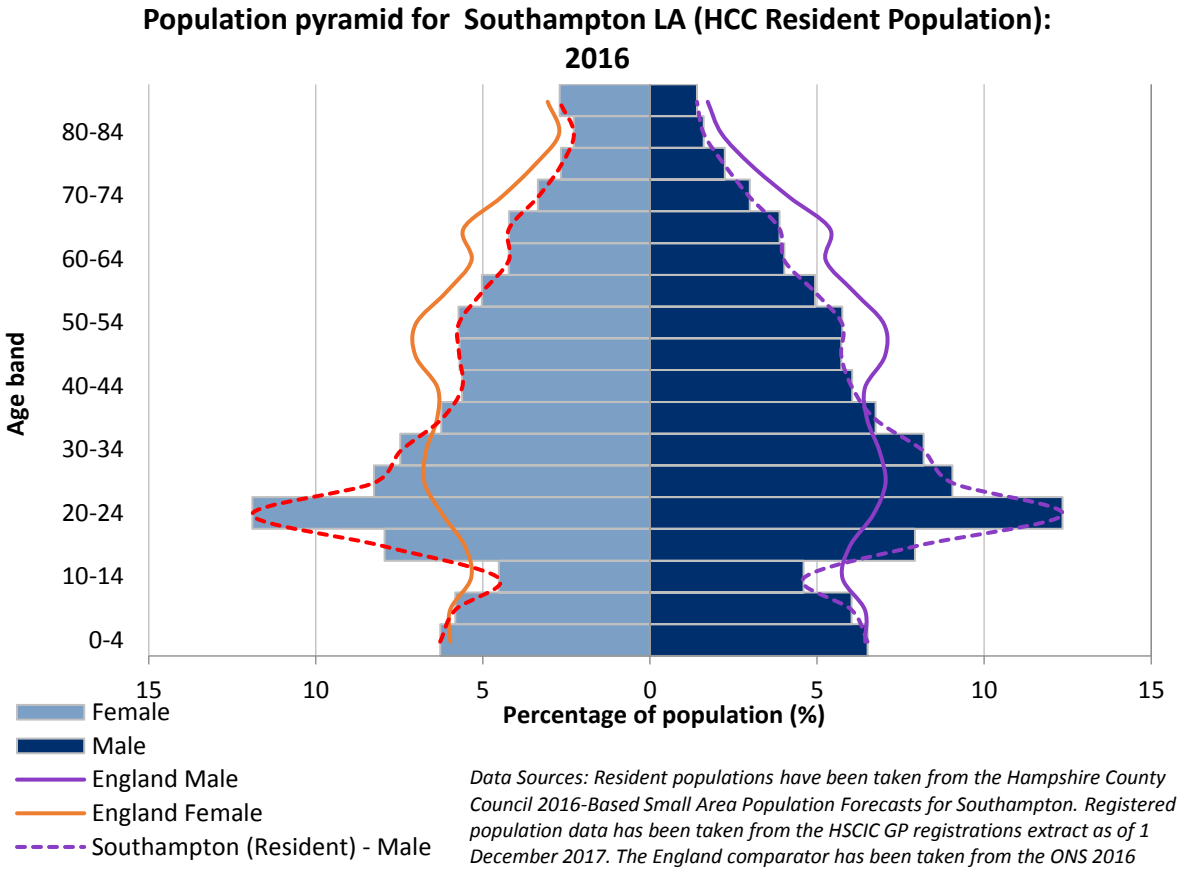
Robert Templeton

Independent Chair of Southampton Local Safeguarding Adults Board

1. Introduction

The current population of Southampton is 254,275 based on the Mid-Year Estimate 2016, of which 129,879 are male and 124,396 are female. The city comprises 98,300 households, 53,000 residents who are not white British (22.3%) and 43,000 students. In 2017 it was estimated that 34,781 of Southampton residents were over the age of 65.

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. Indeed, the over 65 population is set to increase by nearly 5% between 2016 and 2023 and the over 85 population by 19%. It is important to note that on the one hand we can expect to live longer than ever before but the number of years with a limiting illness or disability has also been increasing. The current population for Southampton is shown in the pyramid below (2016).

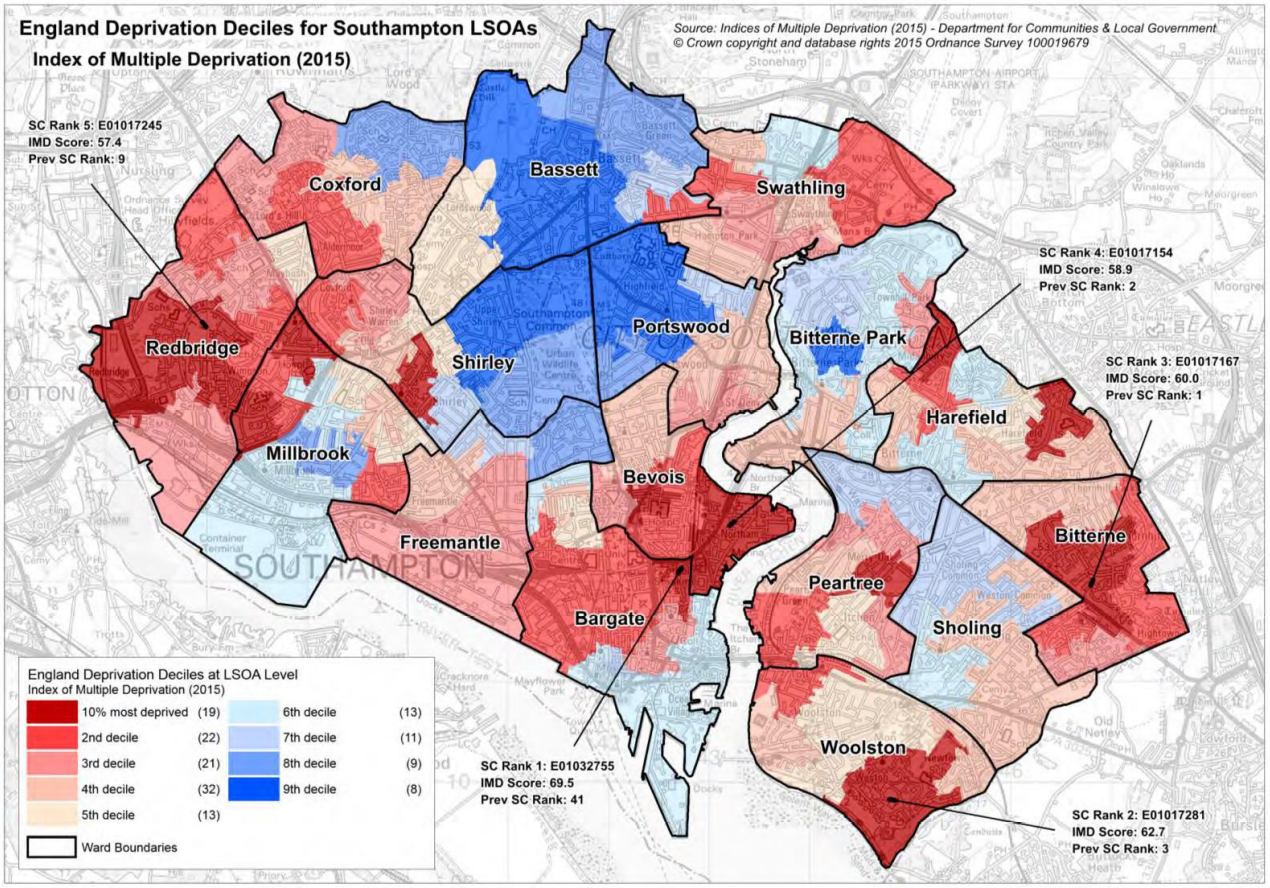


Data Sources: Resident populations have been taken from the Hampshire County Council 2016-Based Small Area Population Forecasts for Southampton. Registered population data has been taken from the HSCIC GP registrations extract as of 1 December 2017. The England comparator has been taken from the ONS 2016

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:

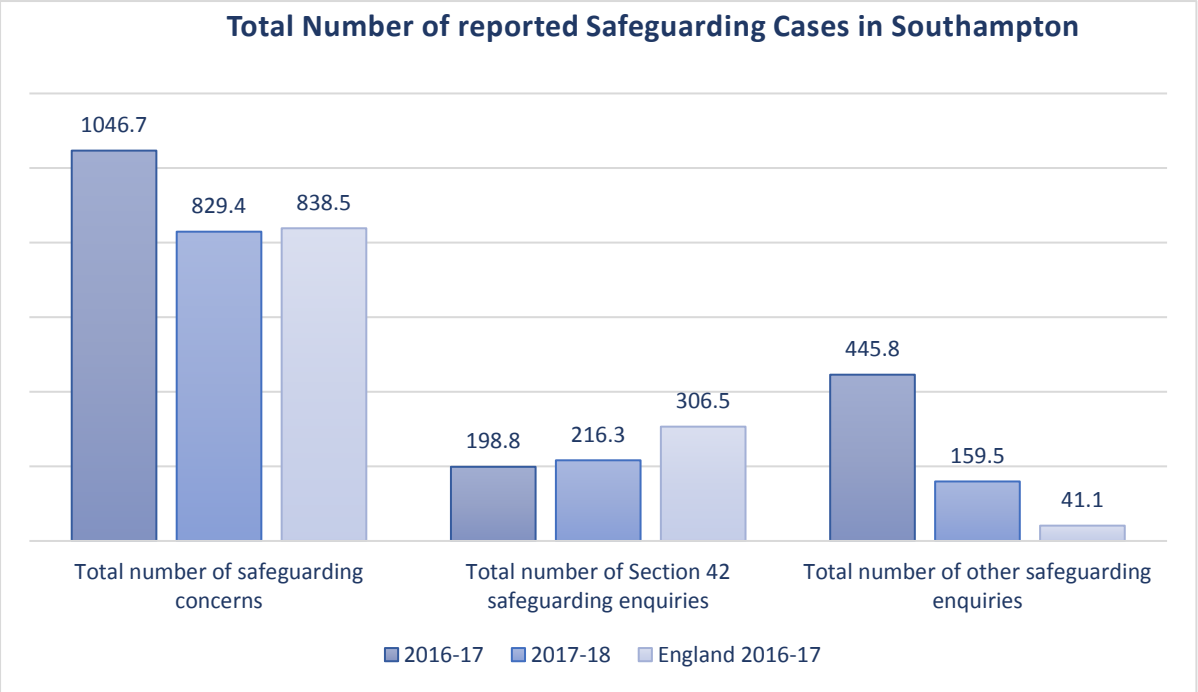


Vulnerability is not just associated with an aging population, and poverty. It can come in many forms, one of which is Learning Disability. Estimating the number of people with Learning Disabilities is difficult and variable because there is no standardised way of defining Learning Disabilities. In addition to this the definition of Learning Disabilities, the incidence and the prevalence have changed over time. Use of service information to estimate the population with a Learning Disability tends to give an under-estimate. It may also produce an inaccurate age profile due to delays in diagnosis and an inaccurate severity profile as those with more severe impairment or co-morbidities are more likely to be in contact with services. That said, it is estimated there are 4,927 people of all ages with a Learning Disability living in the city. Based on the changing demography of the city, and assuming Learning Disability prevalence rates stay the same, this number will increase by 2% between 2011 and 2018. Sixty per cent of all people with a Learning Disability are male.

2. What is the impact of safeguarding partners working together in Southampton?

Demographics of Safeguarding Concerns – What does the data tell us?

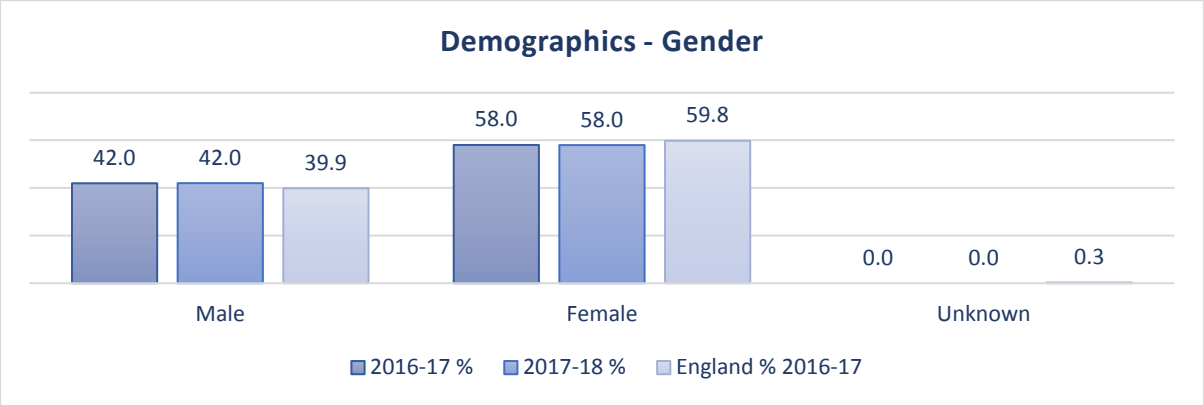
The following data is taken from the Safeguarding Adults Collection comparing Southampton's 2016/17 and 2017/18 data with the National data. This data is submitted to the Department of Health on an annual basis. The data reflects the demographics of individuals involved in Safeguarding Enquiries in 2017-18.



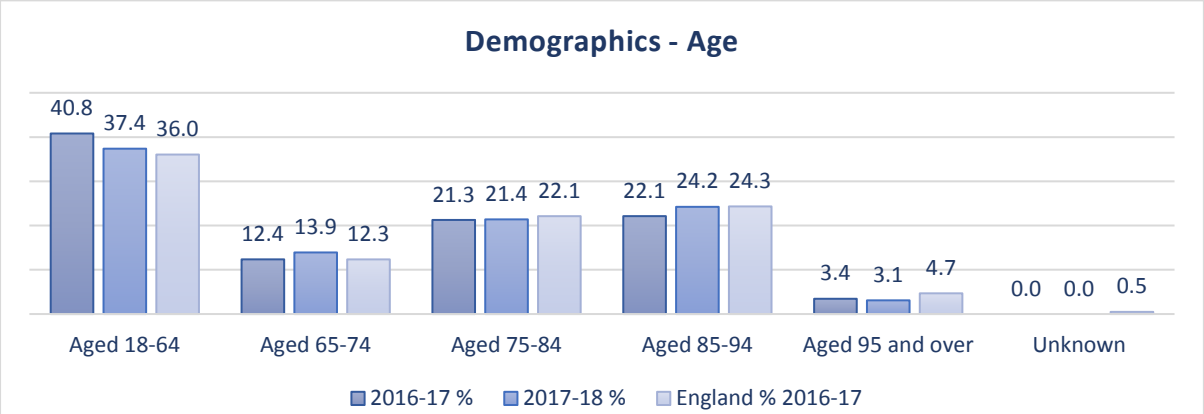
The rate per 100,000 people in Southampton for safeguarding concerns coming in to adult social care is 829.4 for 2017/18. This is a decrease on last 2016/17's figure. There was a 17.7% decrease in the number of safeguarding concerns from 2016/17 to 2017/18. This is not reflected in the national picture, where an increase was seen. However, 2017/18's figure is comparable to the national figure.

There was however, an increase in the rate of Section 42 Safeguarding Enquiries (see page 8 for definition), with an increase of 13% seen in the number of other Safeguarding Enquiries. Southampton's rate of Sections 42 Safeguarding Enquiries is lower than the National rate by 30%.

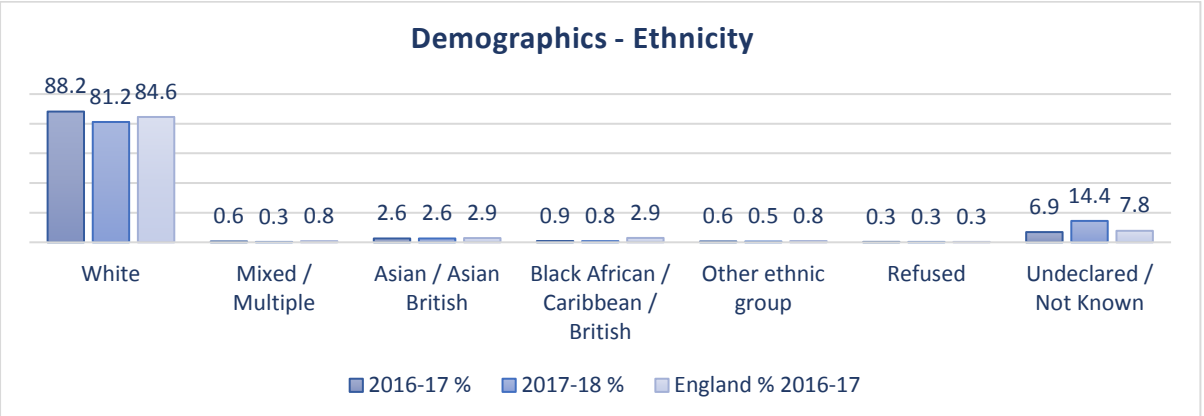
Southampton has seen a significant decrease in the rate of other (discretionary) safeguarding enquiries. However, Southampton's rate of these enquiries is significantly higher than the national rate.



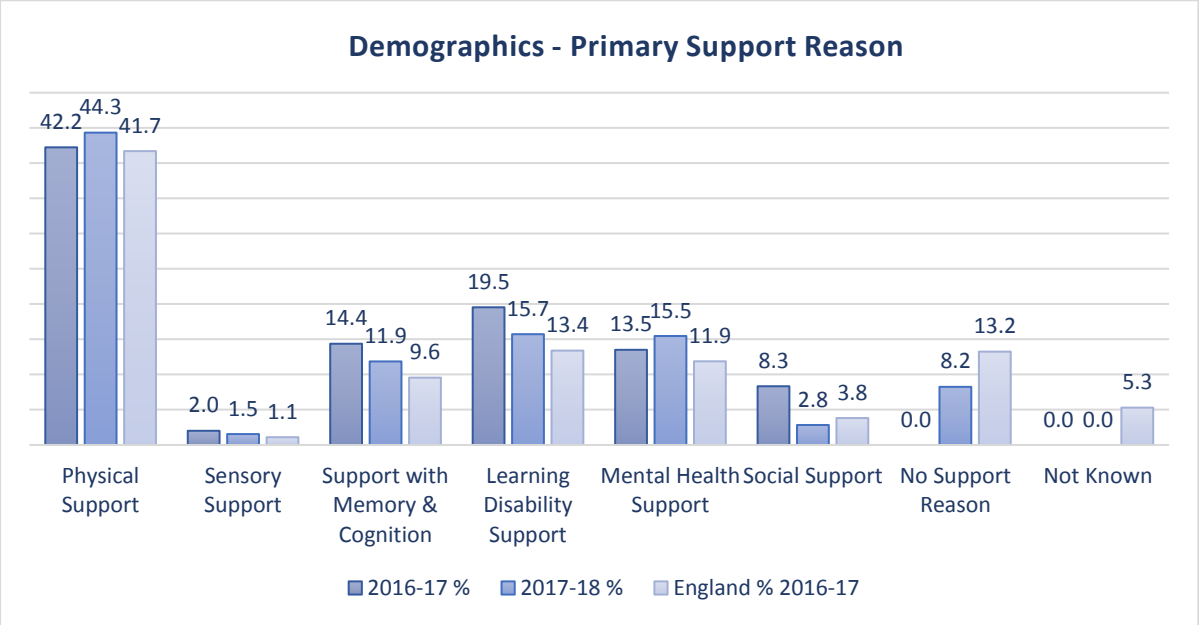
Of all the individuals involved in Section 42 Safeguarding Enquiries in 2017/18, 42% were for men and 58% were for women. This was the case for the gender profile of Section 42 Safeguarding Enquiries for 2016/17. Southampton's gender profile is also in line with the national gender profile of 40:60 men to women. It should be noted that Southampton population is 51% male and 49% female.



With regards to age, in 2017/18 most Section 42 Safeguarding Enquiries are raised for adults in the age group 18-64. This is followed by the 85-94 year, 75-84 year, 65-74 year age groups and finally the 95+ age group. This was also the case in for Southampton in 2016/17 and in line with the national picture.



In 2017/18 the majority of Section 42 Safeguarding Enquiries were raised for adults of a white ethnicity. This trend is in line with 2016/17's data and the national picture.



With regards to primary support reason identified, most Section 42 Safeguarding Enquiries were for adults at risk with a Physical Support need. This was followed by Learning Disability Support, Mental Health Support and Support with Memory and Cognition. This is in line with trend seen in 2016/17 and in line with national data.

Statutory Section 42 Safeguarding Enquiries

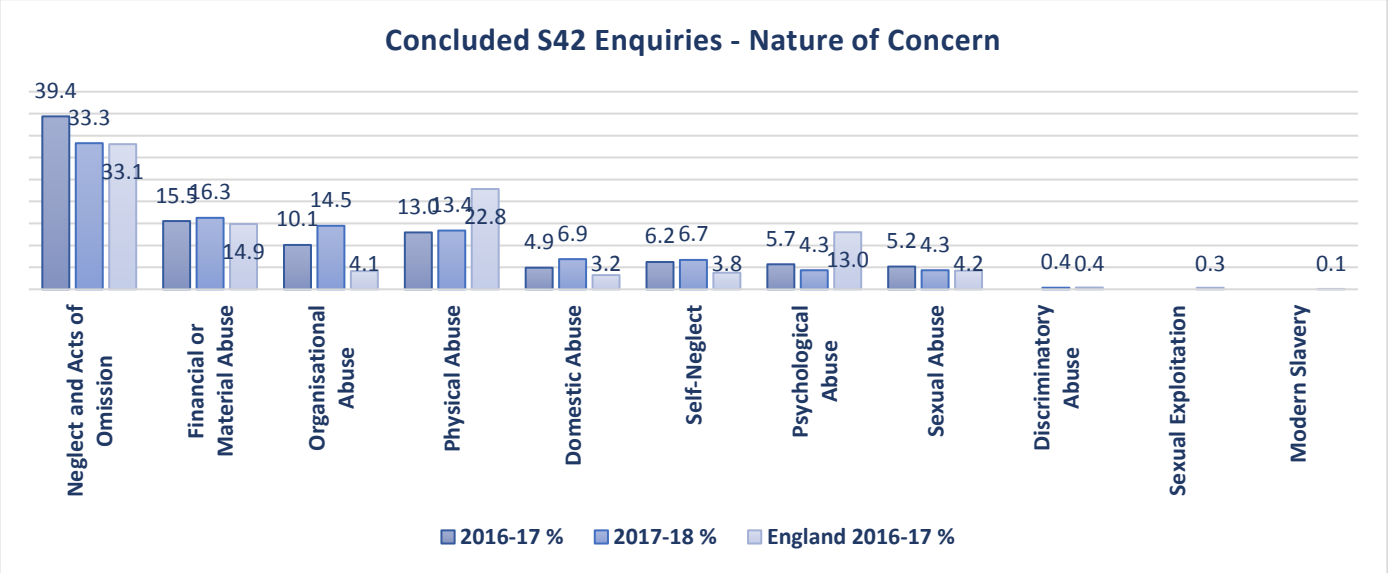
Under section 42 of the Care Act 2014, there is a duty on the Local Authority to make enquiries, or to ask others to make enquiries, where they reasonably suspect that an adult in its area is at risk of neglect or abuse. Safeguarding duties apply when an adult:

- 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 the experience of abuse or neglect.

Safeguarding duties do not depend on the adult's eligibility for services.

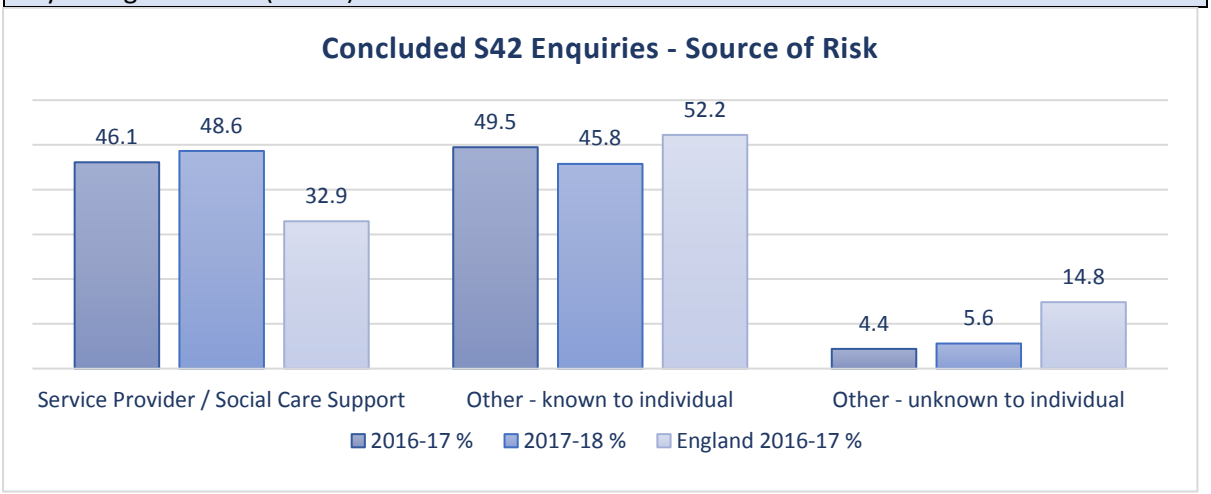
There is a duty to carry out whatever enquires are necessary in order to decide whether any further action is needed. NHS organisations and the Police are legally bound to engage in section 42 enquiries if requested.

Concluded Section 42 Enquiries – What does the data tell us?

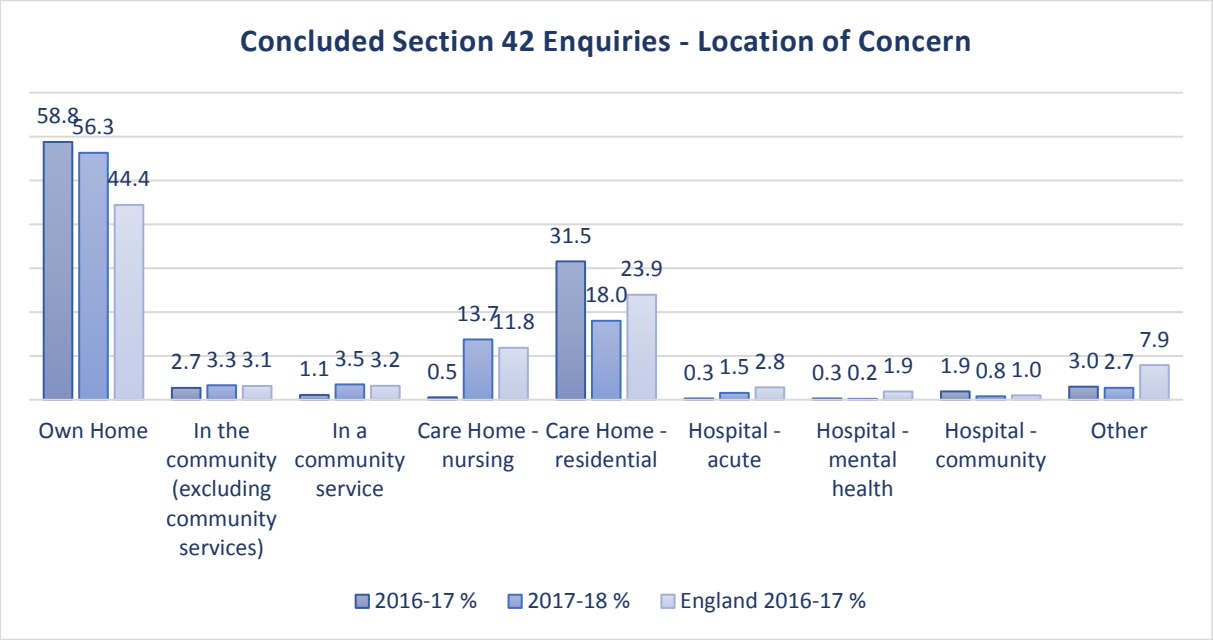


The most prevalent category of abuse in Southampton based on concluded Section 42 Enquiries is Neglect and Acts of Omission (33.3%). This is followed by Financial Abuse (16.3%), Organisational Abuse (14.5%) and Physical Abuse (13.4%).

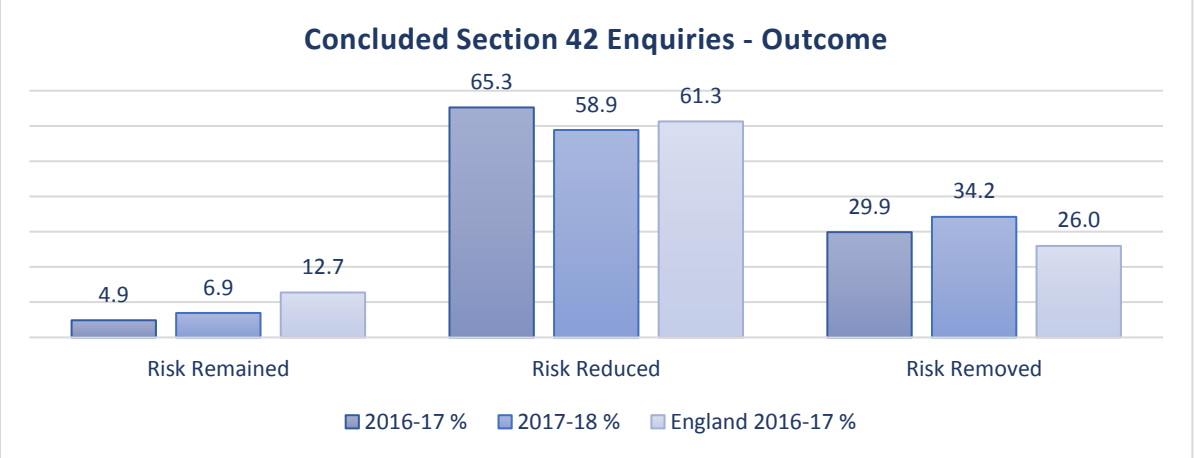
These four types of Abuse were the also the most prevalent in 2016/17 although, 2017/18 has seen an increase in Organisational abuse from 10.1% to 14.5%. Southampton does not reflect the relative prevalence of national picture in this regard. Nationally the most prevalent types of abuse are Neglect and Acts of Omission (33.1%), Physical Abuse (22.8%) Financial Abuse (14.9%) and Psychological Abuse (13.0%)



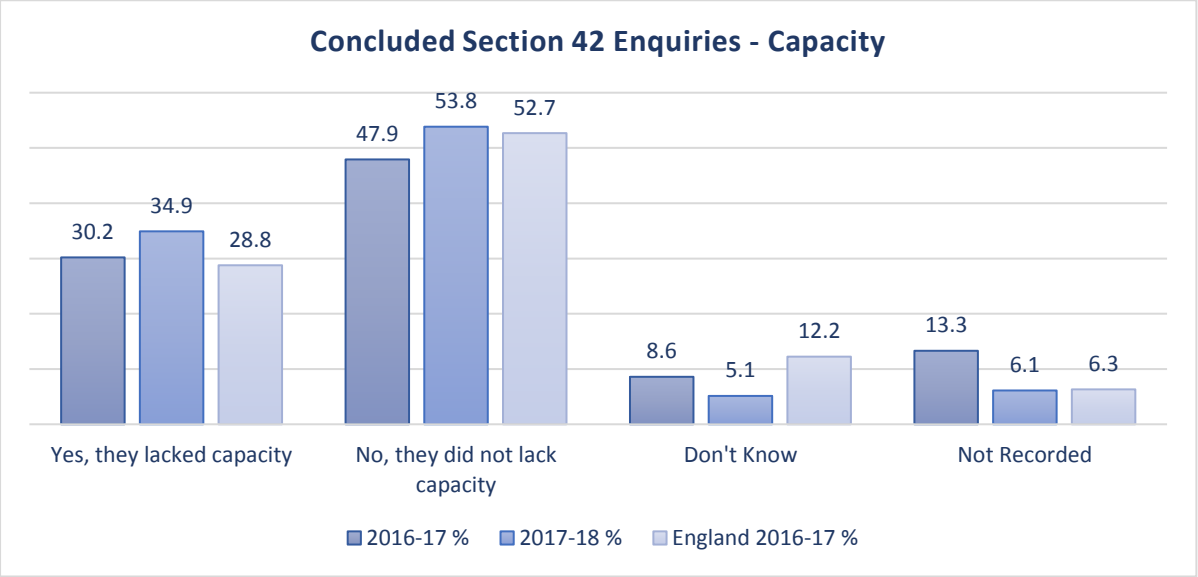
Southampton does not reflect the national picture with regards to the Source of Risk in Concluded Section 42 Safeguarding Enquiries. The data shows that the source of risk in concluded Section 42 Safeguarding Enquiries is a service provider or Social Care support in 48.6% of cases in 2017/18 compared to 32.9% Nationally for 2016/17 and in 45.8% of cases it is an individual known to the adult at risk compared to 52.2% nationally in 2016/17. Nationally the percentage of concluded Section 42 Safeguarding Enquiries where the source of risk is an individual unknown to the adult at risk is significantly higher than in Southampton, 14.8% compared to 5.6%.



With regards to the Location of Concern for Concluded Section 42 Enquiries, Southampton is in line with the national picture. The most prevalent location was in the adults' own home (56.3%). This is followed by Residential Care Homes (18.0%) and Nursing Care Homes (13.7%). There has been a significant decrease in the percentage of cases where the Residential Care Home from 2016/17 (31.5%) to 2017/18 (18.0%). However, there has also been a significant increase in the percentage of cases in Nursing Care Homes from 0.5% in 2016/17 to 13.7% in 2017/18.



With regard to risk outcomes in concluded Section 42 Enquiries in 2017/18, Southampton is comparable with the national percentage for 2016/17 as far as the percentage of cases where the risk has been reduced. The percentage of cases where the risk remained was lower in Southampton (6.9%) compared to the national data (12.7%) and the percentage of cases where the risk was removed is greater in Southampton for 2017/18 (34.2%) compared to the national data (26.0%).



With regards to Sections 42 Safeguarding Enquiries, there were 53.8% of cases where the adult at risk had capacity to make decisions related to the safeguarding enquiry. There were 34.9% cases where the adults at risk lacked capacity to make decisions related to the safeguarding enquiry. Both these percentages are higher than the Southampton's figures for 2016/17 and the national figures for 2016/17.

Southampton has significantly improved in the recording of Capacity. The 2017/18 figures are lower for cases where the capacity is not known (5.1%) or not recorded (6.1%) than last year's figures (8.6% and 13.3% respectively) and the national percentages (12.2% and 6.3% respectively).

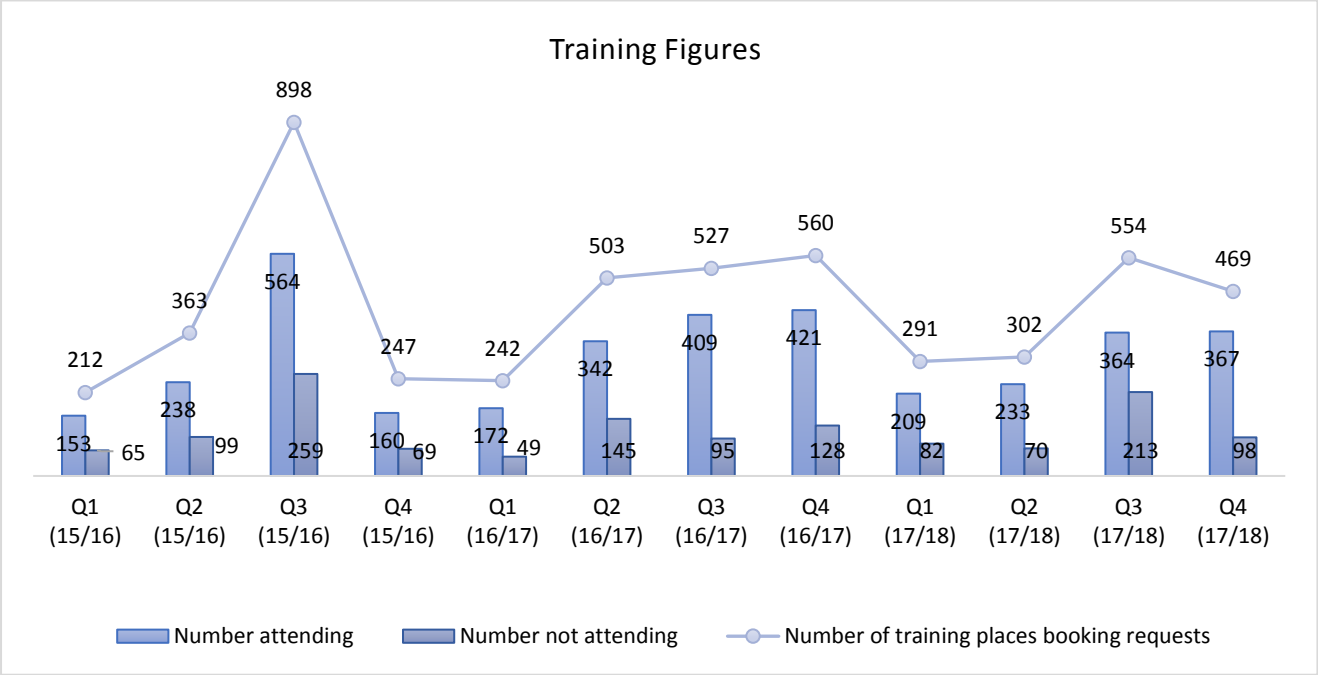
3. Workforce Development within the Multiagency partnership

Since 2016/17 the training offer has been consolidated with the Local Safeguarding Children's Board (LSCB). This offer includes Multiagency Safeguarding Adults Training over 2 days, Working Together to Safeguard Children Level 3 training over two days, Working Together to Safeguard Children Level 3 refresher over one day; half day workshops predominantly around themes from case reviews or emerging concerns; and weekly Wednesday workshops which are 2 hour workshops based on emerging themes or topics where professionals have expressed they would like more learning e.g. County Lines, Substance Misuse, Adult Mental Health

Attendance at training can sometimes vary by professionals' workload and diary availability, but there is an increasing trend overall for attendance.

Feedback from training evaluations is summarised below:

- "Karen is fab - I would love to do more of her workshops if she does any! Great presenter."
- "Very enjoyable."
- "Interactive, interesting session. Great facilitator".
- "Inspiring and motivating trainer".
- "Very informative and engaging."
- "Great workshop - thank you!"
- "Really good informative training."
- "Thoroughly enjoyed today - thank you."
- "Many, many thanks."
- "Excellent session - thank you. Very interesting".
- "Very interesting with lots of useful info".



In 2017 the LSAB coordinated Multiagency Safeguarding Adults Training aimed at practitioners with professional and organisational responsibility for adult safeguarding and who may be called upon to contribute to Section 42 enquiries. This multi-agency LSAB course was developed to refresh professional's knowledge and skills, and explore best practice to safeguard adults in Southampton. This course was designed by key partners to meet the requirements as laid out in the 4LSAB Learning and Development Strategy and the NHS Safeguarding Adults: Roles and competences for healthcare workers Intercollegiate Document, in that adults have the right to expect that staff working with them should have the appropriate level of skill and knowledge to deal with safeguarding issues. The course was well received by 62 practitioners. This training offer is currently under review due to organisational changes and the potential for a Pan Hampshire safeguarding adults training programme to be offered.

4LSAB Risk Management Framework Workshops

Southampton LSAB facilitated 2 4LSAB Risk Management Framework workshops in September 2017 and March 2018 for professionals across the Pan Hampshire area. We had presentations from SHFT, HFRS, UHS, Southampton City CCG and SCC Adult Social Care and Deprivation of Liberty Safeguards (DoLS) Team representatives. The training covered an introduction to the Framework, consideration of mental capacity and best interest decision making and perspectives of using the framework from Local Authority, HFRS and application in cases of self neglect. The training was attended by approximately 50 professionals from across Hampshire.

Joint Safeguarding Adults and Children's Board Annual Conference November 2017

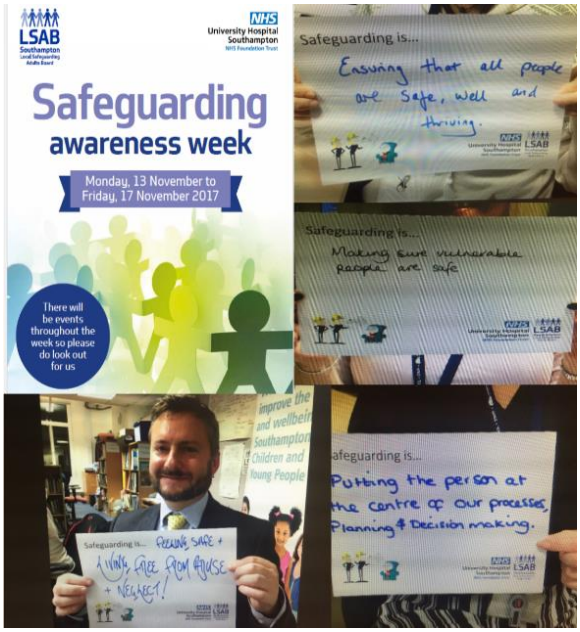
In November 2017 the LSAB and LSCB organised their Annual Conference titled 'Keeping Safe Online – a practitioners guide 'and 100 Practitioners working in Southampton were in attendance. We invited Key Note Speakers from Get Safe Online and Child Exploitation and Online Protection Command (CEOP) to talk through different types of abuse and exploitation experienced by adults and children online. The conference attendees were able to attend 2 different workshops out of 5 workshops on offer on the themes Cyberbullying, Trading Standards and online financial abuse, Grooming and Radicalisation, NSPCC Young Person led workshop and Adults Safeguarding with focus on online safety. There was also the opportunity to watch a performance of 'In the Net' by Alter ego productions which focussed on awareness of internet safety and the real-world effects of cyber bullying.

4. Community Engagement

During 2017-18 the LSAB and LSCB has really focussed on using their joint Twitter account to raise awareness of key safeguarding messages and national awareness raising campaigns including World Suicide Prevention Day, Safer Internet Day and Modern Slavery Day. We have grown our following on Twitter to over 500 followers and tweeted 1774 times since we started the account in June 2016. Both the LSAB and LSCB have 3 active Lay Members who have engaged with main Board meetings, attended Weekly Wednesday Workshops, the Safeguarding Board's Annual Conference and half day training.

Safeguarding Week November 2017

In November 2017 Southampton LSAB held Southampton Safeguarding Week where partners engaged with members of the public and professionals across 2 days of engagement activity at UHS and Royal South Hants Hospital (RSH) during Southampton Safeguarding Week. The primary theme for the week was financial abuse and the LSAB engaged with local bank branches, Hampshire Constabulary, Southampton Trading Standards, UHS Choices Advocacy, Age UK and HFRS. Partners were able to promote their local services available such as community carers groups, HFRS Safe and Well Visits, and how to protect yourself from fraud and doorstep crime. We produced a special edition of the Safeguarding Boards Newsletter for the multiagency partnership which highlighted the engagement activities and key resources for professionals to use with the general public. There was a social media campaign across the week which shared key messages every day using the #sotonsafeweek and as part of this professionals were asked to share their safeguarding pledges to explain what Safeguarding means to them.



5. Priority Issues for Southampton LSAB 2017-18

The LSAB set 4 key priorities for 2017-2018 in the strategic plan; **Trigger Trio, Workforce Transformation, Transition from Children's Services to Adult Services and Financial Abuse**. Board members were requested to present service assurance from their agency on each theme at each LSAB meeting and were asked to include local intelligence, performance data, case reviews and audit recommendations. Below is a summary of the service assurance provided by partners and what the LSAB partnership have delivered on these themes.

Trigger Trio (Domestic Abuse and Violence, Mental Health and Substance Misuse)

What the LSAB individual partners have achieved?

- A full time joint post for Southampton City Council (SCC) Adult Social Care and Adult Mental Health based in Children's Services Multiagency Safeguarding Hub (MASH) and Multiagency Risk Assessment Conference process was funded.
- A social worker based in the Emergency Department (ED) at UHS will focus on mental health and crisis, working with Community and the Out of Hours Services to find the trigger points. These workers will act as champions to work with Mental Health Services.
- Developmental work was undertaken with Hampshire County Council around people transferred into the City under the Mental Health Act to develop a cross border protocol.
- In the National Probation Service (NPS) there has been work around mental health and substance misuse. A piece of work has been completed for female service users of the NPS regarding a trauma informed approach. This links with peer support which hopefully will have a positive impact.
- Successful recruitment has taken place for an individual at Southampton City Clinical Commissioning Group (Southampton City CCG) to work with safeguarding adults to ensure dissemination of learning and consistent messages. Case Studies with a trigger trio theme have been used as part of this.
- Within Health Services in Southampton there are a lot of organisations moving to an integrated safeguarding team across children and adults.
- The new named GP for Safeguarding Adults has links to the LSAB Case Review Group and the focus of their work is how best to get learning disseminated to GP practices.

What has the LSAB partnership achieved?

- The LSAB delivered a themed meeting on the 'Trigger Trio'' in June 2017. The partners considered how well the partnership and individual partner agencies recognise and respond to multiple risk factors.

- Adult F and G Safeguarding Adult Review (SAR) was concluded in 2017-18 and the key theme was trigger trio. A learning event was delivered in January 2018 by the case reviewer with another event scheduled for July 2018.

Workforce Transformation

What the LSAB individual partners have achieved?

- A new Interim Safeguarding Lead for SCC Adult Social Care was appointed.

- SCC Adult Social Care no longer has a dedicated Safeguarding Adults Team. Safeguarding activity will be integrated into all teams. There is a specialist role to coordinate this work and this has been appointed to.

- Hampshire Constabulary has focussed on embedding safeguarding within districts and there is a focus on repeat victims and perpetrators.

- Hampshire Constabulary has a team of people looking at the impact of the financial savings made within safeguarding adults. The LSAB member met with Directors of Children's and Adult Social Care and to assess impact across agencies.

- Within UHS a consultation took place to merge safeguarding adults and children's services; the new structure went live in October 2017. UHS presented these examples of good safeguarding practice:
  - Daily adult multi-agency safeguarding huddles
  - Established key working relationships & processes between safeguarding, patient safety & experience
  - Electronic referral system in adult safeguarding
  - Established model of clinical supervision in child health with plan to adopt in adult team

- Hampshire Crime Rehabilitation Company (CRC) has been through an extended period of transformation since its inception in June 2014. Hampshire CRC have revised job descriptions, new responsibilities, workforce changes and the introduction of a new operating model have brought the need for a significant amount of training; the CRC is now linked directly into the Interserve Learning and Employment division and receives, amongst other regular training opportunities, regular updates in safeguarding; in addition, we have now made virtual college e learning courses available to all staff, which update our safeguarding training to include areas such as MET and CSE and parents with disabled children. CRC Staff have been trained in the Care Act and risk of harm assessment and management, domestic abuse and safeguarding children training which is cross-referenced to safeguarding vulnerable adults' issues.

- The CRC's focus has been on the importance of service users being an integral part to the planning and success of their court orders and has aimed to increase service users ability to desist from crime, make more constructive links in their communities and support positive relationships with families and non-criminal associates.

- Hampshire CRC have been developing new ways to target those who are most often at risk of reoffending and a more highly trained workforce capable of delivering case management and a range of structured (many accredited) programmes. The CRC acknowledges there is more to be done to safeguard victims of domestic abuse; at the moment it does this partly through robust group interventions for male perpetrators and through its development women-only services.

What has the LSAB partnership achieved?

- We have continued to deliver a multiagency safeguarding programme of learning workshops jointly with the LSCB so that partners understand each other's duties and have realistic expectations of multi-agency working.

- The partnership facilitated 3 Multiagency Safeguarding Adults training courses delivered by Adult Social Care to ensure practitioners from across partnership and commissioned support services understand key safeguarding duties and how to work in a person centred and outcome focused way when supporting adults at risk of abuse or neglect.

- The LSAB Monitoring and Evaluation Group developed the LSAB data set to ensure focus and seek assurance of Making Safeguarding Personal within the partnership. Making Safeguarding Personal data is routinely scrutinised as part of the LSAB Dataset by the Monitoring and Evaluation group. Thus far SCC data has informed developments of the recording forms on the client information database (PARIS) and identified training needs with regards to advocacy.

- Following on from the Making Safeguarding Personal (MSP) multiagency audit which was completed in November 2016 an MSP Task and Finish Group was convened (Chaired by SCC Adult Social Care) in order to consider the recommendations from the report with oversight from the LSAB Monitoring and Evaluation Group.

- The MSP Task and Finish Group have produced a risk assessment toolkit for multi-agency professionals to enable a person centred / MSP approach to safeguarding interventions.

- The LSAB delivered a themed meeting on workforce transformation in December 2017.

Transition from Children's Service to Adult Social Care

What the LSAB individual partners have achieved?

- Hampshire Constabulary received funding from the Police and Crime Commissioner's Office for "Project Gateway"; a specific project to look at the re-offending of 18 – 24 year olds, which uses navigators to identify this cohort and divert them from the justice system. There is a lot of evidence from other police forces that this work reduces offending. It is preventative work and the medium to longer term aim is to look at the whole family approach. Hampshire Police would like to align the Troubled Families cohort to the Missing, Exploited and Trafficked (MET) cohort so that they can deal with the families to prevent the children becoming victims.

- Hampshire CRC staff follow the Joint National Protocol for Transitions in England when working with young people who fit the criteria of low/medium risk of harm. The CRC is aware of new research regarding transition and discussed with partners the issues around maturity and decision-making which are important factors in working with this service user group.

- Hampshire CRC are responsible for the delivery of the Senior Attendance Centre; this provides programmes and life skills input to those aged 18-24. The interventions are tailored to the needs of the age group by staff who have received training in safeguarding and are very aware of the particular issues faced by vulnerable young service users, many of whom may have been care leavers.

- A small number of young people are transferred each year from the Southampton Youth Offending Service to Hampshire CRC. Recent research for Her Majesty's Prison and Probation Services (HMPPS) has demonstrated the importance of the link between maturity, risk and proven reoffending outcomes and specifically highlights the link between psychosocial immaturity and young people's criminality. At the point of transfer, the young people are technically adults, though often not yet ready or sufficiently mature to live an adult life in the community. Their experiences as children may mean they are vulnerable to pressure from others and/or have poor coping skills, and they may already have been exposed to the full range of criminal justice disposals. Such familiarity at a young age can prove a barrier to developing a positive and constructive approach to resettlement as an adult. One of the most pressing areas of concern is the lack of appropriate available accommodation.

- Hampshire CRC works with colleagues in the Youth Offending Service (YOS) to plan for each transferring offender to ensure a smooth and collaborative move for all those coming into adult probation services. CRC staff are aware of the differing approaches between services for child and adult offenders and try to work with the Youth Offending Service to build resilience and confidence in the young person to desist from further offending.

- The Integrated Offender Management teams across Hampshire and IOW, a multi-agency approach comprising Police, Probation and the voluntary sector, provide an enhanced service to service users, many of whom are aged between 18 and 24.

- Southampton CCG have been liaising with UHS who have a programme called 'Ready, Steady, Go' to look at how children access Adult Services. Solent NHS are looking to do something similar in collaboration with UHS.

- In Southampton there is a need to review how children are transferred in to Adult Mental Health Services. There are some examples of good practice but also some areas for improvement.

- Transition was identified as key theme in the NHS Hampshire and Isle of Wight Sustainability and Transformation Plan 2016-2021.

What has the LSAB partnership achieved?

- Transition between Children's Services to Adult Services identified as a key joint theme in business plan for both LSAB and LSCB.

- The LSAB and LSCB are delivering a multi-agency independent audit to test the effectiveness and quality of local services in ensuring improved outcomes for looked after children experiencing mental health issues – focussed on the transition between CAMHS and Adult

Mental Health Services. This was commissioned in 2017-18 and is due for completion December 2018.

- The LSAB facilitated a themed meeting in December 2017 with service assurance from key partners presented on the theme of Transition.

Financial Abuse

What the LSAB individual partners have achieved?

- Hampshire Constabulary and Office of the Police and Crime Commissioner have been working together to launch Operation Signature in April 2018. Hampshire is one of six forces who have adopted the scheme, initially developed by Sussex Police, which aims to identify and support vulnerable victims of fraud. This will include a dual response with the British Red Cross to visit the victim and is being organised through victim support.

- Southampton City Council has extended it Service Level Agreement with Hampshire County Council to include a larger number of Deputyship cases, including existing matters and new applications. This process is currently being scrutinised by the Court of protection and the Office of the Public guardian.

What has the LSAB partnership achieved?

- The LSAB held Southampton Safeguarding Week in November 2017 which was organised to raise awareness in the community regarding financial abuse and how to report and recognise safeguarding concerns. The aim of the awareness raising activities was to increase knowledge of the wide range of issues encompassed by financial abuse i.e. Lasting Power of Attorney, Advance Decisions to Refuse Treatment, Cuckooing.

- The LSAB and LSCB Joint Annual Conference 'Keeping Safe Online – A Practitioners Guide' took place in December 2017. The conference included a key note speech from Tony Neate from Get Safe Online regarding online monetary fraud and a workshop delivered by Southampton Trading Standards.

- A financial abuse audit was scheduled to be completed in 2017/18 but due to capacity in the partnership to complete this work it was postponed. The audit is due to be completed in June 2018.

- A themed LSAB main Board meeting on Financial Abuse was delivered in March 2018. Professor Keith Brown from Bournemouth University attended to present on Safeguarding, Mental Capacity and Scamming and he is linked to the National Trading Institute as part of a research team looking at financial crime and scamming.

- A financial abuse audit was scheduled to be completed in 17/18 but due to capacity in the partnership to complete this work it was postponed.

6. Learning from Reviews

When there is any failure in safeguarding, the results can be severe and tragic. LSABs must get the full picture of what went wrong and the LSAB must decide when a case review needs to be commissioned so that all organisations involved can improve as a result. The Reviews are about learning lessons for the future. Case Reviews are delivered these according to the Learning and Review Framework for Southampton based on that agreed by the 4LSAB's of Southampton, Portsmouth, Hampshire and the Isle of Wight. In accordance with the Care Act 2014 a Safeguarding Adult Review 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 become a different type of review such as a multi-agency partnership review or a single agency review. The Southampton LSAB Case Review Group has a key part in overseeing this activity and ensuring that learning is gathered and disseminated widely amongst professionals. In 2017-18 the LSAB received 7 case referrals for Safeguarding Adult Reviews and although no Statutory Safeguarding Adult Reviews were commissioned it was agreed that 4 cases met the criteria for a discretionary Multiagency Partnership Review. The recommendations and learning from these reviews will be detailed in the 2018-19 LSAB annual report.

In 2017-18 the LSAB concluded 2 reviews:

1. **Adult F and Adult G Safeguarding Adult Review**
   The SAR was commissioned after an incident in 2015, involving Adult F and Adult G. The SAR was not published to protect anonymity of individuals involved.

2. **Adult H Multiagency Review**
   In 2016, the Southampton LSAB considered the case of Adult H, a man with a diagnosis of severe learning disability and autism who sadly died following a short battle with cancer. The case was referred to the Southampton Local Safeguarding Adult Board to identify any learning for the system regarding how Adult H's communication difficulties, diagnosis of learning disability and behaviours, influenced the care he received. A Multi-Agency Partnership Review was commissioned and the report is due to be published in September 2018.

All recommendations and actions from Case Reviews are monitored by the Case Review Group and the LSAB seek to ensure learning from reviews is known and acted upon by frontline staff. We want the partners to support practitioners use the learning in their work and help them to prevent similar poor outcomes for adults at risk of harm.

Across the year the LSAB have reviewed how learning is disseminated and consulted with the partners about the best ways to communicate learning themes. The feedback received from LSAB members during in 2017-18 is that learning from reviews is not being communicated as quickly as they would like. The LSAB have developed the following programme to ensure accessibility of information and timely communication of learning from case reviews:

- 6 step briefings
- Workshops and learning events
- Reviewer podcasts/videos
- Key themes fed in to learning and development
- Learning from reviews newsletter
- Via LSAB board members and action monitoring
- Access to learning and findings within Published/not published reviews

What have we learned in Southampton?

The following themes and learning points have been identified from case reviews which have concluded in Southampton in 2017-18. It also includes case reviews which may have concluded in a previous year but the learning, recommendations and actions are ongoing or have been completed in this year.

Good communication between agencies and with service users

- The lead professional for an individual should establish the roles and responsibilities of each professional and family members involved to ensure common goal when decision making and care planning. Effective communication and healthy working relationships are an important part of good multiagency practice.

- The **Annual Health Check** is completed for adults and young people aged 14 or over with a learning disability. It should be an opportunity for a person with a learning disability to become accustomed to clinical environments and the experience of healthcare staff and their GP Practice to get to know their patient. The process would benefit from greater opportunity for involvement from family members, carer support, and by other agencies including health and social care. GP Practices and Clinical Commissioning Groups have reviewed their strategies to ensure annual health checks are not tick-box exercises and involve multi-agency working. Annual health checks completed in isolation and without wide consultation miss the opportunity to utilise the expertise of family members, formal carers, and professionals resulting in a less-good service. (Adult H)

- Southampton LSAB considered the adoption of the **Herbert Protocol Missing Person Incident form** (national scheme introduced by West Yorkshire Police and other agencies) used to compile information obtained from carers, family members and friends regarding a vulnerable person. The form can also aid decision making, risk management for health provider and is completed as part of a person's care plan. This information and clarity of roles should be shared within Care Plans to ensure information and a named contact is available at all times should a vulnerable person go missing. This would be a key part of making safeguarding personal, as the individual will have an opportunity to identify what they would like to happen, should they be reported missing and who they would want to be informed. This would be particularly relevant in cases of onset dementia or those with fluctuating capacity. A further decision around adoption of the protocol is to be made by LSAB partners in June 2018. (Adult E)

- When considering the role of health agencies when using Care Programme Approach, there needs to be a clear link between SHFT and GP's in order to identify risks, make appropriate plans, devise strategies and share information, and involvement. This work is in progress by Southampton City

CCG and Mental Health Matters work streams will review links between GPs and Southern Heath NHS Foundation Trust. The lack of understanding of health and social care professionals, both of the Care Coordinator role and of their own responsibilities under the Care Programme Approach, is impacting adversely upon the quality of care provided to service users whose needs are not acute. In the case of Adult E the Care Programme Approach was implemented as a set of standalone processes and meetings rather than a dynamic approach that supports partnership working that is reactive and responsive to changes in needs and risks. (Adult E).

The importance of the voice of the adult

- Practitioners need to see the adult at risk and consider the context of any exploitation and abuse.
- If the person at risk is not listened to your knowledge about them is limited to their relationships with their primary carer (family member, mother, father, foster carer)
- Practitioners need to consider the daily lived experience of the child or adult at risk i.e. impact of abuse and neglect and the potential long term significant harm.
- Great care should be taken by professionals in determining the underlying causes of particular behaviours especially with people who have a Learning Disability. **Diagnostic Overshadowing** Guidance has been issued to LSAB partners and multiagency practitioner. (Adult H)
- In the case of Adult H there was a lack of understanding by services who infrequently work with people at the end of their life, of the referral pathways and processes for end of life care. The lack of a shared understanding about a clear pathway for end of life care, and disagreements about referral processes may have caused a delay in Adult H from receiving the right care and support. Pathways, referral processes, should be clear and accessible. Good coordination is important, and health professionals involved in the identification or life-limiting illnesses may be best placed to educate other professionals. Services may be less well coordinated, or opportunities missed for good end of life care. There can be limited opportunities to address mistakes, and people at the end of their life may suffer unnecessarily. (Adult H)
- Young Adults and teenagers should not elicit any less of a safeguarding response than a younger child. (Adult F and Adult G SAR)

Risks from 'Trigger Trio' - Domestic Abuse, Substance Misuse and Mental Health Issues

- Professionals need to understand the issue of the commonality of the combination of the trigger trio for Southampton families and the increased risk of significant harm.
- Professionals need to be aware of the risks posed to others not only those directly involved or impacted (e.g. family members and children).
- Professionals to be skilled in early identification of domestic abuse and how this reduces risks, there are issues around specialist support at this level. There is the potential for low risk indicators of domestic abuse to escalate quickly to high risk especially when other factors involved and this adds to the toxicity of the trigger trio.
- The LSAB understands that further training is required regarding the trigger trio and on understanding the impact of ongoing coercive control on families.
- Professionals working with families who are exposed to domestic abuse would benefit from training around the Johnson typologies, how these interrelate and the guidance around

professional responses to each category. This could usefully include a refresher on coercive control. There is a need for increased understanding across agencies around the interface for mental health, substance abuse and domestic violence. (Adult F and Adult G SAR)

- Hampshire Constabulary have secured funding for Safelives 'Domestic Abuse Matters' Training and sessions to be planned and booked as per force requirement, this will include an element relating to coercive and controlling behaviour. In line with the Domestic Abuse Action Plan ensure Police Officers are provided with the relevant safeguarding tools to support victims in need of protection. Further training across agencies is required around the more complex nature of domestic abuse and the impact upon the child and the implications for risk and the notion of hyper vigilance in a child exposed to risk in a domestic abuse context.
  (Adult F and Adult G SAR)

- Professionals working with families across agencies should be familiarised with the AVA Project's Complicated Matters resources which assists in this consideration. The AVA project is the country's leading initiative addressing domestic violence, substance use and mental ill health. As a part of a three year project looking specifically at the needs of domestic violence survivors who are affected by substance use and/or mental ill-health, the AVA Project produced a toolkit and e-learning programme for supporting survivors who experience these interconnected issues. (Adult F and Adult G SAR)

- Agencies and professionals should be aware that separation and strangulation are two high risk factors and can have fatal consequences and assess these accordingly. (Adult F and Adult G SAR)

- All professionals working with families where domestic abuse is a feature should familiarise themselves with the DART domestic abuse high risk factors tool developed by Dr Jane Monkton Smith to better identify, understand and respond to high risk domestic abuse factors. (Adult F and Adult G SAR)

- Children who witness domestic violence suffer psychological impacts such as low self-esteem, anger and fear, and symptoms such as hyper vigilance, and can become over protective of their parent and siblings. (Adult F and Adult G SAR)

- The key findings of the Pathways to Harm and Protection Serious Case Review Triennial report 2011-2014 should be shared or training provided to professionals. The findings refer to the challenges to professionals in the safeguarding system when working with older children and the interface of children/ adult safeguarding and domestic abuse. (Adult F and Adult G SAR)

- Both the Police and MARAC should obtain detailed historic information about individuals past relationships and risk assess accordingly. This information should be shared with the current partner. This is particularly imperative where there are child safeguarding considerations. Promotion of Clare's Law is inbuilt into Hampshire Constabulary Domestic Abuse Action Plan 2016 which incorporates an action to increase officer and staff confidence to consider proactive disclosure when managing risk around Domestic Abuse through clear processes and communication of what is needed. In addition under Right to Ask there is an increase in public awareness through an external campaign. As of December 2017 there had been a 25% increase in Clare's Law application. (Adult F and Adult G SAR)

- The High Risk Domestic Abuse (HRDA) model is operating within Southampton MASH and subject to an independent review by Anthony Wills. While it is reported that MARAC management and quality has been improved since the incident between Adult F and Adult G there should be an objective audit to test how well background and historic domestic abuse information is being

captured and whether this is to the requisite detail and depth. Where information is known this is always to be positively shared with the current partner under the remit of Claire's Law. Needless to say that MARAC will only ever be effective if the correct people are around the table and the quality of information sharing is high. Even with current changes MARAC process and efficacy merits further quality assurance. (Adult F and Adult G SAR)

The Importance of Chronologies

- Frontline practitioners should produce and update a quality case chronology which summarises their agencies involvement and identify risk factors. This should enable consideration of case history to form a holistic view of the individual/families at risk.

- A good quality chronology should also allow for multi-agency professionals to review an individual/family at all levels of intervention. The chronology should be used to inform current practice with a case to prevent future harm through identification of patterns of behaviour which leads to crisis for the family or individual.

Regular and Effective supervision

- Supervision is an area of repeat concern across the partnership regarding support given to those professionals working with children, families and adults at risk.

- Regular and effective supervision of professionals can result in a positive impact on service users. Research shows us that good quality supervision keeps focus on the individual at risk. It avoids the drifting of cases, ensures continuous management oversight, and provides the employee with an opportunity to 'debrief' and reflect.

- Effective supervision is important to promote good standards of practice and to support individual staff members.

Disguised Compliance

- Practitioners should remember the importance of professional curiosity and ensure that they triangulate information with other professionals, carers and family members. Perpetrators of abuse and neglect may try to intentionally deceive professionals by minimising and denying that abuse and neglect is happening. An adult at risk and their family may focus on engaging well with one set of professionals, to deflect attention from their lack of engagement with other services.

- Professionals need to be aware of being over optimistic about progress with adults at risk being achieved as this can delay timely interventions and care planning.

- Professionals and agencies are required to be more curious around inconsistent and mixed messages from an alleged victim of domestic abuse to properly expose the true risk to the individual and others. (Adult F and Adult G SAR)

Impact of Neglect and Self Neglect

- Trigger trio and neglect/self neglect issues are interlinked, for example families experiencing domestic abuse and neglect are at a significantly higher risk of harm occurring.

- It is recognised that housing issues such as rent arrears and anti-social behaviour are apparent in many cases of neglect and self neglect

- There is a link between experience of neglect as a child, the potential for increased risk of abuse and harm in adolescence, and self neglect as an adult.

- A Self Neglect Task and Finish Group was set up to review and implement recommendations from the Thematic Self Neglect Review (completed in 2016). The group was chaired by the Named Professional for Safeguarding Adults from SHFT. The group agreed to not supersede the self neglect guidance in the 4LSAB Policy but to address local implementation needs and produce tools for teams.

- The Task and Finish Group have produced an LSAB Position statement on self neglect and agreed a model of intervention agreed. The Group have also developed a clear Self-Neglect Pathway Document through the completion of the themed meetings and discussions.

- There has been excellent multiagency engagement and contribution within the Task and Finish Group across 2017-18 to developing a pathway and toolkit for use with Self Neglect cases. Service model and commitment of members to the above way of working should be 'resource-investment-light' with improvements to practices and management of existing resource rather than the need for additional investment. The raising of profile of self-neglect may itself bring an increased burden on services as people are identified who need support they may not be currently receiving (unmet need and risk to residents).

- Recognising and responding to issues of Self Neglect is now a part of the regular LSAB and LSCB training programme delivered to partnership.

Escalation

- Practitioners need to constructively challenge their peers and management if the response to safeguarding concerns is inadequate both within own and across agencies

- There is a need for organisations to support staff to be able to escalate issues in care delivery. Organisations may need to take responsibility for educating and empowering their staff to feel confident in challenging practice they have concerns about. Recording of outcomes from appointments and meetings, especially in relation to health matters needs to be robust to ensure the accurate transfer and handover of technical information, agreed actions, and who is responsible for completing them. (Adult E)

- Escalation underpins the principle of 'Safeguarding is everyone's business… until the individual is safe'. The LSAB partners recognise that use of the escalation protocol is a key factor in promoting the welfare of our children and adults at risk. The 4LSAB Safeguarding Adults Escalation policy is currently under review and will be published mid 2018 (Adult E)

- Ensure policy for GP practices to escalate concerns re non-attendance of 'vulnerable/ at risk' patients is operational and widely understood. A reminder to practice managers will be circulated of Non Attendance Policy for vulnerable adults and escalation procedures (Adult E)

- The partnership were unable to escalate or navigate around difficulties in communication in the case of Adult H. There was a general and widespread recognition among participants in the review that the family were pivotal in the raising of concerns and acted as a conduit between services. (Adult H)

Other Case Review Recommendations and Actions completed in 2017-18

Adult K Multi agency Review

- UHS were asked to consider how to reduce the need for patients to leave the department to smoke and provide a potentially safer environment for patients who do wish to smoke. UHS agreed to identify a designated external space for smoking by high-risk patients and security staff will escort high-risk (including high risk of absconding) patients to courtyard for cigarette.

- Funding has been agreed by UHS for the build of three high-risk assessment rooms with accompanying shower & toilet facilities in Emergency Department for patients with mental health needs. This is build scheduled to begin Autumn 2017 and will be completed by Spring 2018. To compliment this the conversion of minor area side room in the Emergency Department to a PLAN accredited high-risk assessment room and conversion of nearby toilet to reduce ligature risk.

- UHS agreed to improve pre-hospital mental health care pathways and decision making to ensure that mental health patients are brought to the most appropriate service provider for their needs. A multi-agency review at UHS has been set up to discuss and agree care pathways and identify which patients should go to which service. UHS are working in partnership with Southern Health NHS Foundation trust, Hampshire Police and SCAS colleagues to review opportunities for helping patients in mental health crisis to access the mental health crisis services directly.

- UHS were asked to explore the possibility of more timely focussed assessment of patients presenting with mental illness. UHS will review the Pitstop assessment process to assess the feasibility of a mental health Pitstop pathway and a meeting will be arranged between the Emergency Department Vulnerable Adult Lead, mental health staff and Pitstop leads to consider options.

- UHS is developing a training programme for all staff in the Emergency Department regarding patients with mental illness. This will include disturbed patients, acute intoxication, fundamentals of mental health care, diagnosis, care pathways, service user experience, and the management of the incapacitous patient.

- UHS to advise on use of Mobimed system (electronic Patient Record system using a structured workflow and support that enhances the clinical decision making process) for notifying UHS Emergency Department staff of incoming high risk mental health patients in order to instigate processes for identifying any risk assessment or care plan in place. SCAS do notify UHS ED when they are escorting high-risk patients but this is usually relating to high risk of violence and aggression and/or due to a police escort wanting to hand over to security staff, and not specifically about mental health risk. The Pitstop area in ED is a very intense, fast paced environment and ED staff would not have the time or capacity to access Anticipatory Care Plans prior to the patient's arrival.

- There is a co-established (UHS and SHFT) multi-agency High Intensity Service User Group that meets monthly to review the High Intensity Service Users with highest ED attendance and/or contacts with other emergency services relating to mental health crises. Funding was secured for a High Intensity Service User Co-ordinator post in 2016/17 and ongoing funding now secured and recruitment is ongoing.

Next Steps and Priorities for 2018-19

Southampton LSAB have had a productive and challenging year coordinating quality assurance of adult safeguarding activity and promoting the welfare of adults at risk of abuse in the City. The LSAB partnership will be reviewing its key priorities and produce a new strategic plan for 2019 – 2021; a business planning session for LSAB partners will take place in late 2018 to undertake this work and the strategic plan will be published in early 2019. Learning from case reviews will always the highest priority for the LSAB and any ongoing actions will continue to be monitored and reviewed by the relative sub group. Any learning themes and actions from case reviews will be detailed in the annual report for next year. The 4LSAB have made excellent progress in 2017-18 on developing key policies and procedures for use by the multi-agency professional network. The 4LSAB's will be progressing plans in 2018-19 to join up the quality assurance and data analysis work of the partnership as well as reviewing the multiagency safeguarding training offer.

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 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.

Appendix 1

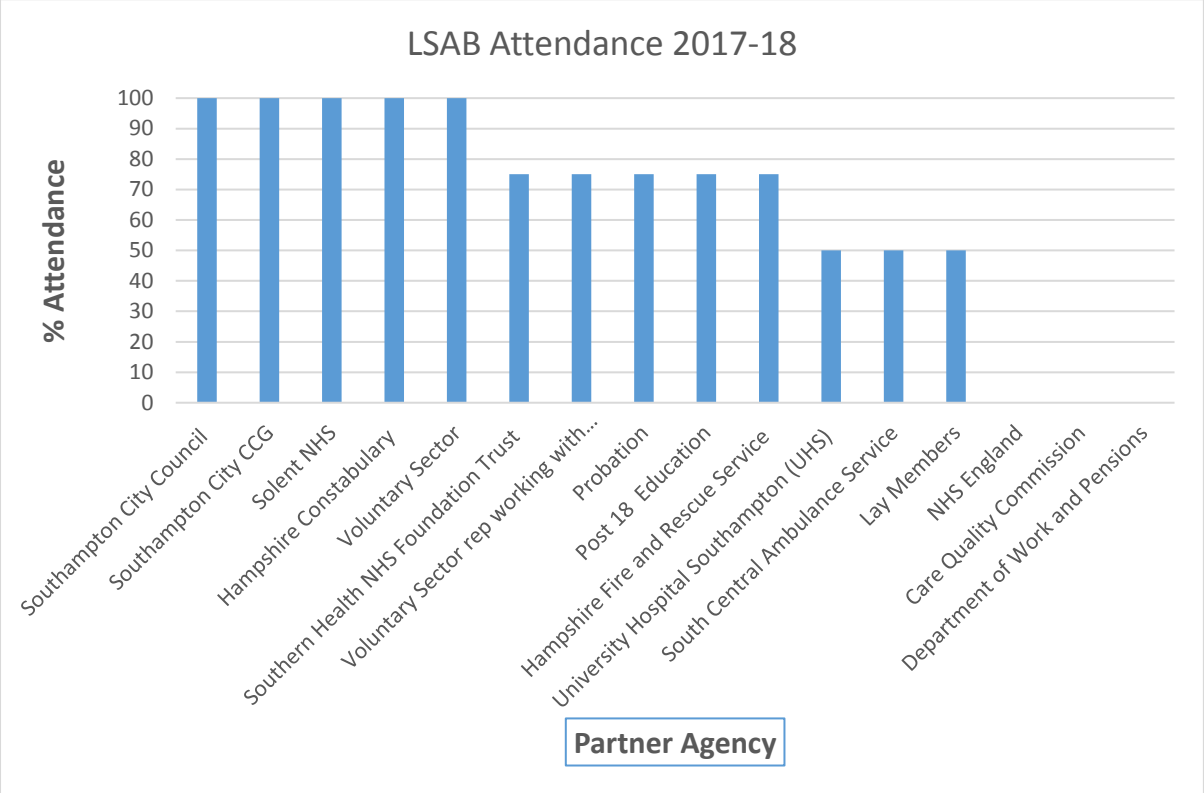
LSAB Finance

LSAB partners agreed to the following contributions to cover 2017 – 18:

Board Partner Agency	Contribution 2017 - 18
Southampton City Council	**£68,099**
Southampton City CCG	**£27,665**
Hampshire Constabulary	**£10,640**
Total:	**£106,404**

Appendix 2

Board Members Attendance



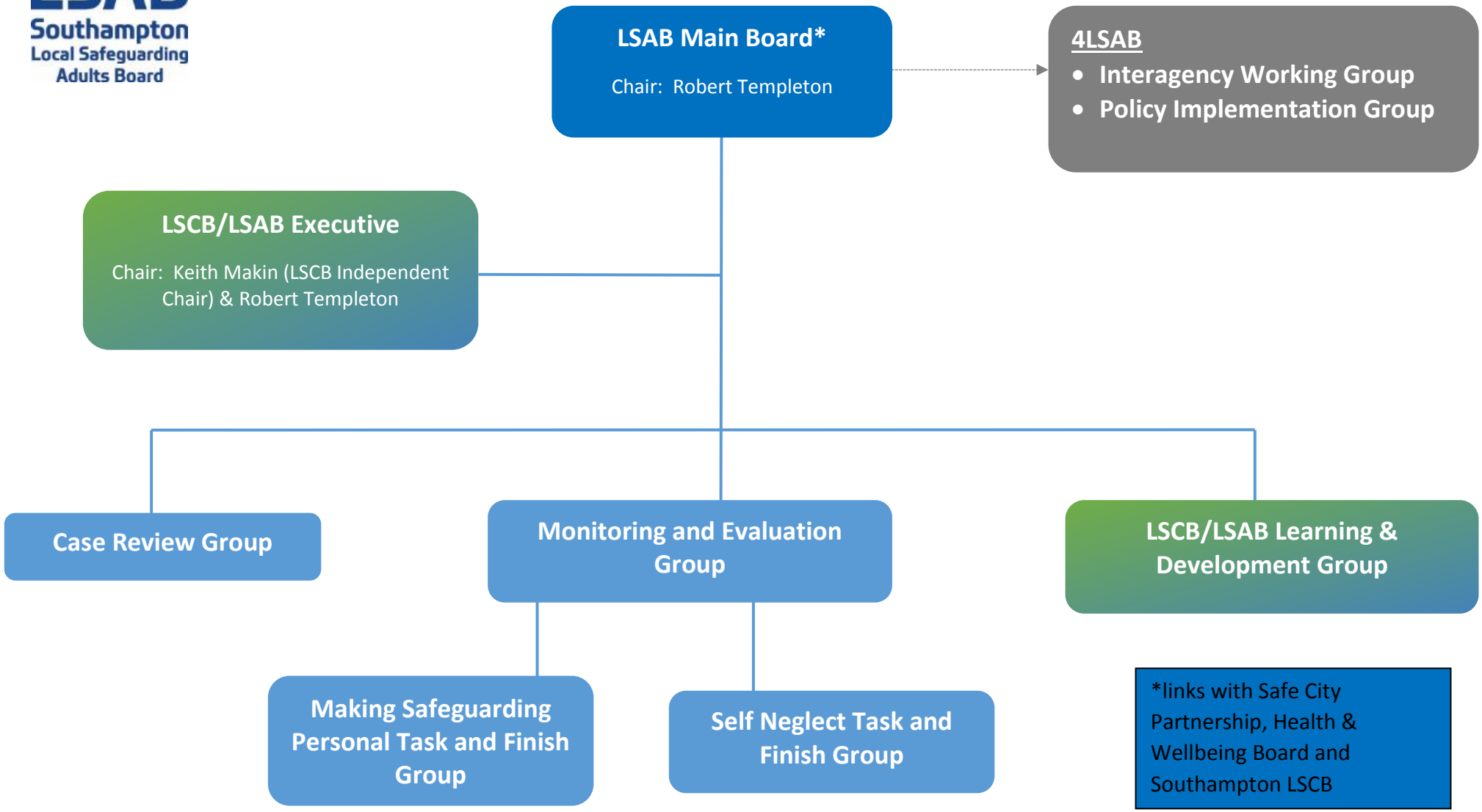
The above graph shows that the majority of agencies had 100% attendance at LSAB meetings. Partners such as NHS England, CQC and DWP are not noted as essential partners at every meeting.

Appendix 3

Glossary

4LSAB	Joint working group LSABs 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 LSAB	Southampton Local Southampton Adults Board
Southampton LSCB	Southampton Local Safeguarding Children Board
UHS	University Hospital Southampton NHS Foundation Trust
YOS	Youth Offending Services

Appendix 4 - Southampton LSAB Structure Chart 2017-18



Appendix 5

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 **Executive** 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 Executive 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 **Monitoring & Evaluation Group** delivers monitoring and evaluation activity to drive improvements in services to safeguard and promote the welfare of children and young people. It receives presentations on Section 11s, has oversight of multi-agency data, delivers thematic audits, and shares good practice. Meetings run quarterly. The **Self Neglect Task and Finish group** was formed to deliver the actions from the thematic review completed in 2016. The **Making Safeguarding Personal Task and Finish group** was tasked to review MSP audit findings and consider how they could be implemented locally.

Learning & Development Group sits across the Children & Adults Boards & ensures that multi agency staff can meet the standards for safeguarding outlined in pan-Hampshire Safeguarding Policy & Procedures. The Group ensures that the workforce is trained to effectively safeguard children, young people and adults at risk of or experiencing abuse and neglect, it enables and promotes learning & development, commissions Safeguarding Level 3 training and reviews multi agency training to ensure it is fit for purpose.

The **4LSAB** coordinated work includes a merged Chair/Strategy Group, a Quality Assurance Group which is closely aligned to other 4LSAB sub groups, and a Workforce Development Group, which is looking at merging adults' workforce development and so relieving the current Learning & Development Sub Group of its adults' responsibilities.