



Annual Report 2022 / 2023

Southampton Safeguarding Adults Board

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Adult Social Care foreword

I joined Southampton City Council as DASS in January 2023 and wow what a year we have had! I have enjoyed meeting partners, stakeholders and people with lived experience through my year and I am proud to see the amazing work agencies are doing across Southampton to support adults who require extra support in life.

The Southampton Safeguarding Adults Board's 22/23 annual report this year is slightly different from previous years and yet it still provides data showing that the Board has continued to progress in its goal to keep adults safe and free from harm.

Some projects that are worth mentioning are:

the creation of the Transitional Safeguarding Protocols which is helping to improve the transition to adulthood for young people who may require extra support to keep them free from harm

an exciting and informative Adult Safeguarding Awareness Week with special webinars and online events sharing best practice and the stories of people with lived experience

Those achievements have been made possible by the support and commitment of our safeguarding partners, healthcare services, us and the Police, who provide the funding for the Board and take a lead role in its governance.

In addition to the Board, the Safeguarding Adults Review sub-group, which manages any case reviews that meet the criteria set out in the Care Act. Based on the review findings, the group strongly desires to learn and improve practice.

We have published 7 SARs where we have embedded good practice and learnt from the experiences of those impacted by our services.

After four years in the role, our Chair, Deborah Stuart Angus has stepped down as the Independent Chair at the end of November but she did so confident that the Board has made considerable progress and that there's a strong commitment by all partners to our aims and knowing the board will continue to work hard to safeguard adults in Southampton, we thank Deborah for all her hard work in Southampton and wish her every success in the future.

Claire Edgar
SSAB Chair and DASS

Hampshire and Isle of Wight Constabulary

Project Foundation

Southampton Neighbourhood Team delivered a pilot project in relation to Serial & Repeat perpetrators of Domestic Abuse.

The Project has provided clear supervision, close monitoring, and control over perpetrator behaviour, and is heavily focused on delivering interventions through Partners such as the Hampton Trust and the ADAPT programme. Where perpetrators are not willing to engage, and or, change their offending behaviour, they are subject to control measures to prevent further harm. Officers also ensure there is a robust safeguarding plan in place for victims. The project outcomes have seen increased referrals to the Hampton Trust; Right to Know, and Right to Ask (under Claire's Law), as well as earlier arrests for offences committed by perpetrators. The DASH Risk Indicator Checklist and bail conditions are also used to safeguard victims.

Operation Fortress has seen Southampton Neighbourhood Policing teams identify and support vulnerable adults who are at risk of being exploited and cuckoo'd by either local drug networks or County Line drug dealers. Engagement with vulnerable tenants is seen by police partners as vital and is supported both by safeguarding measures and sign posting - with a wide range of services such as: housing providers, Adult Social Care, Mental Health Services, Drug and Alcohol services. In cases where drug lines are resilient, execution of drug warrants, and partial and or full house closures, have taken place to prevent unwanted persons inside the address.

Operation Defender was launched to tackle these issues. Partners and police work closely, with a visible presence to safeguard vulnerable people and identify those who are a risk. Police are using a wide range of powers to prevent further harm, for example, section 34 Dispersal Authority; Community Protection Warnings; Notices in support of Anti-Social Behaviour and Injunctions - all alongside traditional policing activity. Operation Defender has been supported with significant funding through a Safer Streets Bid to bring about improvements in the local environment, to make the night time economy safer for all.

Operation Hem is a Southampton District management plan, focusing on an area where there are sex workers, almost exclusively' women, who have a complex combination of needs in relation to drug and alcohol addiction, housing, health, and mental health. It is the view of the police that these are some of our most vulnerable adults in the City.

Safer Street Funding has also been achieved, providing additional facilities, such as CCTV to support greater safety in sex working. The work has built trust within this community, evidenced in increased reporting of serious violence and sexual offences, giving a more accurate picture of risk faced and the challenge for policing and our partners.

Safeguarding Training

Southampton District policing team has seen significant recruitment of new officers. This provides an inexperienced workforce in meeting the challenges of understanding and responding to adult safeguarding. To mitigate this, training has been delivered to all frontline officers, by Hampshire MASH training Sergeant and Staff Managers, to enable understanding about when to submit referrals (PPNs). This recognises that only relevant information should be shared, in an attempt not to overwhelm stretched resources within Adult Social Care (ASC). Following a successful pilot programme, information relevant to an adult's GP is now shared directly with surgeries, rather than sending directly to ASC. This process ensures opportunities for early intervention with the ambition of creating space within ASC and Policing by directing the most appropriate service to the Adult at risk.

The main challenge for the Police in Hampshire MASH is about demand management and early identification of which agencies require involvement, and to what extent. For example, the early identification of criteria for a section 42 Enquiry are met, or whether a MARM referral is required.

The SSAB Learning and Development Group (chaired by the Police Head of Safeguarding & MASH) are also carrying out scoping with agencies, through its members to put together learning briefings in relation to assessment of Mental Capacity and legislation, and Self Neglect, to support current safeguarding priorities. Police also receive the SAR learning briefings and work closely with the Serious Case Review team to fully implement any recommendations throughout the force.

Integrated Care Board

- **3 key challenges:**

- Volume of SARs and capacity to robustly implement the learning and impact upon frontline practice. Criteria is led by legislation so efficiencies will need to be achieved and agreed as a place with regards to the process of them.
- Covid challenges remain within the health system and inevitably impacts upon patient access to care and pressure upon the workforce when meeting the health needs of Southampton population in an efficient and effective time frame. We have seen little change to the way of working (from remote) due to the increase in demand that we have seen since Covid and the opportunity that virtual access in terms of increased productivity to managed the demands.
- Workforce challenges in terms of high vacancy rates, and the challenges that this presents across health and social care in the delivery of effective, prompt services to the Southampton population.
- Financial challenges across health and partner agencies at place. Impact of this upon safeguarding functions, volume and complexity.

- **3 key achievements:**

- Continued to collaborate transparent and mature approach across Southampton partners
- Ongoing development of the safeguarding case review group to managed and understand the learning opportunities identified as part of the Safeguarding adult reviews.
- Southampton continue to see strong collaboration across agencies in terms of multi-agency partnership working for our local population.

Hampshire and Isle of Wight Fire and rescue Service

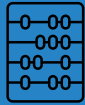
Challenges:

- Increase in attendance to mental health related incidents and related safeguarding concerns.
- Difficulties in obtaining an immediate response and support for the individual from partner agencies – due to workloads; priorities; and areas of expertise of different teams (at time of incident)
- Significant delays in support services / interventions being available or provided (probably due to demand) and this being a contributing factor for re-occurring MH safeguarding concerns being attended.

Successes:

- Internal review, update and re-publication of safeguarding level 1, level 2 and level 3 training
- Internal Making Safeguarding Personal Campaign to raise awareness and improve quality within referrals
- Amendment to the Rehabilitation of Offenders Act 1974 has resulted in Fire and Rescue Authority personnel and volunteers nationally being eligible for a Standard Level of DBS.

The City Context



In 2022, the estimated population of Southampton was 263, 769



In the 2021 census, 68.1% of the population identified as White British, 12.6% as White other and 10.6% as Asian / British Asian



Southampton has a young population, with 14.3% over 65, lower than the national average of 18.5%



1.13% of registered patients had a diagnosed severe mental illness which is higher than the national average of 0.94%



Southampton has been found to be 55 / 317 most deprived in England. There are links between severe mental illness and deprivation



In the 2021 census, 43.4% identified that they had no religion, 40.1% identified with the Christian faith, 5.6% Muslim, 1.7% Sikh, 1.3% Hindu and 0.7% as Other



In 2020 / 21, Southampton had a 5 x higher rate of admissions episodes for mental and behaviour disorders related to alcohol than the national average



Between 2018 – 2020, Southampton had the 5th lowest life expectancy with 78.3 for males (79.6 nat.) and 82.5 for females (83.1 nat.)

The Purpose of the Safeguarding Adults Board

The Care and Support Statutory Guidance (DHSC, 2023), which supports delivery of the Care Act 2014, confirms that “the main objective of a SAB is to assure itself that local safeguarding arrangements and partners act to help and safeguard adults in its area” who meet the safeguarding criteria (Care Act 2014).

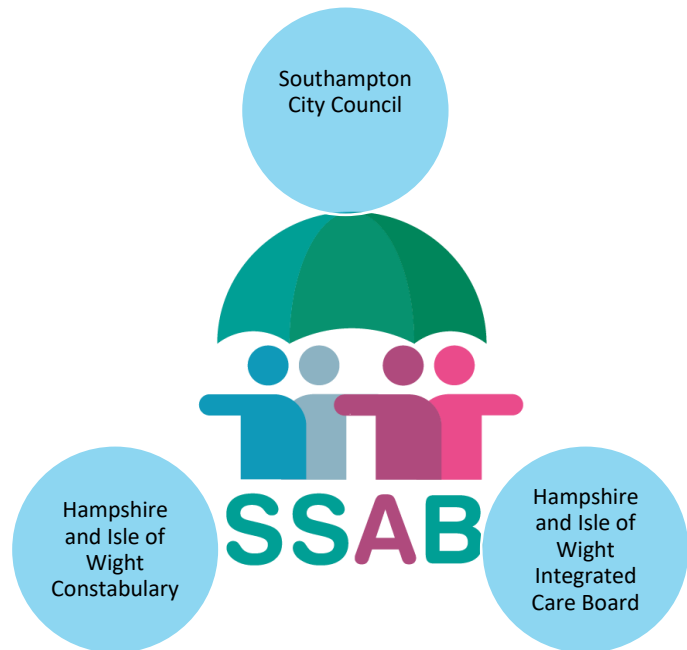
The Southampton Safeguarding Adults Board has an independent Chair who provides objective scrutiny and challenge and acts as a constructive critical friend, aiming to promote reflection and improvement.

The three core duties of SSAB are to:

1. Develop and publish a safeguarding adult strategy, for the partnership, which sets out our safeguarding priorities for adults at risk, how we will meet our objectives via partnership contribution, delivery and participation.
2. Publish an annual report detailing how effective our work has been
3. Commission Safeguarding Adults Reviews (SARs) for any cases which meet the criteria set out in Section 44, Care Act, 2014

Southampton Safeguarding Adults Board

Who are we?



The Southampton Safeguarding Adult's Board is a statutory body as specified in the Care Act 2014.

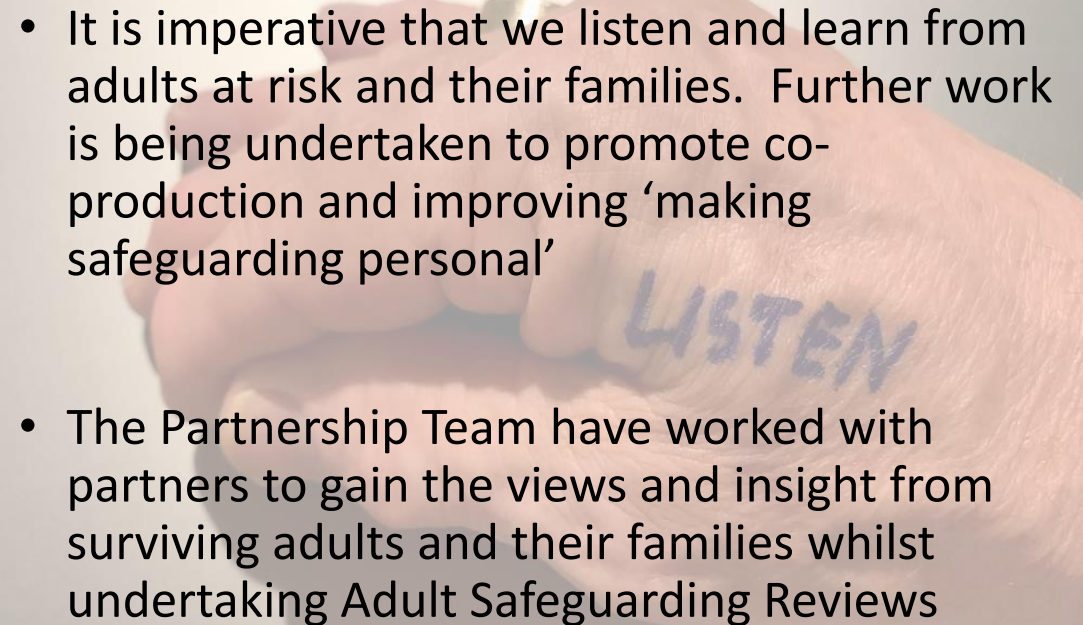
The three statutory safeguarding agencies – Police, Health and Adult Social Care, work together to gain assurance that partners are working effectively together to safeguard and promote the welfare of adults at risk in our city.

This is achieved by the implementation of local and national learning from safeguarding adult reviews, identifying strategic priorities, overseeing how agencies work together, safe challenge and seeking assurance.



We cannot do this alone

- The SSAB has a Chair who provides leadership, focus and scrutiny over the multi-agency safeguarding arrangements to ensure all are contributing effectively, providing challenge, support, national perspectives and an in depth safeguarding knowledge.
- The wider partnership including contributions from Probation Services, voluntary sector, Hampshire Fire and Rescue Service, South Coast Ambulance Service, the DWP, the ICB and Health Services.

- 
- It is imperative that we listen and learn from adults at risk and their families. Further work is being undertaken to promote co-production and improving 'making safeguarding personal'
 - The Partnership Team have worked with partners to gain the views and insight from surviving adults and their families whilst undertaking Adult Safeguarding Reviews

How we work together

- The work of the SSAB is governed by the Executive and SSAB Main Board who both meet quarterly to ensure statutory obligations are fulfilled and progress is reviewed for optimum impact for adults at risk.
- Partners contribute to a range of sub-group activity designed to quality assure safeguarding across the city and identify areas for improvement with a range of audit activity, analysis and policy /procedure review.
- In Southampton the following sub-groups work collaboratively to facilitate growth and challenge when required:

Learning and
Development

Quality
Assurance

Prevention and
Awareness

Case Review
Group (SARs)

Wider Safeguarding Arrangements

There are a number of Boards with multi-agency representation which work together to inform and oversee safeguarding arrangements in the city. Work is underway across the Partnership to ensure that each Board communicates better together to provide a cohesive plan for activity across the City and to avoid any duplication of work

Southampton Boards

- Health and Well Being Board
- Domestic Abuse and Violence Against Women and Girls Board
- Southampton Safeguarding Children's Partnership
- Safe City Partnership

4LSAB

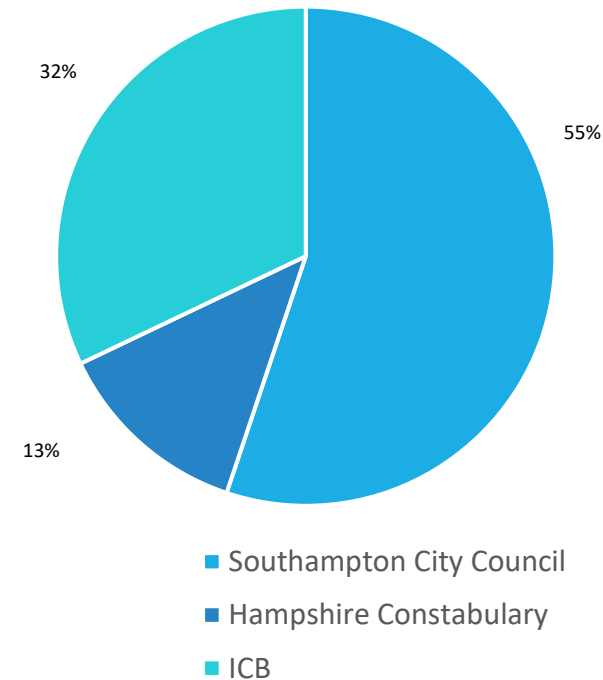
Southampton, Portsmouth, Hampshire and the Isle of Wight Safeguarding Adults Boards work strategically together where we share common priorities and objectives.

SSAB Funding

The statutory partners are jointly responsible for the Partnership and hosted by Southampton City Council.

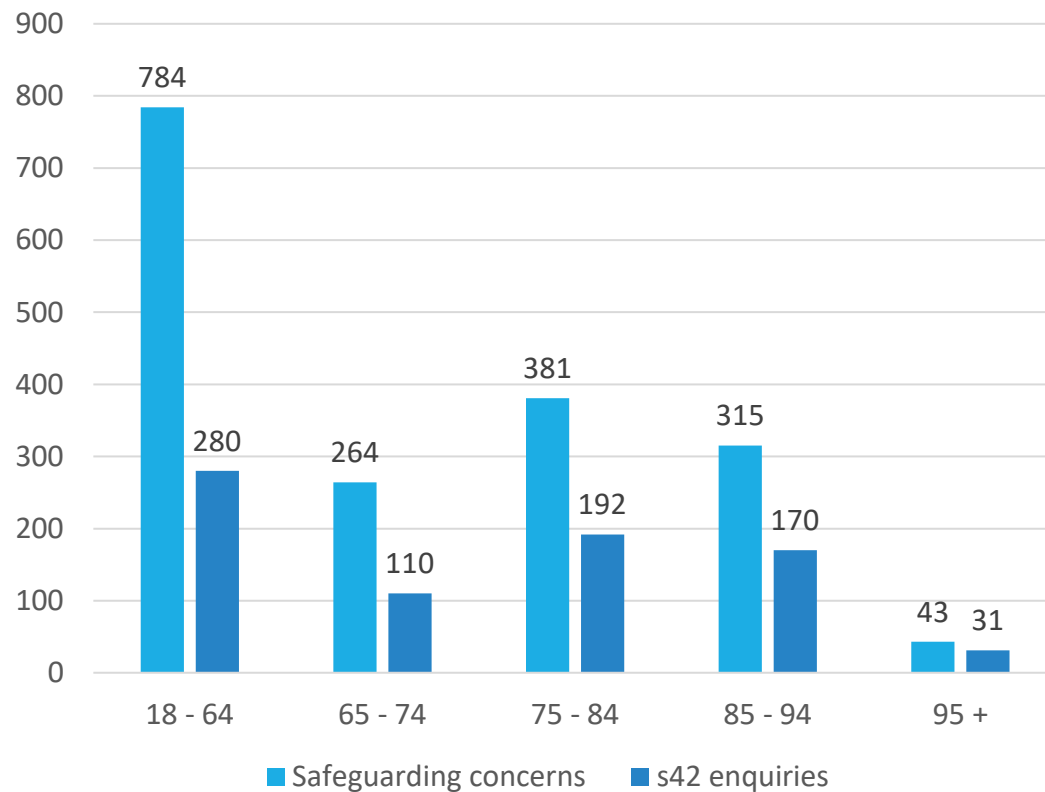
Partners provide joint funding and both statutory and non-statutory representatives are members of the sub-groups, promoting quality in safeguarding practice, safeguarding adult awareness and learning across the city.

Contributions

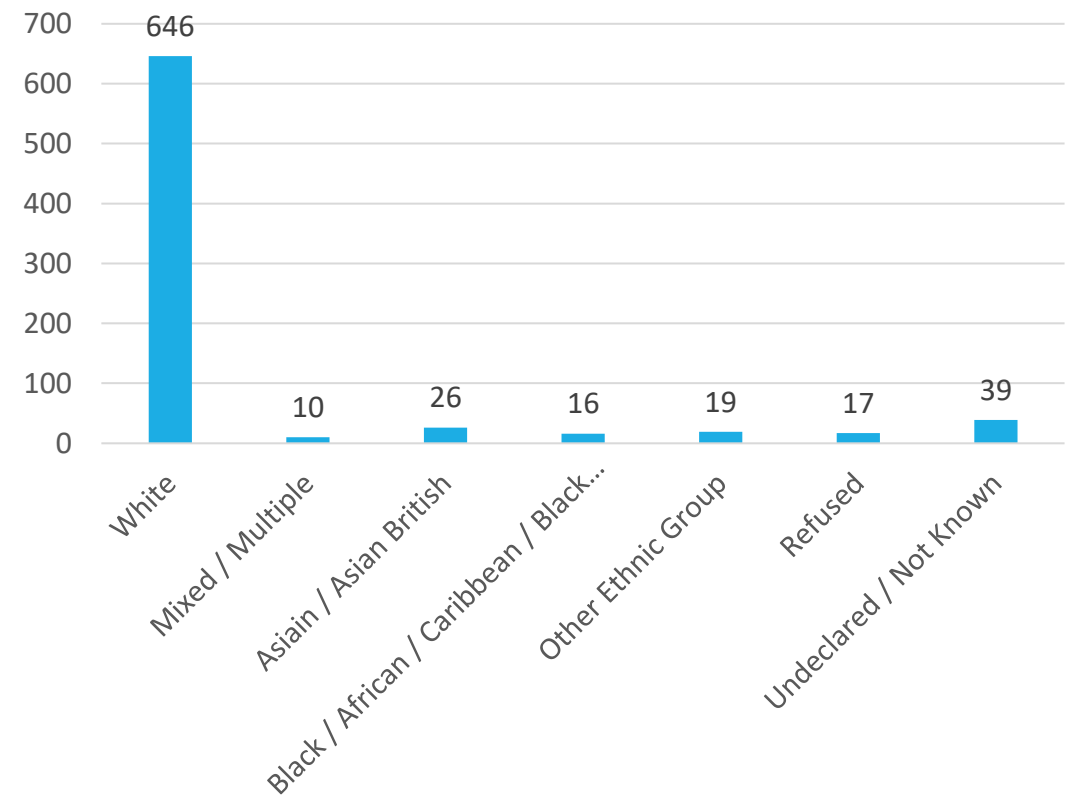


Adults at risk data April 22 – March 23 – Adult Social Care figures

Counts of individuals by age band

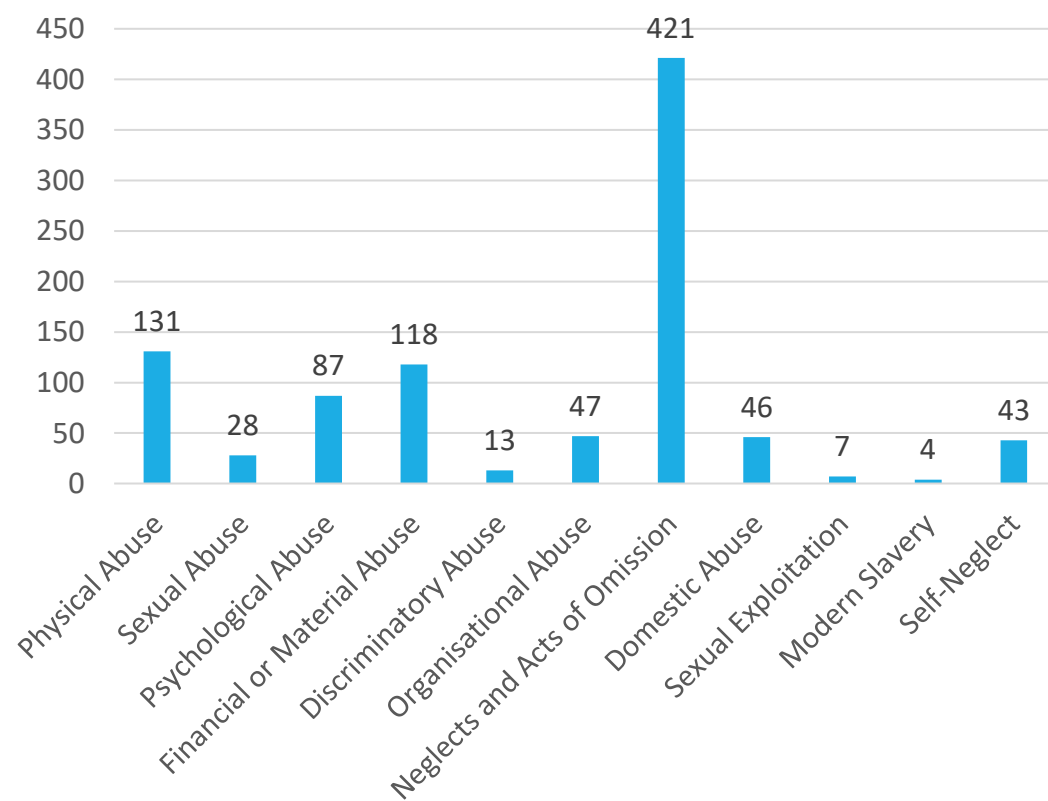


Adults involved in S42 enquiry by ethnicity

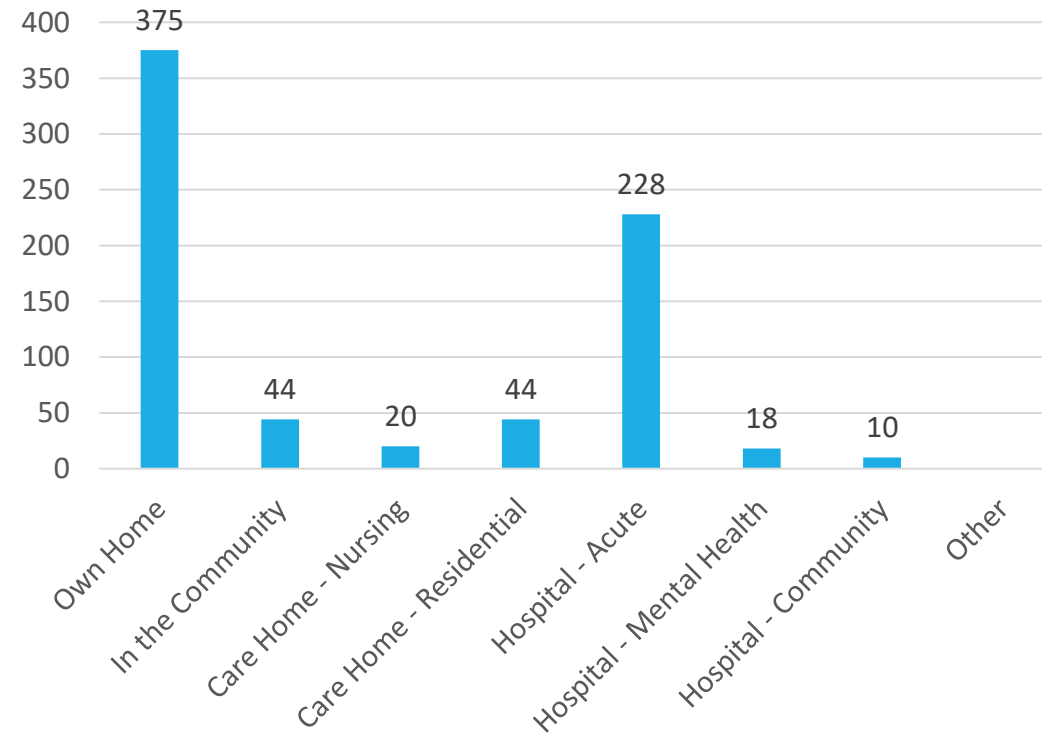


Concluded s42 Enquiries April 22 – March 23

Concluded S42 enquiries by type of risk

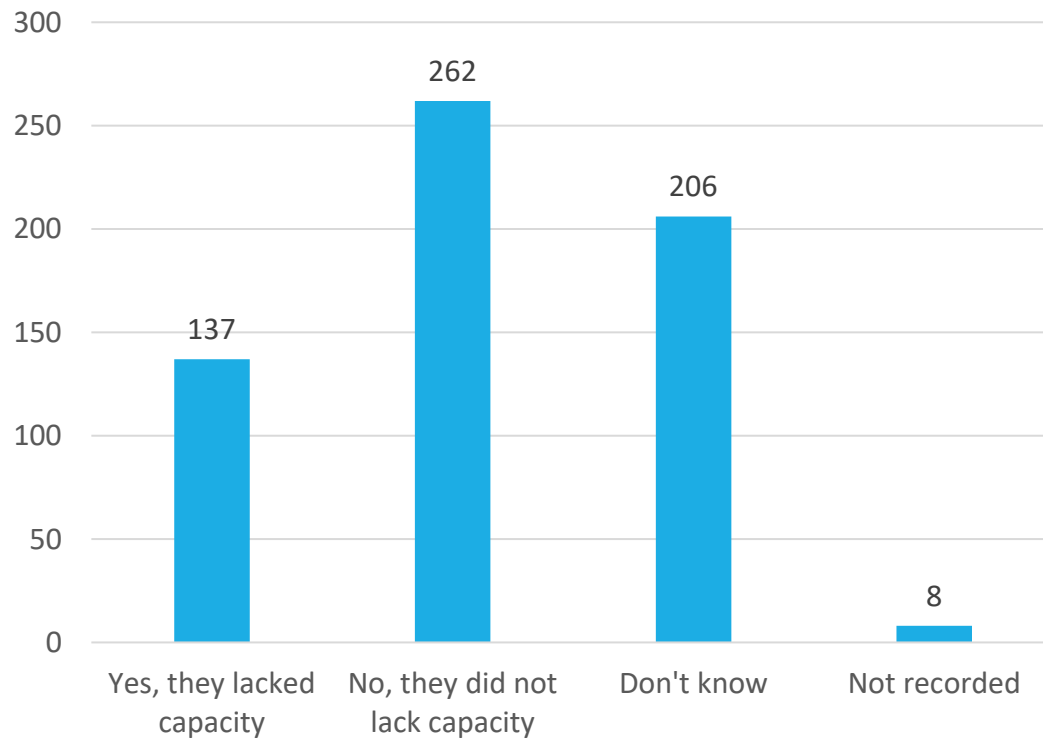


Concluded S42 enquiries by location of risk

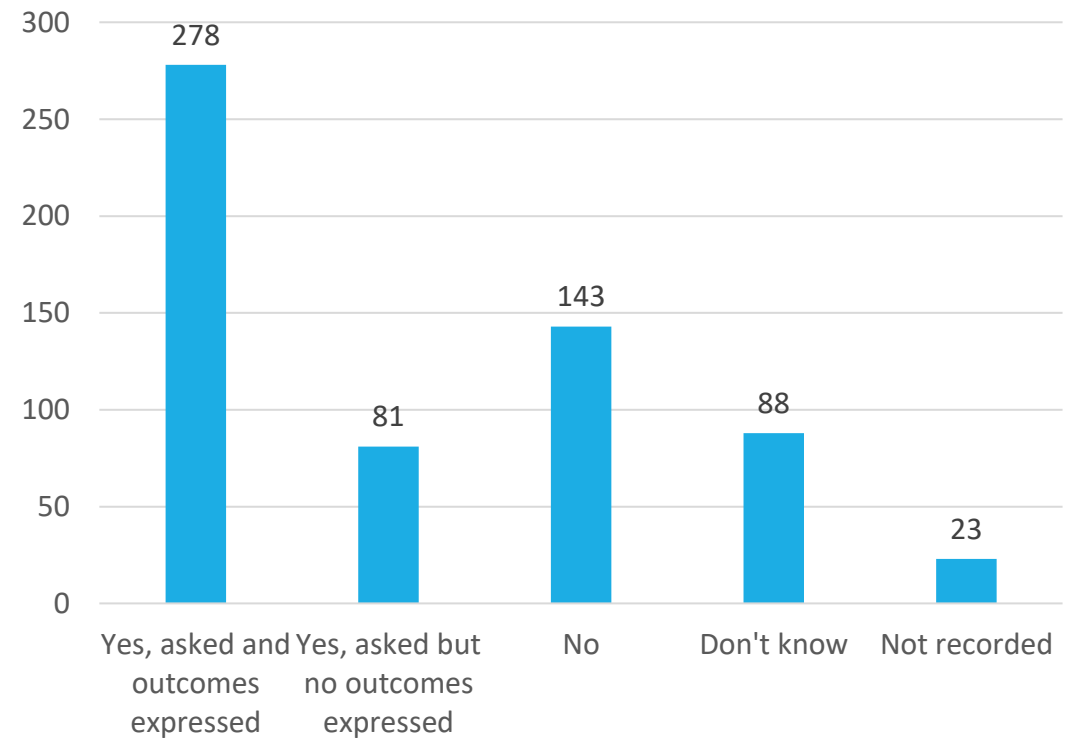


Mental Capacity and Making Safeguarding Personal data April 22 – March 23

Mental Capacity for concluded S42 enquiries



Making Safeguarding Personal for concluded S42 enquiries





Learning from Safeguarding Adults Reviews (SARs)

A key statutory duty of the SAB is to carry out a SAR under Section 44 of the Care Act 2014

The purpose of the SAR is to gather the facts about a case and how agencies worked together, to identify and improvements that can be deployed to both the partners involved and the partnership. If SAR criteria are not met, the Learning and Development subgroup may recommend other learning activity, including single agency learning and or a thematic reviews.

The Case Review Group received **16 new referrals** between April 2022 and March 2023. **1 new SAR** was commissioned and is underway. The SAB has **published 2 SARs** during the reporting period.

11 SARs were ongoing from previous referrals. Revised processes ensure that SARs are progressed in a **timely manner** and that **learning is identified and reviewed**.

Going forward the SSAB aim to develop a framework whereby partners can assure SSAB they have embedded across the safeguarding partnership agencies.

Published SAR - Martha

Background

Martha was an 89 year old lady, having lived in Southampton for the majority of her life.

In May 2020, Martha suffered a closed fracture of her left ankle and was discharged from hospital to a care home with nursing for a 5-6 week episode of respite care. An air cast boot had been placed on her fractured ankle on discharge from hospital.

The boot was removed in July 2020 and Martha was found to have developed pressure ulcers. Her condition deteriorated in the following months and rehabilitation of her ankle was unsuccessful. Martha was later admitted to hospital where she tragically died of an infected pressure sore and dehydration.

The care home investigated and concluded that there were failures in the care of Martha and that her pressure sores were preventable. A Safeguarding Adult Review was held with regard to this case.

Learning

- Standard hospital discharge practice to ensure that hospital staff complete an 'onward' care report, to include the care needed to support a patient in the community, when an air cast boot has been put into place.
- Discharge paperwork must be shared with the care home to include information required for appropriate care to be given.
- There must be a process in place to access equipment upon discharge from hospital.
- There must be clear lines of responsibility between acute settings, care homes and community services.

Published SAR - Louise

Background

Louise was an 87 year old lady who had lived in a supported housing scheme for 20 years, with noted declining cognitive abilities. Louise had a friend called Trevor who was the registered Lasting Power of Attorney for health and finance.

Trevor often rejected engagement by agencies for care and support and safeguarding concerns were raised, but rejected as there was no evidence of intentional neglect.

The GP found Louise to have overgrown toenails that were digging into her skin and described Trevor as very controlling.

The podiatrist found Louise's feet to be very neglected, with 5 – 8 cm toenails which were growing into her flesh.

In December 2019, Louise was admitted to hospital, severely malnourished, emaciated, incontinent and confused and with significant pressure ulcers. She initially improved, but sadly deteriorated and died in January 2021.

Learning

The escalation policy must be followed if decisions to take no further action are not agreed.

Professional curiosity must be explored if there are concerns around carers and relationship dynamics, even if the carer has lasting power of attorney.

Multi-agency communication must be meaningful and not reliant upon e-mails and telephone calls in order to share information as a whole network.

There must be awareness raising of the differentiation between neglect and self-neglect, along with the criminal offence of coercion and control.

A better understanding of the Mental Capacity Act and its application must be shared.

Knowledge of the legal duties of the LPA, how to challenge this and the role of the Court of Protection needs to be better, enhanced through multi-agency discussion.

What are we doing to gain assurance and embed learning?



Safeguarding Network Events

Facilitating a series of events across the partnership to share learning from SARs and to ensure updated policies are understood



SSAB oversight and Scrutiny

The multi-agency action plans are overseen by the SSAB and a requirement that an update is provided to evidence learning is a standard part of the Board's activity



Spot the Signs

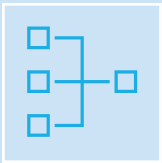
The Partnership have compiled a series of Spot the Signs leaflets which are available online and a programme of sharing across community spaces is underway

What are we doing to gain assurance and embed learning?



Mental Capacity Act User Guide and Self- Neglect Guides

A collaborative user guide for practitioners has been compiled and is due for sign off by the SSAB. This will be available on the website and will be launched across the partnership



Systems Improvement Learning Framework Subgroups (SILF)

Southampton, Hampshire, Portsmouth and the Isle of Wight have worked together to develop a framework to support a shared understanding of learning from SARs. This will inform priorities to improve systems for adults at risk and support the work of the 4LSAB to review and update policies and procedures



Involving adults with lived experience

SSAB continues to improve contact with families, involve surviving adults and family members early in the process, as their views are key to understanding the learning required to make a difference across the partnership. This work will be driven forward during 2023- 24 to include those with lived experiences, in shaping priorities and understanding the needs of the city

Workforce Development

E-Learning

- The below links will take you to free E-Learning on a variety of key topics:
- [Safeguarding Adults and Children Awareness Level 1 Presentation for Volunteers](#) (Source: Solent NHS)
- [Safeguarding Adults Awareness \(Level 1 and Level 2\)](#) – Source: NHS Health Education England.
- [Understanding Domestic Violence \(Level 1 and Level 2\)](#) – Source: ‘AVA’ - Against Violence and Abuse
- [Home Office Female Genital Mutilation – Recognising and Preventing FGM](#)
- [Modern Slavery](#) – Source: Department of Health
- [Prevent E-Learning](#) – Developed by Southampton City Council as a valuable tool for partners, voluntary groups and residents of Southampton. The e-learning is also there for any external users to complete. *Please NOTE: if you are an SCC Employee you will need to complete this training via the My Learning Portal via the Staff Intranet.*
- [Home Office Prevent Training](#) – New Government Prevent Duty Training (February 2023) is available [here](#). This training which will help you to support people vulnerable to radicalisation, and is for those working in sectors covered by the Prevent duty, such as education, health, local authorities, police, prisons, probation and youth justice. Other sectors that are not covered may also complete the training.
- [Home Office Prevent Training](#) – source Home Office - Information Sharing
- [SCIE E-Learning](#) – source Social Care Institute of Excellence - free e-learning modules (registration required)
- [Dementia Awareness](#) – Source: Social Care Institute of Excellence (SCIE)
- **4LSAB Training**
- The Hampshire Safeguarding Adults Board Learning and Development Programme 2023/24 has been published, where you can book virtual ‘lunch and learn’ sessions held between 12 – 1pm. Details of courses available, and how to book a place, can be found on the [Browse and Book Courses](#) page of the HSAB website.



Strategic Safeguarding Priorities: 2024-27

- **Prevention and Well-being**

1. Putting the public first
2. Making safeguarding personal
3. Collaboration and Co-Production
4. Continue to raise awareness of abuse and neglect

- **Quality**

1. Person-centred, lawfully compliant, good quality safeguarding practice
2. Positive, just culture with respectful challenge and ensuring Accountability

- **SARs and Learning**

1. Continuing to improve SAR governance and oversight
2. Embedding systems learning
3. Maximising Inter-Agency training opportunities
4. Continuing to gain assurance, with positive, sustainable learning outcomes





Thank you for reading this Annual Report

If you have any questions or comments please contact

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