

ANNUAL REPORT

2020 - 2021

Southwark Safeguarding Adults Partnership



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Foreword



It is my pleasure to introduce the Southwark Safeguarding Adults Board's annual report 2020/21. This report covers an unprecedented year during which we were in the midst of the COVID-19 pandemic, which has raised the profile and importance of adult safeguarding to a new level. COVID-19 has had a significant impact on our more vulnerable.

Despite the impact of the pandemic, the Board and its subgroups have continued to operate on a virtual basis; Board members have also participated in many meetings and forums designed to monitor and respond to the impact of the virus, to ensure that the health and well-being of adults with care and support needs is prioritised and that lessons are learnt.

This annual report provides information as to what has been achieved in Southwark and includes updates on priorities and learning. This is built on a robust audit programme and performance data and evidences good progress with regards to the safeguarding priorities identified in 2019/20.

We will continue to build on those successes to set the priorities for the future. We will do this by building positive learning opportunities into practice. We will particularly listen to the voice and influence of our communities and service users, and this will be reflected in the priorities of the Board.

The challenges brought about by the past year and the COVID-19 pandemic, have further emphasised the benefits we can derive from proactive collaborative partnership working. We are extremely proud of the way our partners responded and as we work towards a period of recovery, we recognise the vital role the SSAB will continue to play in coordinating a robust safeguarding response.

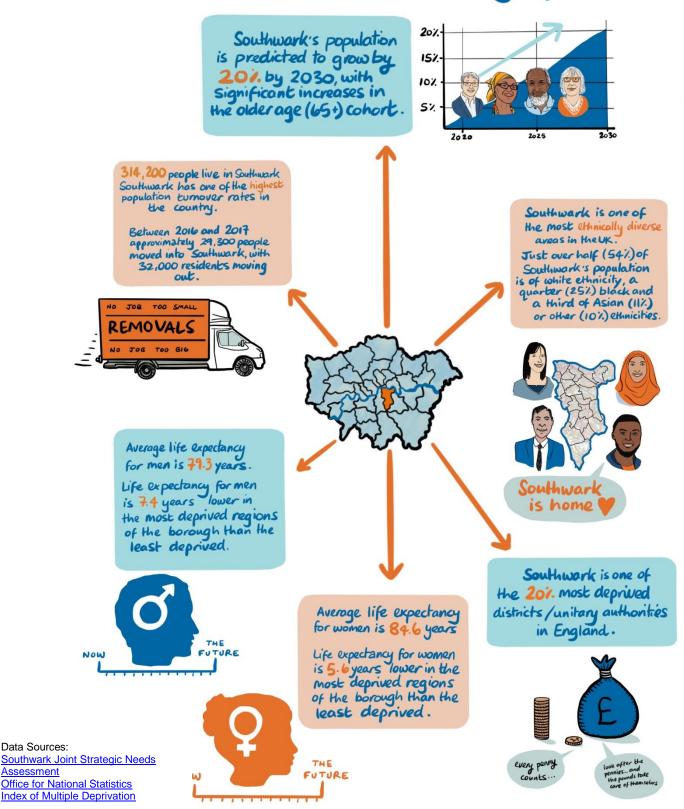
Finally, I would like to thank the team that has supported the work of the Southwark Safeguarding Adult Board, Cabinet elected members, board members and all of the staff who work in this challenging and complex area.

Anna Berry Independent Chair, Southwark Safeguarding Adults Board (SSAB)



1. The Southwark Local Safeguarding Context

Southwark Adult Demographics



Data Sources:

<u>Assessment</u>



2. The Board

Our vision

We believe all adults at risk that are living in or visiting Southwark have the right to be safe and protected from harm. We will all work together to support these adults and their carers to make informed choices and to provide the highest quality services so they can live full, independent and self-determined lives.

Southwark Safeguarding Adults Board's primary objective is to assure itself that local safeguarding arrangements and partners act to help and protect adults who are at risk of/or experiencing abuse or neglect.

The Board will hold agencies to account for their key safeguarding responsibilities, so that:

- All those who work with vulnerable adults know what to do if there are concerns about possible harm or abuse.
- When concerns are raised regarding an adult who is vulnerable to harm / abuse, action is taken in a timely manner and the right support is provided at the right time.
- Agencies which provide services for vulnerable adults ensure they are safe, and monitor service quality and impact.

Key strategic questions for the Board

- Is the help provided effective? How will we know our interventions are making a positive difference? How will we know all agencies are doing everything they can to make sure vulnerable adults are safe?
- Are all partner agencies meeting their statutory responsibilities as set out in The Care Act (including Empowerment, Prevention, Proportionality, Protection, Partnership and Accountability), Mental Capacity Act and Deprivation of Liberty Safeguards?
- Do all partner agencies quality assure practice and is there evidence of learning and improving practice?
- Is safeguarding training monitored and evaluated and is there evidence of training impacting on practice? This includes multi-agency training.



2.1 Our Partners

Partnership work is vital to the successful delivery of safeguarding services and interventions in Southwark. We remain confident that safeguarding is at the heart of the services delivered by statutory and voluntary services in Southwark, and we also remain committed to maintaining an open dialogue with all our partners, and working jointly with partners to ensure the best, person-centred outcomes to protect adults who are vulnerable to harm / abuse.

SSAB Membership

Southwark Council
Cabinet Member for
Children, Schools
and Adult Care
Cabinet Member for
Community Safety
and Public Health
Strategic Director of
Children and Adults'
Services
Strategic Director of
Housing and
Modernisation
Strategic Director of
Environment and
Leisure
Director of Adult
Social Care
Director of
Communities
Director of Public
Health
Director of Resident
Services
Director of
Commissioning,
Children and Adults'
Services
Assistant Director,
Community Safety
and Partnerships
Principal Social
Worker for Adults
· · · ·

CCG/NHS	
Place-Based	
Director (CCG)	
Designated Nurse	
for Adult	
Safeguarding	
(ČCG)	
Named GP for	
Adult	
Safeguarding	
(ČCG)	
Head of	
Safeguarding	
Adults (GSTT)	
Safeguarding	
Adults Lead	
(KCH)	
Safeguarding	
Adults and	
Prevent Lead	
(SLaM)	

Police
Chief
Superintendent
Southwark and
Lambeth BCU
Detective
Superintendent –
Head of Pubic
Protection

Other Organisations
Borough Commander,
London Fire Brigade
S
Head of Probation
Service, Southwark
,
London Community
Rehabilitation
Company
5 5 p s y
CEO, Community
Southwark
Children and Family
Court Advisory and
Support Services
(CAFCASS)
Provider
Representatives
112 112 114 1

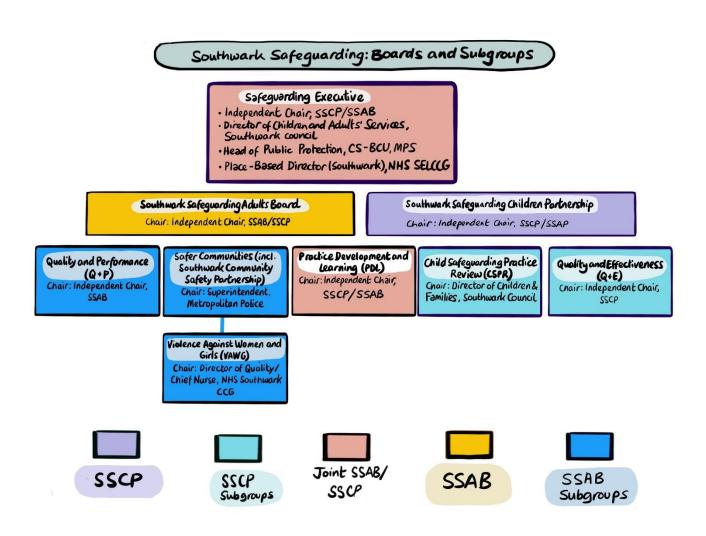


2.2 Governance Arrangements

During 2020/21 Southwark Safeguarding Adults Board (SSAB) held four main meetings, including one joint meeting with the Southwark Safeguarding Children Partnership (SSCP). The Board has a number of subgroups, illustrated in the diagram below, which meet quarterly.

Anna Berry is the independent chair of both the SSAB and SSCP.

To ensure the Board fulfils its duties effectively, our membership is made up of senior officers from across the partnership who are able to promote the respective priorities of the organisations around the partnership.





2.3 Communications

It is vital that key messages are cascaded to front line staff and as a partnership we are committed to continually strengthening our approaches to this. As a result, during 2020/21, a quarterly newsletter was established jointly with the SSCP. This is circulated to all members of the Board and subgroups, and shared widely with partners, including the community and voluntary sector. Copies of the newsletter can also be accessed from our website.

2.4 Our Subgroups

Practice Development and Learning Subgroup (joint with SSCP)



The Safeguarding Practice Development and Learning (PDL) subgroup is a joint subgroup of the SSCP and SSAB. It is chaired by the SSCP/SSAB Independent Chair.

The Board is committed to promoting a culture which values and facilitates learning and in which the lessons learned are used to improve future practice and partnership working. This approach facilitates robust mechanisms to review, analyse and develop practice. We are confident that our approach to learning and development drives improvements in the wider safeguarding system as well as in the outcomes experienced by users of services.

Traditionally there has been an emphasis on "training" and although uptake of training programmes can be measured, we require further assurance as to the impact this has on practice. As a result, during the latter part of the year a review of our current model commenced and as we move into 2021/22 we will transition in to a strengthened approach where learning is embedded in the culture of all safeguarding practice.

Safer Communities Subgroup

The Safer Communities Subgroup is our local Community Safety Partnership. The role of the group is to oversee multi-agency responses and provide a problem-solving approach to community safety issues by sharing information and ensuring activity is taking place to protect individuals and communities from crime and disorder.

The subgroup is proactive in promoting awareness, learning and good practice, and in establishing links with partnership organisations. It is chaired by a Metropolitan Police Superintendent.



During the year, the group focussed on the impact of COVID-19, including holding a special meetings to focus on Domestic Abuse and violence against women and girls (VAWG).

The subgroup is also responsible for overseeing Domestic Homicide Reviews (DHR) processes in Southwark. For more information on DHRs, please see section 4.2.

Quality and Performance Subgroup

The purpose of the Quality and Performance Subgroup is to provide the Safeguarding Adults Board with assurance around the quality and effectiveness of the safeguarding responses within Southwark, and through this to improve effectiveness. One of the key assurance pieces of work undertaken was the safeguarding self-assessments: the key themes from these audits are reported on below. In addition, this subgroup drives forward the priorities of the SSAB, such as the development and roll out of the complex case pathway and the domestic abuse deep dive.

The subgroup is also responsible for overseeing the Safeguarding Adults Review (SAR) process. For more information on SARS, see section 4.1.

Work is ongoing to review the existing performance dashboard and align it with the Board's agreed priorities.

Safeguarding Adults Partnership Audit Tool (SAPAT)

Under the Care Act (2014), Safeguarding Adults Boards must have an audit process to monitor and evaluate their performance and that of the member organisations. The SSAB disseminated a self-assessment audit tool to all partner agencies and following submission, held a multi-agency Challenge event.

Key themes from the 2020/21 SAPAT:

Engagement across the partnership strengthened during the pandemic; for instance, online meetings improved attendance levels and innovative approaches to training were adopted.

Conversely, the period also brought its challenges, with concerns about capacity and demand issues, and the increase in mental ill health, loneliness and isolation. Partners were also concerned about ways to support the resilience of the workforce.

There were also challenges arising from the restructuring of agencies, for example the amalgamation of probation services, and the CCG move to an integrated care system (ICS).

Areas identified for improvement included:

- How learning is embedded in frontline practice, and how the Board can be assured that it is having an impact.
- How the voice of people with lived experience can best be taken into account in the work of the SSAB.
- Promotion of safeguarding across communities in Southwark.

These areas will be driven forward by the Board subgroups during 2021/22.



2.5 Financial Arrangements

Contribution	Total
Police (MOPAC)	£5,000
NHS Southwark CCG	£55,000
London Fire Brigade	£500
London Borough of Southwark	£63,421.50
Total from contributions	£123,921.50

SSAB receives financial contributions from a number of agencies and other forms of in-kind support. Money received in 2020/21 is detailed here.

2.6 Core Adult Safeguarding Data

During 2020/21, 1,558 adult safeguarding concerns were received – a 17% increase on the number received in 2019/20.

436 S42 safeguarding enquiries and 29 non-statutory enquires were commenced, involving 402 individuals – a decrease of 12% overall on 2019/20.

The concern to enquiry conversion rate for the year was 30%, compared to the 2019/20 average of 37% for England and 39% for Southwark.

Risk was identified in 77% of cases, and, of those cases, risk was reduced or removed in 92%.

Of the individuals who were asked to define the outcome they wanted from the enquiry, 60% expressed their desired outcome.

Where a desired outcome was expressed, individuals felt this had been fully or partially achieved in 93% of concluded enquiries.

The introduction of a new case audit framework will enable Adult Social Care (ASC) to select specific areas of safeguarding for themed audits across service areas. For instance, where individuals are subject to more than one safeguarding enquiry in the year, these cases will be looked at further. We also plan to gain more understanding of the type of cases which come under non-statutory enquiries.

In line with Making Safeguarding Personal (MSP), Adult Social Care plan to look into the correlation between individuals under S42 enquiries, who lack mental capacity, who require advocacy support and whose desired outcomes are not detailed. We will be launching a Making Safeguarding Personal information leaflet and a questionnaire for collating feedback.

Concerns and Enquiries	Total	S42	Oth
•			
Safeguarding concerns received	1,558	-	-
2. Safeguarding enquiries commenced	465	436	29
3. Rate of Concerns to Enquiries	30%	-	-
Safeguarding enquiries concluded	458	421	37
5. Safeguarding enquiries concluded within 30 days	330	302	28
%age of enquiries	72%	72%	76%
6. Concluded enquiries where the individual assessed as lacking capacity	108	102	6
7. Safeguarding enquiries concluded where risk was identified	351	327	24
%age of enquiries	77%	78%	65%
8. Where risk identified - risk reduced or removed	324	301	23
%age	92%	92%	96%
Safeguarding enquiries for which the individual expressed desired outcomes	275	258	17
%age of enquiries	60%	61%	46%
10. Safeguarding enquiries for which the individual's expressed outcomes were fully or partially achieved	256	239	17
%age	93%	93%	100%



Core DOLS Activity

	2019- 20	% of total	2020- 21	% of total
Total applications received	1035	total	769	total
From Care Homes	643	62	475	62
From Hospital	392	38	294	38
Granted	781	75	252	33
Not Granted	220	21	204	27

Following the publication of the DHSC COVID guidance for MCA/DOLS in April 2020, Southwark DOLS assessors have undertaken remote assessments and refer to previous evidence where appropriate. We continue to review our local position via benchmarking with other local authorities and consulting our assessors about returning to face-to-face assessments.

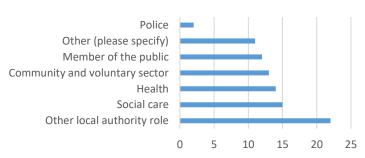
A Liberty Protection Safeguards (LPS, replacing DOLS / Deprivation of Liberty Safeguards) project brief and action plan is under regular review, in consultation with

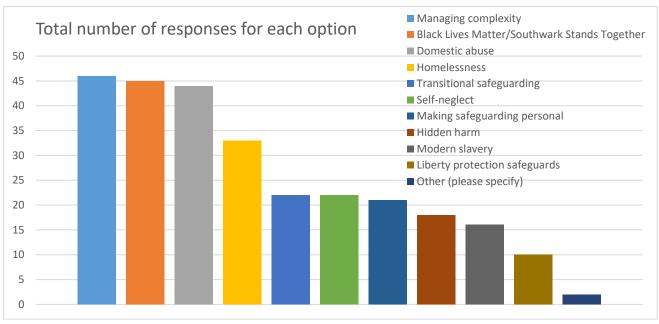
senior stakeholders across ASC. Essential communication is shared with colleagues in Adults and Children's social care, Education, Commissioning, Legal and Finance colleagues, as well as CCG and provider forums. Further partnership work will progress with the planned publication of the Code of Practice and Regulations late in 2021 for consultation, in line with the revised implementation date of 1 April 2022.

3. Our Priorities

At the beginning of 2020/21, the SSAB undertook a consultation with partners to ascertain wider views on what should be the SSAB priorities for the forthcoming year and why. Despite us being at the height of the pandemic, we received a total of 90 responses; the majority being from front line staff.

Total number of responses by agency







Following the consultation and a priority setting focused SSAB meeting, the following three priorities were agreed:

- 1. Domestic Abuse (joint with SSCP)
- 2. Managing Complexity
- 3. Homelessness

The Board also felt there should be three cross-cutting themes running across all of the priorities:

- 1. COVID-19
- 2. Black Lives Matter / Southwark Stands Together
- 3. Making Safeguarding Personal

It was agreed that these priorities should run until March 2022. While the partnership will work on all the priorities during this period, there will be a quarterly focus on particular priority areas.

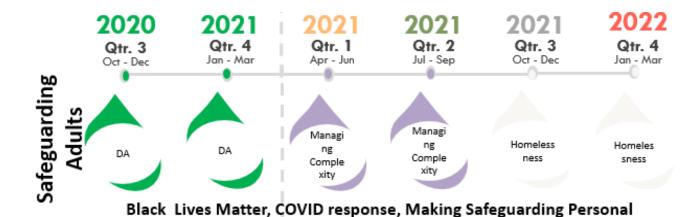


Quotes from survey respondents:

"BLM is something that everyone needs to focus on"

"...issues are on the increase as a result of the pandemic and a change in peoples' social interactions."

Quarterly areas of focus





3.1 Domestic Abuse



"Domestic violence often keeps victims in situations that perpetuate poor mental & physical health, substance misuse; and also creates a new generation of victims if children are present in the family."

The SSAB acknowledged that Domestic Abuse (DA) has many interconnectivities to other complex behaviours and situations and thus in order to be effective, it was important to identify specific areas of focus and development. The SSAB held a mirror up to itself and identified some specific areas of challenge:

- Challenge Can we be more proactive and preventative and intervene earlier?

 Action A stocktake of what is on offer across the partnership what works well? What could be strengthened?
- Challenge are we assured that older victims victims are sufficiently identified and supported?

Action – a data collection / deep dive / thematic review into this area.

A task and finish group has been established in year to take this work forward, and the outcome of this will be reported in 2021/22.

3.2 Managing Complexity

"...many people may require support but don't fit classic criteria for social services input, or because they are deemed to have capacity to refuse, options become very limited."

Local, regional and national SARs have highlighted significant learning around managing complexity.

There is often concern that an individual's lifestyle choices or behaviour are likely to result in serious harm, or even death, and current agency involvement has not been effective in managing the risk.

Some of the themes are: complex illnesses and disabilities including mental health issues, dementia, complex trauma, learning difficulties/disabilities, long term physical health needs and people with chronic self-neglecting behaviour. These cases can be high risk and indicate a need for a coordinated response.



The Board are keen to promote a multi-agency approach to the assessment and management of risk for adults who appear to have capacity, may have care and support needs and who are deemed to be at high risk of serious harm or even death, and multi-agency escalation is required. In conjunction with neighbouring SABs, Southwark SAB have begun developing a Complex Case Pathway to ensure a consistent multi-agency approach to managing these cases.



The Board recognises that this issue has been particularly highlighted during COVID-19.

There are multiple risk factors and correlations between the other agreed priorities. Some of the factors associated with homelessness that could result in serious safeguarding concerns include: drug and alcohol misuse, mental health needs, the lack of availability of accommodation, the impact of family breakdown, the incidence of domestic violence and abuse, the influence of criminality and involvement in the criminal justice system.

Board members want to see a focus on homelessness from a preventative perspective. Consideration will be given to the development of a partnership risk assessment tool together with the development of a pathway for homeless people/ rough sleepers that will ensure that needs are being met in the best possible way by all agencies, thus facilitating the response to safeguarding concerns.



4. Learning from Case Reviews

4.1 Safeguarding Adults Reviews (SARs)

The SSAB must carry out a SAR when an adult at risk dies or is seriously harmed, and there is concern that partner agencies could have worked more effectively to protect them.

Four cases were considered during 2020/21, and two were deemed by the partnership to meet the criteria for a SAR.

These reviews are close to completion, and will be published in 2021/22. The Board is taking forward relevant learning from both reviews.

In the past two years we have tragically lost two of our residents to fire. While these cases were not felt to meet the criteria for a SAR, the Board agreed to carry out a thematic review into these deaths to identify any commonalities and lessons to be learned. This review will be completed in 2021/22.

4.2 Domestic Homicide Reviews (DHRs)

The Community Safety Partnership, which sits within the SSAB, must carry out a Domestic Homicide Review (DHR) if someone aged 16 or over dies as a result of violence, abuse or neglect by someone they were in a relationship with or someone who was a member of the same household. The aim of these reviews is to improve responses to domestic violence across the partnership.

Tragically, we lost one of our residents to domestic violence in 2020/21. A review into the death has commenced, but has been delayed to allow criminal proceedings to be completed, and thus will be reported on fully in 2021/22. Southwark are also contributing to two reviews led by other boroughs: in both cases the perpetrator was a resident in Southwark.

Despite these reviews not yet being completed or published, once learning is identified, it is shared across the partnership, and action plans are monitored and progressed in a timely manner.

4.3 Learning Disability Mortality Reviews (LeDeR)

The Learning Disability Mortality Review (LeDeR) programme was set up by government to ensure that possible learning opportunities from circumstances leading to individual deaths are captured and shared. All deaths of people with learning disabilities aged four and over must be reviewed.

LeDeR is reported annually and the key themes are presented to the Quality and Performance subgroup; learning is then cascaded via the Practice Development and Learning subgroup.

During 2020/21 key themes, learning points and recommendations from these reviews included:



- Closer collaboration and integration amongst health and care teams regarding people living with learning disabilities and autism.
- To consider training in national health and social care curriculums for understanding learning disability and autism.
- The wider health and social care workforce should ensure they fully understand the complexities of identifying and working with people with learning disabilities.
- A stronger emphasis on the delivery of the actions coming out of the reviews and holding local systems to account for delivery, ensuring there is evidence of service improvement locally.

5. Looking Ahead 2021/22

At the end of the year SSAB members undertook a facilitated session that focused on what the partnership could strengthen and improve during the coming year. Their responses can be grouped into the following areas:

Learning and Development

- Embedding a learning culture
- Effectiveness of current learning model

Assessing Impact

- Benchmarking
- Outcome focused approach
- How do we know we are effective?

Communication and Engagement

- Improved communication to front line staff
- Voice of the service user
- Practitioner voice
- Engagement

As we head into 2021/22, a review of the effectiveness of our current arrangements will be undertaken to ensure our structure fully supports the areas of development identified above. Areas of focus will include strengthening the current structure to include a Violence Against Women and Girls (VAWG) subgroup and a SAR subgroup. This review will be completed in 2021/22, and the outcomes will be reported in our next annual report.



Contact information

If you have any questions about the content of this report, or thoughts about what we should include in future reports, please contact ssab@southwark.gov.uk.

If you are concerned about an adult at risk in the borough of Southwark you should notify us immediately on OPPDContactteam@southwark.gov.uk.

If the adult has been injured you should seek advice from their GP, or in an emergency call 999.

If you believe a crime has been committed you should notify the police.

