Southampton Safeguarding Adults Board

Annual Report 2012 – 2013

Foreword by the Independent Chair

I am delighted to provide this foreword to Southampton's Safeguarding Adults Board (SSAB) Annual Report for 2012/13. I was appointed as the Independent Chair of SSAB in September 2012 and chaired my first SSAB in November 2012. My role is: to provide informed support and challenge to the work of all agencies working with adults at risk in Southampton; to ensure that the SSAB operates effectively (setting clear, evidence informed, priorities for multiagency working and driving progress towards meeting those priorities and targets); to commission Serious Case Reviews where needed (and to ensure that any recommendations are enacted by SSAB members); and to ensure that the SSAB contributes effectively to broader work and other partnerships devoted to the wider safety and wellbeing of adults at risk. As an independent chair, my role is to add value to the quality and impact of safeguarding adults partnerships and practice locally, focussing clearly on the best interests of adults at risk. It is with this independence in mind that I write this foreword.

Throughout 2012/13, the SSAB has operated within a context of significant systems change and funding pressures. These have affected all agencies working with adults at risk in Southampton. Of particular note, the level of structural and systems change that has taken place across the NHS over 2012/13 has been enormous. The city's Primary Care Trust and the Strategic Health Authority covering Southampton have been abolished and replaced by a GP led Clinical Commission Group and new commissioning support arrangements. Southampton City Council assumed new responsibilities for public health in this period and created a People Directorate from its previously separate children and adults departments. Hampshire Constabulary has appointed its first Police and Crime Commissioner. New partnership working arrangements have accompanied these changes. Of most particular note, Southampton's Health and Wellbeing Board has a duty to produce a health and wellbeing strategy for the city (that will improve people's health and wellbeing and reduce health inequalities), ensure that the Clinical Commissioning Group retains and meets local public health priorities and, most recently announced, review and approve the local plans for the new integrated health and social care fund that will be available for 2014/15 and 2015/16. Throughout 2012/13, therefore, many of the agencies in Southampton responsible for safeguarding adults have been subject to wholesale change and transition. This has inevitably been accompanied by changes in personnel (including membership of the SSAB) and governance systems.

The SSAB has also been acutely aware of the significant financial stress that all member agencies have experienced throughout 2012/13. It is factually accurate to say that, nationally, local authorities have been cut earlier and harder than the rest of the public sector – and this is true also of Southampton. But the NHS, the police and the fire and rescue service in Southampton have also experienced unprecedented levels of financial pressures – with significant budget reductions in the Hampshire Constabulary and the Hampshire Fire and Rescue Service as well as very challenging efficiency targets for all local NHS organisations. Equally, the voluntary and independent sector organisations who work with adults at risk in Southampton (whether as campaigning organisations or as service providers) have seen grants reduced (or even removed altogether) and fee levels held at previous year's rates, regardless of inflation. For the SSAB, therefore, these budget cuts and pressures have meant that agencies have had to interrogate every aspect of their investment in safeguarding adults work, ensuring that maximum value and impact is derived from every pound and penny spent. It is testament to the priority given to safeguarding adults at risk by all SSAB members that we have already identified and agreed our multiagency budget for 2014/15.

Of course, also throughout 2012/13, safeguarding adults has been subject to significant public scrutiny and policy change nationally. The horrific abuse of adults at risk, perpetrated by staff at Winterbourne View Hospital, and exposed by the Panorama programme in May 2011, created a national outcry of outrage and derision. In responding to the Winterbourne View Hospital Serious Case Review and its own internal inquiries, the Department of Health issued revised statutory guidance to the NHS and local authorities. Amongst other things, this guidance marks a radical change in commissioning practice across health and social care and the SSAB has been scrutinising local plans developed in response to the Department of Health requirements. The Francis Report into the poor care and excessive deaths of patients using Mid Staffordshire NHS Foundation Trust services has also resulted in key new policies, procedures and practices designed to safeguard adults at risk including a "duty of candour" across all health professionals. As a consequence, the SSAB has undertaken a key piece of work this year to develop and implement a comprehensive integrated performance management system. This will be completed in 2013/14, but the SSAB is already better able to scrutinise the quality and impact of safeguarding practice deployed by different agencies, not just adult social care as previously.

All told, 2012/13 has been an exceptionally busy year for the SSAB and I am very grateful for the support I have been given in my role as independent Chair, especially by Sue Lee, Eleanor Wilson and Carol Valentine. This 2012/13 Annual Report is grounded in the key questions issued by the Association of Directors of Adult Social Services and the Local Government Group in late 2011:

1) How do you demonstrate that people's lives are improved as a result of safeguarding? Are they and do they feel safer and are their circumstances improved?

2) Has safeguarding (and dignity) been subject to some form of independent scrutiny or checking? What has changed as a result?

3) What can you tell your local population about the quality and safety of local services – Personal Assistants, care at home, care homes and hospitals etc?

4) What can you tell your local population about police and criminal justice sectors' responses to safeguarding?

5) How is your SAB demonstrating its effectiveness?

(Local Accounts: Safeguarding - Advice Note for Directors).

These are the key questions which, in our duties and responsibilities as the SSAB, we must deliver transparency and critique. I commend this Annual Report to you.

Dr Carol Tozer
Independent Chair
SSAB

9 August 2013

1. What is driving change in the safeguarding agenda in Southampton?

1.1 Since the publication of the last annual report, there have been many and significant changes in the adult safeguarding arena. For example, the Care Bill proposes to place Safeguarding Adults Boards on a statutory footing and contains a number of clauses relating to the protection of adults who are subject to abuse and are unable to protect themselves. The Care Bill not only formalises the local authority's duty to lead adult safeguarding but it also recognises the pivotal role played by Safeguarding Adults Boards by putting them on a statutory footing:

- Local authorities will be responsible for establishing and running Safeguarding Adults Boards.
- Boards must co-ordinate and ensure the effectiveness of what each of its members does.
- The local authority, Clinical Commissioning Group and chief officer of police must be core members (Boards have the power to determine other appropriate members).
- The Board must publish a strategic plan each financial year setting out how it will protect people at risk of harm and what each member is to do to implement the strategy.
- At the end of the financial year the Board must publish an annual report on its achievements, members' activity and findings from any Safeguarding Reviews during that period.
- It must consult its area's Health Watch and involve the community in preparing the strategy.

1.2 In March 2013. the Association of Directors of Adult Social Services published advice and guidance which outlines a clear framework for the on-going development of and improvement in safeguarding services including the role of local safeguarding adults boards. The following priorities are highlighted:

- personalised safeguarding by focusing on people and the outcomes they want;

- Collaborative leadership as the key to cross agency engagement and effectiveness in the safeguarding agenda;

- Effective interfaces with Health and Wellbeing Boards, Community Safety Partnerships, Safeguarding Children Boards, etc.;

- Access to responsive specialist services so that there are a range of responses and options to support people with difficult decision making;

- Proportionate safeguarding so that our systems are not swamped and we do not miss the really serious concerns;

- Fully integrating commissioning, contracts management, care management review and safeguarding intelligence;

- Availability of good quality local services which prevent abuse and afford people dignity and respect;

- Access to criminal and/or restorative justice so that some people get extra support to challenge and change harmful or abusive situations, and arrange services and supports that meet the outcomes they want and

- Effective preventative work and early intervention to address risks before they reach crisis point.

1.3 There have also been a number of high profile scandals such as Winterbourne View and Mid Staffordshire highlighting critical failings in care and the safeguarding systems designed to protect vulnerable service users. The reports into both of these make far reaching recommendations for adult safeguarding which emphasise the need for joined up risk management and intelligent commissioning.

1.4 In 2012/13, the Hampshire 4LSAB local Multi Agency Safeguarding Adults Policy and Procedures were reviewed and updated with the new version being published in July 2013. The updated Hampshire 4LSAB local Multi Agency Safeguarding Adults Policy and Procedures are informed by national best practice and local learning. They provide a clear focus on the need for safeguarding responses to be led by the person affected e.g. "*no decision about me without me"*. It also highlights the range of community safety contexts where abuse may be happening such as 'mate crime', so called honour based violence, human trafficking, exploitation by extremist radicalisers, etc. The Policy focuses on promoting a culture of positive risk taking where individualised support can be offered and choice and control is maintained by the individual. It provides tools to ensure proportionate response to risk and enhanced practice guidance such as managing self neglect. The Policy is based on the principles of:

- *Empowerment and a presumption of person led decision making*
- *Protection by providing support for those in greatest need*
- *Prevention by taking action before harm occurs*
- *Proportionality by making the least intrusive response to risk*
- *Partnership by services working with their communities*
- *Accountability through accountable and transparent service delivery*

2. How do we operate as Safeguarding Adults Board in Southampton?

2.1 SSAB leads a commitment to improve outcomes for people at risk of harm and is a standing committee of senior/lead officers within adult social care, health, housing, community safety, criminal justice, voluntary organisations and service user representative groups. Its remit is to agree objectives, set priorities and co-ordinate the strategic development of adult safeguarding across Southampton. The SSAB safeguards and promotes the welfare of adults' significant risk through three main areas of activity:

- Co-ordinating what is done by each agency represented on the Board for the purposes of safeguarding and promoting the wellbeing of adults at risk in the area of the authority;

- Ensuring the effectiveness of what is done by each such person or body for that purpose and

- Increasing community involvement and awareness of Safeguarding Adults to ensure the principle that 'Safeguarding is Everybody's business' is promoted.

2.2 In September 2012, an Independent Chair was appointed to lead the SSAB. Since this appointment, a number of steps have been taken to improve the effectiveness of the Board including a review of membership to ensure representatives have sufficient seniority and authority to make commitments and decisions on behalf of their organisation; introduction of the 'Real Life' case study as the first agenda item at Board meetings to provide immediate focus on effective partnership working to secure positive outcomes for service users; use of impact analysis reports to evaluate the difference made as a result of partner agencies' implementation of recommendations arising from Serious Case Reviews and finally, the introduction of Board Development Days. SSAB members are now asked to complete an evaluation following each meeting and the information gained is used to improve the management of the meetings.

3. Who are adults at risk in Southampton?

3.1 Our safeguarding adults' arrangements emphasise the importance of keeping the safeguarding effort focused on working with the person being harmed and to support improvement in their safety and wellbeing. Our local safeguarding arrangements are designed to support an adult who:

1) has needs for care and support (whether of not the local authority is meeting any of those needs),

2) is experiencing, or is at risk of abuse or neglect, ***and***

3) *as result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.*

3.2 In 2012/13 285 number of people in Southampton were identified as at risk and requiring support under local safeguarding adults' procedures. Of these only 12 were repeat referrals during the year. Compared to last year, this represents a decrease of 17 (5.0 %) in the number of people referred. We have analysed referrals received locally and can see that compared to other similar local authorities our referral rates for 2011/12 are lower than average by nearly 40 per cent. The most common form of abuse reported in 2012/13 was Financial followed by Physical which is not consistent with other similar local authorities.

3.3 In terms of safeguarding referrals related to care and support services, there has been a small increase compared to the number received last year. In 2012/13, a total of 280 safeguarding alerts were received from a broad range of sources including adult social care and NHS professionals, care providers, Care Quality Commission, relatives, etc. Unsurprisingly, the main type of concern reported was neglect/acts of omission (221 cases) but there was also an increased number of physical abuse referrals (35) where I the main a staff member was alleged to be responsible. The 280 safeguarding alerts related to 83 separate providers (including Acute, Community and Adult Mental Health NHS services). A number of important trends have emerged from the analysis of the provider safeguarding interventions and these include poor standards of nursing competencies, poor management and leadership, poor governance, difficulties in recruiting good calibre staff and poor organisational culture. The number of providers referred together with the repeating pattern of concerns is concerning given the relatively small geographic area covered by Southampton. This clearly indicates the need for continued quality assurance and service improvement work within commissioning and contracts teams across agencies.

3.4 In order to better protect local people at risk, SSAB has recognised the importance of effective risk management and of engaging people in their own risk management in order to prevent risks escalating to the point of crisis. SSAB has asked local agencies to focus on timely preventive support and early intervention. For example, Adult Social Care holds regular multi disciplinary Risk Panels to which local professionals can make referrals if they are concerned about a person at risk in order to develop a risk management plan.

3.5 SSAB has recognised that the number of safeguarding referrals received provides only a narrow window to understand the nature and prevalence of risk/harm experienced by local vulnerable people and for this reason, it has recently introduced an Integrated 'Adults at Risk' Monitoring Tool. The information provided will enable a more realistic picture to emerge

and will, over time enable SSAB to monitor the effectiveness of a wide range of processes aimed at safeguarding local people and to target preventive work in key areas based on the intelligence provided.

3.6 SSAB recognises that learning from experience is the key to improving the safety of adults at risk locally. To that end, the Board commissioned a report on the circumstances surrounding the tragic death of Mr A. It developed a robust action plan to improve practice locally and has evaluated how actions have improved safety of vulnerable adults locally. Adult safeguarding was represented on the Domestic Homicide Review Panel regarding Miss Y. The Board also recently reviewed the report and recommendations arising from the report and will be ensuring that action is taken over the next year to improve safety for those at risk of domestic abuse. During 2012/13, there been four serious case review referrals relating to Southampton residents. None of these resulted in a serious case review being commissioned by the Board as the chronologies provided highlighted that the cases referred did not meet the criteria. However, where chronologies highlighted potential learning, further actions were taken for example, by SSAB commissioning an overarching review of cases in one local NHS trust to identify trends and root causes regarding a number of suicides and another NHS Trust undertaking a trend Serious Incident Requiring Review (SIRI) into a number of serious safeguarding concerns raised regarding one of its services.

4. What difference does our safeguarding services making to the lives of local people?

4.1 The following section provides a number of case studies to illustrate the positive impact good safeguarding can have on the lives of people at risk or in vulnerable situations. They show that effective outcomes are achieved by offering personalised safeguarding which focus on the individual and the outcomes they want. An underlying theme in a number of the case studies is the importance of effective prevention and early intervention work to avoid risks escalating to the point of crisis. However, where a safeguarding intervention is necessary, the case studies illustrate the importance of effective information sharing and partnership working in order to make proportionate responses at the lowest level of intervention possible to manage the presenting risks. The case studies also show that often safeguarding is often a gateway for people to get the extra support and services they need to manage their own risks and to achieve the outcomes they want.

Making a Difference: safeguarding against financial exploitation

Information was reported to police of regular, high value cash withdrawals being debited from a 76 year old vulnerable customer's account. The account holder was elderly and being cared for by two family carers and there were also concerns about the person's welfare. Initial safeguarding actions were taken. The accounts were frozen by the bank and the Police led a planned arrest operation working in conjunction with adult social services which provided an emergency placement in a local care home for the elderly person. The carers involved were arrested. During the investigation it became clear that one of the carers had been abusing the trust and confidence of his elderly relative and had withdrawn £4400 in a month to spend on personal items having recently lost their job. As part of the safeguarding process, an allocated social worker assisted the elderly client to attend the bank and gain access and control again over his banking. In May 2013 the offender received 4 months imprisonment suspended for 2 years, 60 hours unpaid work and was ordered to pay back £4400 in compensation.

Making a Difference: early intervention and supporting people to manage their own risks

Steven is 71 years old and was living in his own 3 bed house which was subject to possession proceedings for mortgage arrears. He also had multiple debts. Concerns were raised about a number of people who had befriended Steven staying at his property and to whom he gave money. Items were reportedly stolen from the house which had no electricity and was in a state of disrepair. Steven was described as having a chaotic lifestyle having little money to live on because when his pension was paid into the bank it was swallowed up by his overdraft. A safeguarding referral was made and through this process, housing support staff helped Steven find suitable supported accommodation. Eventually, Steven secured a 60plus flat which included an emergency alarm cord. On-going 60plus support was provided until the remaining issues were resolved. Steven felt much more positive about the future as moving to the flat was a fresh start.

Making a difference: safeguarding against 'mate crime'

James is 40 year old and lives in supported housing. He has a diagnosis of paranoid schizophrenia and has a long history of solvent abuse. James is in regular contact with the community mental health and substance misuse teams. Support staff became concerned about James' drug use after used needles were found in his room as he was not known to inject substances. On questioning he said his friends were visiting him and that he would buy some drugs which they would use. Also, his 'friends' would inject him with some substance in return for him buying all the drugs. James didn't know what he was being injected with. Staff made a safeguarding alert and James was actively involved in the subsequent safeguarding process. His drug screen was positive for heroin and benzodiazepines and whilst James was assessed as having the capacity to make decisions about his use of illicit substances and allowing other people to inject him, staff were able to talk to him about the risks and consequences posed. As a result, James decided to reduce and then stop his drug use and to limit the amount of money he was prepared to spend on himself and others. There was a marked improvement in James' engagement with services which helped him obtain clean needles and syringes for injecting and a sharps box for safe disposal of his drug equipment. Improved security at his accommodation discouraged his 'friends' and drug dealers from visiting him and he noticed an improvement in his financial situation as a result. James has now stopped using heroin or injecting substances, and although he still occasionally uses solvents or legal highs, the level of his drug use has decreased. James decided not to pursue drug rehabilitation services at this time and has chosen to remain at his accommodation. He has begun to attend the cinema regularly but is no longer in regular contact with his drug dealers or 'friends'.

Making a difference: keeping people safe in care settings

A safeguarding alert was received into the Safeguarding Adults Team regarding a local nursing home highlighting a wide range of serious issues and practices which if true, were placing residents at significant risk. These included:- medication being used without prescription; inadequate/inappropriate wound care for pressure ulcers; unsafe moving and handling practice; insufficient staffing levels for the dependency levels of the residents; nursing competencies not being assessed; care not reflecting dignity for residents. In view of the seriousness and number of concerns raised, placements into the service were suspended whilst the Safeguarding Adults Team worked with the service to ensure the safety of the residents. More safeguarding concerns were uncovered during the investigations which led to daily monitoring visits being carried out by the Safeguarding Adults Team. Multi agency assessments and reviews were carried out on all residents which identified that a small number of residents were at significant risk because the service was consistently failing to meet their needs. The Safeguarding Team led a multi-disciplinary review process (involving social workers, specialist nurses, consultants and GP's) to decide if a move to alternative accommodation was in the best interests of each of the residents concerned. The resident themselves and their families were involved in the decision making. Six people moved to an alternative care home. This approach gave the nursing home more capacity to meet the needs of the remaining residents. It worked with the Safeguarding Adults Team throughout the process and significant progress was made to improve practice and the residents' wellbeing. The safeguarding process was completed once the nursing home could evidence that the improvements it had made had been sustained. As a result of this intervention, the nursing home is now considered to provide good quality and safe care for residents.

5. Review of the SSAB Business Plan 2012/13

5.1 2011, SSAB produced a Business Plan detailing key priorities and objectives for 2011/14. During the year, SSAB has received regular updates on progress. The mechanism for delivering Business Plan objectives is through the work of Sub Groups or Task and Finish Groups which will focus on tackling specific aspects or tasks within the Business Plan. Whilst these groups are co-ordinated by the SSAB Board Manager, there is an expectation that Board Members and/or their representatives will either lead and/or actively participate in these work streams. Last year a wide range of such groups were set up covering topics such as Fire Safety, Integrated Dashboard, Safety Net, Multi Agency Thresholds Audit, User Feedback, Community Safety etc.

5.2 In order to achieve consistency across Hampshire in safeguarding policies, procedures and practice guidance the four Hampshire local safeguarding boards meet on a regular basis and undertake joint work. For example, in 2012/13 we jointly reviewed and updated the local Multi Agency Safeguarding Policy which was published in June 2013. The Policy now contains pan Hampshire practice guidance covering a range of topics such as Managing Self Neglect, NHS Safeguarding Investigations, Safeguarding in Provider Services, etc. This collaborative approach between the 4LSAB's is important not only from a consistency point of view but also for agencies either with a county wide remit or where they work with more than one of the Hampshire local authorities.

5.3 Progress against the current SSAB Business Plan is highlighted below:

What we said we would do	What we did
Effective governance to deliver better outcomes for adults at risk.	
Review of SSAB Terms of Reference and Board membership.	SSAB Terms of Reference were revised. A Constitution and Member Handbook was produced outlining role requirements for members. Board membership was revised to ensure senior representation from key agencies.
Review of chairing arrangements and improvements to management of meetings.	A jointly funded Independent Chair has been appointed. A standardised meeting agenda and report template have been introduced. A 'Real Life' case study is the first agenda item placing immediate focus on effective partnership working to secure positive outcomes. Meetings follow a standardised agenda and are evaluated.
SSAB Peer Audit and Self Audit	A LGA Peer Review was planned for 2013 but has been deferred until 2014. However, a collaborative audit was undertaken in 2012 by SSAB to assess how the board was functioning in the light of the ADASS/LGA Standards and Performance Framework. An organisational self audit tool was introduced to assist partner agencies develop their safeguarding.
Scrutiny arrangements and links with key strategic partners	Regular reports have been made to the SCC Overview and Scrutiny Panel. Links have also been established with the Health and Wellbeing Board and Health Watch. SSAB is represented on the LSCB and has established links with the Safe City Partnership which now includes a section on safeguarding adults.

What we said we would do	What we did
***Prevention and awareness*:**	
Links with Support with Confidence.	Work has been undertaken with the Support with Confidence scheme to ensure appropriate safeguards have been built into the operation of the scheme.
On line information about adult safeguarding.	A new on line abuse reporting process has been set up and the SCC Safeguarding Adults website has been updated.
Publication of publicity and information raising awareness of safeguarding awareness and how to report concerns.	Co-production of a safeguarding public leaflet which has been distributed across the County. A Wellbeing Tool has been drafted and will be published in the autumn 2013.
Tacking financial Abuse	Trading Standards have delivered 34 presentations to target groups. 30+ active No Cold Calling Zones have been established. 270 reports of consumer complaints relating to mass marketing fraud (lottery, prize draws, directory entry etc) were responded to together with 118 reports of consumer complaints relating to doorstep crime cold called doorstep sales).
Wellbeing Trigger Tool	The content, contact details and referral processes have been identified. However it has not been possible to translate this into a useable tool without the allocation of resources. It has been identified that this task was also being pursued by a third sector organisation and additionally had been commissioned from Capita. It will be necessary therefore, to link the work of these strands. This will be included in the SSAB Priorities for 2013/14.

What we said we would do	What we did
Prevention and Awareness	
Southampton Voluntary Services	SVS has continued to highlight safeguarding adults to the voluntary sector as part of its support and advice role. It has briefed the sector on the new Disclosure and Barring Service & has hosted a well attended 2 days regional training for counter signatories with Disclosure and Barring Service. specialists. In 2012/13 SVS had the umbrella CRB checking role which ended in July 2013. Now SVS, in partnership with a private sector provider, facilitates online checks for local groups wishing to use the Disclosure and Barring Service.
Effective joint working:	
Clear information about the range of community safety casework services and clear links and referral routes between community safety casework services and adult safeguarding.	A Community Safety Resource Pack has been published explaining all community safety casework services and referral routes. A Community Safety training module has been developed and delivered to Adult Social Care. Training on safeguarding adults has been provided to Community Safety staff.
Adult safeguarding in the Safe City Plan.	Adult safeguarding issues are included in the current Safe City Plan.
Clear protocols between Adult Social care and Police Central Referral Unit (CRU).	The CRU now screens all CA12's prior to sending these to SCC. This has led to a decrease in the overall number of CA12s being raised and the quality and relevance of the reports has improved. A SSAB priority for the coming is to implement a joint triage process. An Audit will take place in the autumn 2013 to review what is referred by agencies to ensure that process is picking up cases appropriately.

Effective joint working:	
Fire Safety	HFRS and ASC have developed a process for responding to the fire safety needs of people at risk or in vulnerable situations. Fire safety has been built into the initial assessments undertaken by domiciliary agencies' when they set up a care package. HFRS has introduced an on line referral form. Training has been provided by HFRS to carers.
Community Safety	In 2012-13, there were 219 Anti Social Behaviour (ASB) incidents involving vulnerable victims of which 102 were identified as at being 'high risk'. There 109 ASB Multi Agency Risk Assessment Conferences (MARAC) held. 483 people were referred for a Domestic Violence MARAC, of which 94 were repeat cases. 140 hate crime incidents were reported to SCC (130 of these were reports of graffiti.) No Hate Crime MARAC's were held. No PREVENT referrals have been received.
Tackling financial abuse	Trading Standards has identified thresholds, drafted referral criteria and are signed up to receive CA15 reports direct from Hampshire Police. Access to PARIS is required in order to create a problem profile to ensure that Trading Standard's response is accurately targeted to maximise positive outcomes. Trading Standards has undertaken safeguarding interventions for 5 people identified as repeat victims of financial abuse. Trading Standards has established a Memorandum of Understanding with Hampshire Constabulary to receive CA15 reports re financial abuse.
Safety Net pilot – using address to flag safeguarding concerns.	The preparatory work has been undertaken for a pilot study which will be included SSAB Priorities 2013/14.

What we said we would do	What we did
Effective Joint Working	
Risk Panel	ASC has established a Risk Panel to respond to the needs people at risk or in vulnerable situations but who may not meet the threshold for interventions under safeguarding procedures. Operating to agreed terns of reference and referral criteria the Risk Panel has reviewed 40 cases high risk cases (falling sort of safeguarding thresholds) and agreed a risk management plan for each during 2012/13. The Risk Panel is a collaborative process and involves partner agencies.
Human Trafficking	ASC provided a rest centre during Operation Helm in which the police removed a number of people believed to be at significant risk, from a local traveller site. This work led to a member of ASC staff receiving an award from the Chief Constable. Links have been made with the Salvation Army, who is the Home Office approved local provider.
PREVENT	Southampton has established a multi agency 'Channel Panel' to respond to people at risk of radicalisation. Hosted by Community Safety, Adult safeguarding is represented on this panel. No PREVENT referrals were received in 2012/13.
Domestic Violence Homicide Reviews (DHR) integrated into safeguarding process	The Community Safety Partnership has implemented a clear process for conducting DHR's. SSAB was included on a recent DHR and the resulting report was presented to SSAB in 2013.

What we said we would do	What we did
Clear legal, policy and professional framework for staff:	
Review and update the 4LSAB local multi agency Safeguarding Policy and Procedures.	The Hampshire 4LSAB Safeguarding Policy and Procedures was reviewed and an updated version was launched in June 2013. The Safeguarding Policy reflects best practice and national/local developments. The Policy and related practice guidance is available on the intranet and internet. This policy now contains a section on practice guidance that has been adopted Hampshire wide and in a number of cases, reflects guidance developed in Southampton.
Revise training programmes and materials in light of revised 4LSAB Safeguarding Policy.	Revision of training programmes and materials has not yet been completed but will be included in the SSAB Priorities 2013/14.
Develop a 4LSAB wide Information Sharing Protocol	A joint information sharing protocol is included in the 4LSAB Safeguarding Policy and Procedures.
Develop and launch a local Self Neglect policy and practice guidance.	SCC has published a Managing Self Neglect Policy and related practice guidance. A staff training module has also been developed and included in the Modular Safeguarding Training Programme. This policy has now been adopted by the other Hampshire local authorities. Solent has produced internal guidance on Supporting Clients who Self Neglect which has been ratified by the NHSLA group. This is accessible to all staff via the internet.

What we said we would do	What we did
Provider organisations safeguarding policies	
Southampton Voluntary Services	SVS is updating its safeguarding adults' policy in line with the latest Hampshire 4LSAB guidance and once approved, will be disseminate across the sector as a model for other groups to use.
NHS providers	The Hampshire NHS Consortium has developed a decision making thresholds tool to guide NHS staff on making safeguarding referrals to the local authority. This mirrors other NHS thresholds developed in other regions. The draft went out for consultation in October 2012 and is now ready to be piloted by Solent, Southern Health and Southampton University Hospital trust. Solent will be piloting the tool in the Portsmouth area to evaluate the effectiveness of the tool. In 2013/14, SSAB will be commissioning an audit from the NHS Trusts of concerns raised and the decision making regarding referrals to local authority safeguarding teams.
Skilled, competent staff:	
Programme of safeguarding workshops for managers.	In 2012/13, a series of multi agency safeguarding workshops for managers was held and delivered by nationally recognised subject experts. Topics included Managing Self neglect and Safeguarding and the Law. There was good cross sector representation on all the seminars. A programme for the coming year has been agreed for the coming year.
Increase uptake from partner agencies on the multi-agency Safeguarding Modular Training.	Attendance from partner agencies on the SCC Safeguarding Modular Training has remained very low. This is possibly because agencies deliver their own in house training (NHS providers) or they buy into course run by HCC.

What we said we would do	What we did
Skilled, competent staff:	
Support the safeguarding awareness training of front line staff and provide partner organisations	A cascade safeguarding awareness training pack has been developed and is available to partner agencies to assist with their in house training. Various cohorts of SCC frontline staff have attended safeguarding adults training such as financial assessment officers and community safety staff.
Undertake a review of the Training Strategy in 2012.	The review of the Safeguarding Training Strategy has not been completed but will be included in the SSAB Priorities 2013/14.
Offer professionals forums to discuss safeguarding practice	A Health Providers Forum has been set up to allow cross sector learning and development of cross sector polices and processes. However, a professionals' forum in ASC has not been set up.
Safeguarding in Social Work Education	In 2012/13, SCC delivered the Safeguarding Unit on the Post Qualifying Social Work course at Solent University and provided input on the Social Work degree course.
Pilot National Competency Framework for Safeguarding.	This has not been completed but will be included in the SSAB Priorities 2013/14.

What we said we would do	What we did
Prevention and safeguarding at the centre of personalised services	
Outcome statements	SSAB has agreed a set of statements against which to measure outcomes in safeguarding. Work is in progress to have these adopted by the Hampshire 4LSAB's to provide consistency and synergy for partner agencies with a county wide remit.
Risk Panel to support staff.	The Risk Panel has met regularly and of the 40 cases referred, a significant number relate to direct payment holders.
Develop "Keeping Safe" and "How to Guides" for direct payment holders and keeping safe" template for personalised support plans	These have been produced via Spectrum CIL. 'Keeping Safe' included in Support Plan template in Adult Social Care.
Establish process for Direct Payment users to access DBS checks for personal carers.	Not completed but will be included in SSAB Priorities 2013/14.
Develop mechanisms for privately employed carers to access training and development.	Funded training and development opportunities are available e.g. via Skills For Care. This information is promoted nationally and is locally targeted to individual employers through the Direct Payment Support Service Contract that SCC has with Spectrum CIL.

What we said we would do	What we did
Facilitate informal networks for Direct Payment holders *Provide workshops for Direct Payment users to support them in their role as employer.* *Develop Financial Abuse Guidelines (to reflect ACPO guidance).*	3 x Peer Support Group sessions have been facilitated by Spectrum CIL and will form part of a rolling programme. 3 x training sessions for individual employers have been held during the year, facilitated and delivered by Spectrum CIL Not completed but will be included in the SSAB Priorities 2013/14.
Ensuring the availability of good quality local care services: *Further quality develop in contract monitoring in services contracted by CCG and SCC and implement a quality audit programme in commissioned services.* *Protocol for Managing Safeguarding in Provider Services (SIPS).*	Capacity within the Integrated Commissioning and Contract Monitoring Team has been increased. Over the past year, the new Quality Assurance Team has developed the tools to work with care homes, domiciliary care providers, day centres and other care providers. Quality audits have been undertaken in 44 care homes. Day centre reviews have commenced. In domiciliary care, 10% of service users have been asked their views on care provision and feedback given to the care agencies as part of the quality assurance process. The SIPS process has been updated to reflect the key findings arising from the West Sussex Judicial Review. The safeguarding clause in the contract Terms of Inclusion have been updated and rewritten. Both processes have been adopted by 4LSAB.

What we said we would do	What we did
Ensuring the availability of good quality local care services:	
Launch the Best Practice in Care Checklist (BPICC) audit tool and use in future contract monitoring.	The BPICC is routinely used in provider audits, contract monitoring and Support with Confidence registration.
Improving standards in nursing care.	The SCC safeguarding team hosts a regular clinical forum for nurses to improve clinical competencies. A Panel has been set up to review all grade 3 and 4 pressure ulcers to determine root causes.
Developing practice and promoting training and support of staff in contracted services	A training programme for voluntary and independent providers (VIP) has been implemented. This includes the Managing Safely course (based on the BPICC and linked to CQC Outcome Standards). In 2012/13, a total of 42 local managers attended this training (4 courses in total).
Robust performance monitoring	
Audits of practice across all agencies	A process is in place in Solent, Southern Health and Adult Social Care to audit individual workers practice. A multi agency Thresholds audit has been planned to take place autumn 2013.
Integrated 'Adults at Risk' Monitoring Tool	An integrated *'Adults at Risk' Monitoring Tool* providing dashboard performance information has been developed and is now being reported to SSAB. The other Hampshire LSAB's who are considering whether to adopt this.

What we said we would do	What we did
Service user feedback	A *User Feedback Tool* and process have been developed. This is designed to foster the involvement of people in their own safeguarding as a means of meeting the SSAB goal of local services providing P*ersonalised Safeguarding*. However, the survey has not yet been implemented but will be included in the SSAB Priorities 2013/14. This approach has been adopted by some of the other Hampshire LSAB's.
Professionals views on "what works".	Regular *Real Life* case study on SSAB agenda allows practitioners to highlight cases where good partnership working has led to positive outcomes and to feedback on practice issues.
Publication of regular key performance indicators and safeguarding activity reports.	Regular reports are presented to SSAB together with trend and comparator information to inform the Board of the effectiveness of local safeguarding and any gaps to target key areas for service planning and development.
Mechanisms to promote learning from experience and evidence based practice:	
Learning from Serious Case Reviews and national inquiries.	The Safeguarding Manager reviews national SCR and highlights learning to SSAB via briefings and an on line learning log was set in up Adult Social Care.

What we said we would do	What we did
Mechanisms to promote learning from experience and evidence based practice:	
Mr A Serious Case Review	Learning from the Mr A Serious Case Review has been a key focus of SSAB. A multi agency action in response to the recommendations made was produced by SSAB and partners required to report progress at each Board meeting. In 2013, as a means of assessing the difference SCR action plan made in practice and to outcomes, SSAB introduced an impact analysis tool.
Winterbourne View	The *Winterbourne View SCR* has been a key focus of SSAB. The response of local agencies has been closely monitored. SSAB developed a multi agency action plan and a local implementation group was set up. This group has been making regulars to the SSAB on the progress against the recommendations in the action plan.
Mid Staffordshire Inquiry	SSAB has also closely monitored local agencies' response to the *Francis Report* and the *Patients First and Foremost* government response and asks for regular progress reports.
Review of Serious Case Review Process	SSAB and HSAB jointly commissioned a review of the current policy which has yet to be finalised. This will be in the SSAB Priorities 2013/14.
Systems Learning Approach	SSAB jointly commissioned SCIE led System Learning Training course. A pilot will be set up to test System Learning for Partnership Reviews.

What we said we would do	What we did
Services shaped by users and carers:	
Revise contents of training to reflect carer perspective.	Not yet undertaken but will be included in the SSAB Priorities 2013/14.
Seek feedback from carers on their experience of safeguarding.	Not yet undertaken. This will be included in the SSAB Priorities 2013/14.
Recognise carers as expert partners in safeguarding.	Integrated Commissioning Team are developing "Experts by Experience" to support quality assurance. This will be included in the SSAB Priorities 2013/14.

6. How do we know local professionals have the right knowledge and skills to provide good safeguarding?

6.1 Learning and development is the key to ensuing safeguarding concerns are responded to effectively and to fostering an ethos where safeguarding is seen as *"everybody's business"*. Learning and development is promoted through a wide range of approaches. Providers of adult social care such as care homes and domiciliary agencies can access training via a Council funded Voluntary and Independent Providers Training Programme which has this year been built around learning from quality assurance reviews of services and trend analysis of safeguarding activity in provider services. Statutory agencies offer safeguarding training as part of their mandatory programmes. As the information below shows, awareness training is offered to staff working in a very wide range of roles. The following table provides a summary of partner agency training and development on safeguarding during 2012/13.

6.2 Multi-Agency Safeguarding Learning and Development Summary 2012/13

Agency	What's available?
SCC	SCC provides a wide range of safeguarding adults' related training both for its own staff as well as those working in the independent sector. A total of 144 staff attended courses related to MCA/DOLS (75 SCC and 69 VIP staff). A total of 177 provider staff attended Safeguarding Awareness Training (112 SCC and 65 VIP) and a further 81 provider staff attended safeguarding refresher training (65 SCC and 16 VIP). SCC also provides modular based safeguarding training for staff involved in safeguarding investigations reflecting the various aspects of the safeguarding process. A total of 303 staff attended these training courses. However, only 4 of the places were taken by colleagues from partner agencies. Over a third of the total number of places on the modular training (108) was for Community Safety related subject areas which underlines the success of the Community Safety Resource Pack and Training launched in 2012.
Police	In 2013, Hampshire constabulary organised seminars for officers covering a number of themes in mental health including Restraint, Patient Violence within a Health Setting; Transport, Section 135 Mental Health Assessments, Mental Capacity Act, Autism Awareness, Care Plans, Section 136 MHA . These have been opened up to colleagues from other agencies.
University Hospital Trust Southampton	UHTS care groups are required to undertake multi professional DOLS and MCA training as part of statutory and mandatory training days. Face to face training on MCA is delivered on the half rolling days on a monthly basis for senior nurses and medical staff. Publicity and awareness material has been produced for medical staff in the form of a business card and poster campaign which is provided on their induction training (x 2 cohorts per user). MCA, DOLS and safeguarding training x 2 sessions has been delivered to overseas nurses and foundation degree students. MCA, DOLS and safeguarding is included in the induction training for overseas nurses. The Trust provides online training for MCA/DOLS and safeguarding. The DOLS component will be updated over the coming year. The Trust's DOLS process has been updated and publicised on the intranet and DOLS training is available to individuals when they apply for a DOLS in their area.

Agency	What's available?
Solent	Solent's corporate induction course covers Safeguarding Adults MCA/ DOLS and are also addressed in the Essential Training updates all staff are required to undertake every two years. The Trust also makes available to clinical staff half day courses on Disclosures and Raising Alerts and Safeguarding and the Law which covers information sharing, MCA and Best Interests. A full day Mental Health Act course is also available for relevant staff groups. Bespoke training is also provided to small clinical groups on safeguarding adults. PREVENT Health WRAP has been provided for approx 1560 staff across the Trust.
Southern Health Foundation Trust	In SHFT mandatory training is delivered at two levels and is supported by a structured programme of professional development: Level 1: Non-clinical staff attend an Integrated children and adults session (day 2 of corporate Induction); e-learning refresher and bespoke face to face sessions as required. Level 2: Clinical staff attend a Children and Adults session (day 4 of corporate Induction which includes MCA & DOLS); Children and Adults session (as an Essential Training Day which includes MCA & DOLS). Level 3: Advanced Safeguarding Adults (a one day optional session); Advanced Safeguarding Children; Mental Capacity Act & DOLS; Domestic Violence & Abuse (incorporates MARAC & CAADA-DASH approved training). Level 4: SCC Modular training and HCC 6 day assessment and investigation training. Additional courses are available: PREVENT Short Health WRAP; Safeguarding Adults Road Show (adapted for delivery in adult mental health, learning disability and community health services).

Agency	What's available?
South Central Ambulance Service	SCAS have developed a Trust wide face to face training programme on mental capacity which includes DOLS with in an emergency setting. This is being delivered to all front line staff and will be completed by the end of December 2013.
Housing	A total of 479 members of front line and support staff completed Safeguarding Children and Adults Awareness Training in 2011-12 run by Solent University. Office based staff were sent the presentation and asked to fill in a checklist at the end to confirm completion. Frontline staff included all trade staff; supported housing staff; Neighbourhood Warden; Community alarm Service; Tower block Wardens; Housing Managers and support staff. All office and business support staff also attended this training.

7. SSAB Actions and Priorities 2013/14

7.1 As the Business Plan Review shows, there has been a significant amount of progress and success in achieving the goals set by SSAB in its Business Plan. This has been achieved through strong and collaborative leadership by the Board and the on-going commitment of partner agencies to work together to achieve these goals. It is clear however, that the work must continue and for the coming year SSAB will be focusing on the following priorities:

Board management:

- Produce a Safeguarding Strategic Plan each financial year setting out how it will protect people at risk of harm and what each member organisation will be doing to implement the strategy. The Strategy will be developed in consultation with Health Watch and the local community.

- Review Board membership to ensure service user and family carer representation, Lead GP, Health Watch, Crown Prosecution Service and the Police and Crime Commissioner.

- Member organisations to conduct the Safeguarding Organisational Self Assessment and collated results reported to SSAB.

- SSAB to participate in the LGA Peer Review.

- At the end of the financial year, publish an annual report in May 2014 on its achievements, members' activity and findings from any Serious Case Reviews.

- Update the SSAB Media and Communications Protocol.

- Produce a SSAB Dispute Resolution Protocol.

- Review Task and Finish Groups to reflect 2013/14 Priorities.

Governance:

- Implement clear reporting arrangements and assurance that safeguarding is embedded in the strategies and plans of the Council and its partners.

- Maintain clear links with the Overview and Scrutiny Committee, Cabinet and portfolio holders.

- Regularly review governance arrangements to anticipate and quickly respond to outside organisational changes.

- Finalise and implement the Serious Case Review (Safeguarding Reviews) process and reporting arrangements.

- Implement a process for keeping track of action plans and implementation of recommendations

- Actively monitor the implementation and impact of local action plans regarding Winterbourne View and the Francis Report.

- Implement a Pilot the 'Learning Together' (Systems Learning Approach) for cases with bad outcomes but falling short of SCR criteria.

Robust performance monitoring and quality assurance mechanisms:

- Implementation of the Integrated Dashboard

- Implementation of User Feedback Tool

- Implementation of a multi agency + single agency safeguarding audit programme.

- Development of pan Hampshire approach and shared I statements

Operational Developments

- Development and implementation of a joint triage process between Adult Social Care, Police and Adult Mental Health
- Implementation of the Fire Safety Action Plan and Fire Deaths Review process
- Implementation of the Safety Net pilot
- Implementation of the user feedback process
- Implementation of the Well Being Trigger Tool.
- Undertake an audit from the NHS Trusts of concerns raised and the decision making regarding safeguarding referrals.

Partnership working

- Maintain corporate links with the Local Safeguarding Children's Board, Safe City Partnership and Learning Disability Partnership Board to ensure the work of the SSAB and each of these boards is mutually compatible, both strategically and operationally.
- Links and regular meetings with Hampshire 4LSAB's via the Inter Authority Management Committee.
- Regular meetings of the Hampshire 4LSAB chairs and board managers to develop a joint work programme.
- Links with Regional and National Safeguarding Leads Networks.

Workforce Development:

- Review the multi agency safeguarding training strategy.
- Increase partner agencies uptake of Southampton Modular Training.
- Develop a Hampshire 4LASB training strategy and provision
- Pilot Safeguarding Competency Framework
- Provide multi agency safeguarding workshops for managers to ensure ethical and legal literacy around safeguarding.
- Set up a multi agency professional safeguarding practice development forum.
- Revise training programmes and materials re updated 4LSAB Safeguarding Policy.
- Publish multi agency practice guidance on responding to financial abuse.

8. Recommendations

8.1 SSAB to endorse and ratify the Annual Report.

8.2 Once the Annual Report is ratified, SSAB to establish a small Task and Finish to develop the action plan to enable the priorities highlighted above to be realised, to agree a work programme for the coming year and to assign lead roles amongst member organisations. Implementation of the action plan should be and contributions from member organisations secured as appropriate.

8.3 The Annual Report to be presented at a range of senior management and strategic forums as follows:

- SSAB Independent Chair to present to People Director, Overview and Scrutiny Committee, Council Management Team and Health and Wellbeing Board.

- SSAB member organisations to present to chief officers and relevant strategic forums within their own organisations.

8.4 SSAB to agree (in accordance with the SSAB media protocol) a media release to promote the positive work on safeguarding at a local level highlighted in the report.

8.5 A SSAB development day to be held in January 2014 to review progress and to ensure appropriate arrangements are in place for April 2014 when the Board is placed on a statutory footing.