Southwark Safeguarding Adults Partnership

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Foreword

Message from the Chair

It is my pleasure to introduce the Southwark Safeguarding Adults Board's (SAB) annual report 2021/22. The aim is to provide insight to the activity over a 12-month period, and the collective response of our partners within the SAB. It has been positive to observe continued collective approach through the work of the Board at a strategic level and within the subgroups, and the content of this report provides assurance on that commitment and activity.

The report articulates the review of the overarching governance arrangements that have been implemented to strengthen the effectiveness of the Safeguarding Adult Board, enhance the community engagement and drive forward local and national learning into practice. This includes hearing the range of voices of members and stakeholders, establishing and working together on co-produced priorities, connecting SAB sub-groups firmly into a shared vision and work plan.

Work throughout the year has been informed by the wider (and local) evidence base in adult safeguarding and includes surveys and consultations across stakeholders and its membership which demonstrates a commitment to inclusivity. Looking forward, the SAB will build on this foundation to facilitate further feedback and challenge from the wider community to really develop methods of engagement and explore lived experience.

Over the past year, the areas of focus included homelessness, complex safeguarding and Domestic Violence and Abuse and this report articulates the breadth of work that has been done and continues to be embedded and measured. The revised arrangements have allowed for strengthened approaches to Safeguarding Adults Reviews (SARs) with particular emphasis on how the learning impacts practice and outcomes. Seeking assurance that local safeguarding arrangement help to protect adults from abuse and neglect is the main objective of a SAB and further development throughout the coming year will strengthen the methodology for continual assurance.

I would like to thank the team in its very widest sense for their tireless commitment to the work of the SAB.

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

The Southwark Local Safeguarding Context

Southwark Adult Demographics

In 2021, Southwark's estimated population decreased by over 12,000 people compared to the previous year

The census was taken during the COVID-19 pandemic, with respondents required to answer questions based on their place of residence on Census Day. At this time many COVID-19 restrictions were still in place

Though there was an overall increase (18%) in numbers of residents aged 90+ over the past 10 years, the 2021 year saw a substantial drop of 22% when compared to 2020

Southwark's usual resident population on Census Day 2021 was 307,700, an increase of 7%, or 19,400 people since 2011

The number of adults aged 55 to 70 in Southwark between the 2011 and 2021 Census was up by 12,500 people, or 47%

Southwark Safeguarding Adults Partnership

1. 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.

1.1 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.

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.

SSAB Membership

Southwark Council	ICB/NHS	Police	Other Organisations
Independent Chair, SSAB	Chief Operating Officer, Southwark, SELICB	Chief Superintendent Southwark and Lambeth BCU	Borough Commander, London Fire Brigade
Strategic Director of Children's and Adults Services	Designated Nurse for Adult Safeguarding (ICB)	Detective Superintendent - Head of Public Protection	Head of Probation Service, Southwark
Strategic Director of Housing and Modernisation	Named GP for Adult Safeguarding (ICB)		Community Southwark
Strategic Director of Environment and Leisure	Head of Safeguarding Adults (GSTT)		Provider Representatives
Director of Adult Social Care	Safeguarding Adults Lead (KCH)		
Director of Communities	Safeguarding Adult and Child Lead (SLaM)		
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			
Cabinet Member for Community Safety			
Cabinet Member for Council Homes and Homelessness			
Cabinet Member for Health & Wellbeing			

1.2 Governance Arrangements

During 2021/22 the Independent chair of Southwark Safeguarding Adults Board (SSAB) undertook a governance review with a focus on whether our current arrangements had a strong focus on holding agencies to account for their safeguarding activity. There was an emphasis on quality assurance, learning and improving practice, ensuring a feedback loop across all agencies and with the frontline was evident.

The purpose of the review was to ensure the SSAB achieved the following functions;

- Sharing, promoting, and embedding learning
- Assurance of the effectiveness of safeguarding practice/ services
- Independent oversight
- The voice of the service user / people with lived experience

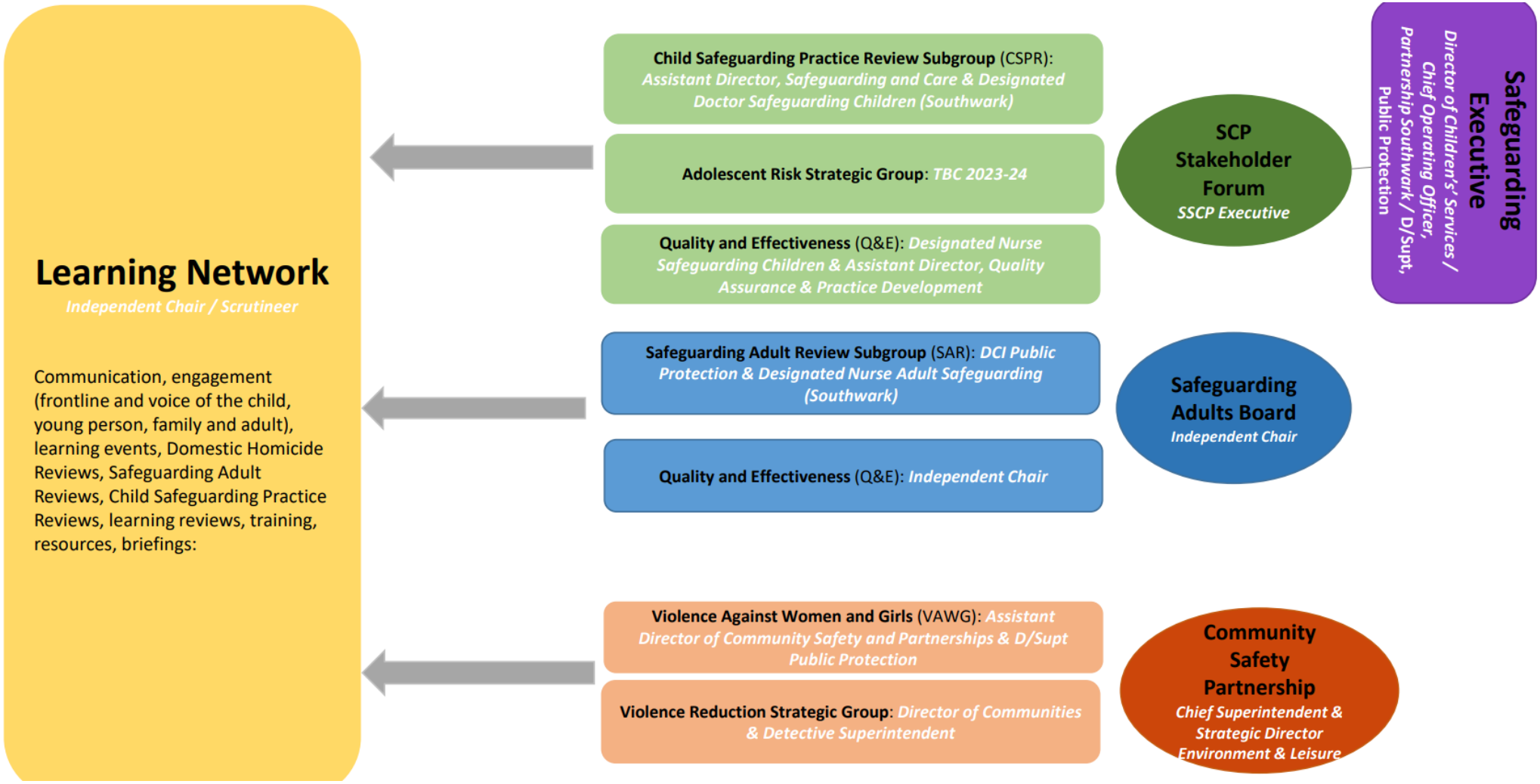
As part of the governance review, consultation took place across the partnership with focus groups being held with the following groups:

- Safeguarding Executive Group
- Health, including ICS representatives and provider organisations
- Police
- Adult Social Care
- The VCS
- Community Safety
- Public Health
- The consultation was communicated widely to all sub-groups and comments invited.

The review considered the connectivity between the Southwark Safeguarding Adult Board (SSAB), the Southwark Safeguarding Children Partnership (SSCP) and Southwark Community Safety Partnership (CSP) and how they can operate effectively in terms of Safeguarding by being clear on respective roles. These could be considered as the three core partnerships integral to safeguarding practice and thus the focus of the review was to ensure that the arrangements demonstrated a commitment to cross partnership working, the connectivity across the sub-groups was strengthened and a shared learning function was implemented.

Southwark Safeguarding Adults Partnership

Refreshed Governance Structure 2021/22



1.3 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 2021-22 we circulated 3 newsletters, containing key safeguarding messages. These were shared widely with partners, including the community and voluntary sector.

The SSAB remains committed to promoting a culture which values and facilitates feedback from front line staff and users of services but acknowledges this is an area that would benefit from being strengthened. With that in mind, a key work stream for the newly established Learning Network is the development of a communication and engagement plan. This plan will embrace the 'think family' approach and engage with service users, families and wider community. We will challenge ourselves to identify the best way to share messages with the public and professionals and to capture the voice of service users and residents.

Looking ahead to 2022 – 23;

- We will ensure that we ask the frontline staff in Southwark what is working well for them and where there are challenges or barriers.
- We will engage with people receiving services in Southwark and learn from them what works well and what could be improved
- We will consider the best techniques and create innovative methods to get key messages out, including the use of social media, roadshows, themed events and videos.
- We will not overcomplicate messages as we recognise that safeguarding can feel daunting and complex to many frontline staff.

1.4 Our Subgroups

Learning Network

The Learning Network subgroup is a joint subgroup of the SSCP and SSAB. It is chaired by the SSCP/SSAB Independent Chair. Following the governance review and development of a new structure, there has been a transition away from focusing on training, towards a renewed focus on the implementation of learning, developing communication and seeking assurance. The establishment of the learning network will enable a strengthened approach where learning is embedded in the culture of all safeguarding practice.

The SSAB 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.

During 2021/22 this network has focused on aligning our Quality Assurance processes for adult and children carefully with our learning approach to ensure that we are able to measure effectively the changes that we embed across the partnership. In addition, the network has reviewed its multi-agency safeguarding training offer, ensuring it is relevant to the partnership priorities whilst recognising that this is only one part of embedding learning into practice.

A key work stream of this group has been the development of a referral pathway to enable other subgroups and professionals to advise the network of key messages that need cascading and embedding. To support this, a ‘7 minute briefing’ template has been developed and is being utilised for learning from safeguarding Adult Reviews (SARs) in particular.

Looking ahead into 2022/23 this network will be focusing on its Communication and Engagement Plan to ensure engagement with both frontline staff and people receiving services in Southwark, to enable a better understanding of what is working well for them and where there are challenges or barriers.

Quality and Effectiveness Subgroup

The purpose of the Quality and Effectiveness 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.
Work is ongoing to review the existing performance dashboard and align it with the Board's agreed priorities.

One of the main areas of focus for this subgroup is the safeguarding Adults Partnership Audit Tool (SAPAT), which all partners complete annually. This group identifies the key themes from the assessments which informs the priorities for the forthcoming year. In addition, the group has driven the recruitment to the London Safeguarding Voices Group (LSVG) to ensure that people with lived experience of safeguarding and their voices are at the heart of governance and practice. Whilst the recruitment process locally was unsuccessful, we continue to benefit from the London wide initiative. In addition the group has undertaken a thematic review into domestic abuse, received updates on the development of the Integrated Care System, including their Safeguarding Governance and Accountability framework, as well as developed a Complex Case Pathway.

Safeguarding Adults Review (SAR) Subgroup

This is a newly formed subgroup, launched in the final quarter of 2021/22. Prior to its existence, this area of work was subsumed within the Quality and Effectiveness subgroup. However, it was acknowledged that to align with our commitment that the lessons we learn within Southwark, from national learning and the findings from reviews or other investigations will have a positive impact on frontline practice, it was essential that a standalone SAR subgroup was established. This group will review and discuss recommendations regarding learning from the National SAR Analysis and take forward priorities for sector led improvement as well as gain assurance from across the partnership with regards to SAR recommendations and action plans. Other emerging areas of focus as we move into 2022/23 include SARs in rapid time.

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, with a specific focus on areas held a multi-agency Challenge event.

The key themes that were identified from the 2021/22 SAPAT include:

1. Management of complex cases
    - The complex case pathway has been developed but next phase is embedding it into practice.

2. Engagement of Service users
    - Appropriate structures are required to enable those with lived experience to feed into reviewing and improving the systems in place in Southwark

3. Dissemination of learning from SARs
    - Partnership pathways to be formalised for embedding learning regarding from SARs, and for monitoring single agency and multi-agency action plans

These areas have begun to be addressed, and will continue to be driven forward by the subgroups of the Board during 2022/23.

1.5 Financial Arrangements

SSAB receives financial contributions from a number of agencies and other forms of in-kind support.

Money received in 2021/22 is detailed here.

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**

1.6 Core Adult Safeguarding Data

During the 2021/22 period Adult Social Care (ASC) received a total of 1400 concerns.

401 of the concerns received led the Social Worker to conclude that an enquiry was necessary. 75 cases were however managed under the guise of non-statutory enquiries.

ASC had plans in 2021 to deep dive in to the types of cases that constituted 'non-statutory enquiries'. This piece of work is now scheduled for 2023/24.

The conversion rate for concerns to enquiries was 29%, which is 2% greater than the previous year's figures but still 6% less than national figures which presently stand at 35%.

Risk was identified in 100% of the completed enquiries. Risk was subsequently reduced or removed in 94% of cases.

Of the individuals who were asked to define the outcome they wanted from the enquiry, 67% expressed an outcome.

In the instances where an outcome was expressed, individuals felt this had been fully or partially achieved in 98% of concluded enquiries.

It is important to note that a data cleanse has taken place since this period, meaning that figures presented to the board for 2020/21 have changed (please see the column highlighted below for updated figures). The data cleanse is part of an ongoing effort to improve the validity of the data that ASC holds. As

such, a comparative account with figures previously presented to the board would not be a true representation of any trends. Any comparisons made will instead be to newly cleansed data. New training was commissioned for Safeguarding Adults Managers (SAM) in 2020/21. The uptake for this during the 2021/22 period has however not been high. Attendance rates will be reviewed over the course of 2022/23 and consideration will be given to the frequency at which training should be repeated as this is not presently mandated.

It is noted that the desired outcomes recorded by individuals is relatively low at 67%. Through further analysis of a selection of the cases where no outcomes were recorded ASC have been able to identify that this may have been attributed to the following: clerical errors, mental capacity or unwillingness to contribute toward the enquiry. Further work will be done to promote Making Safeguarding Personal (MSP).

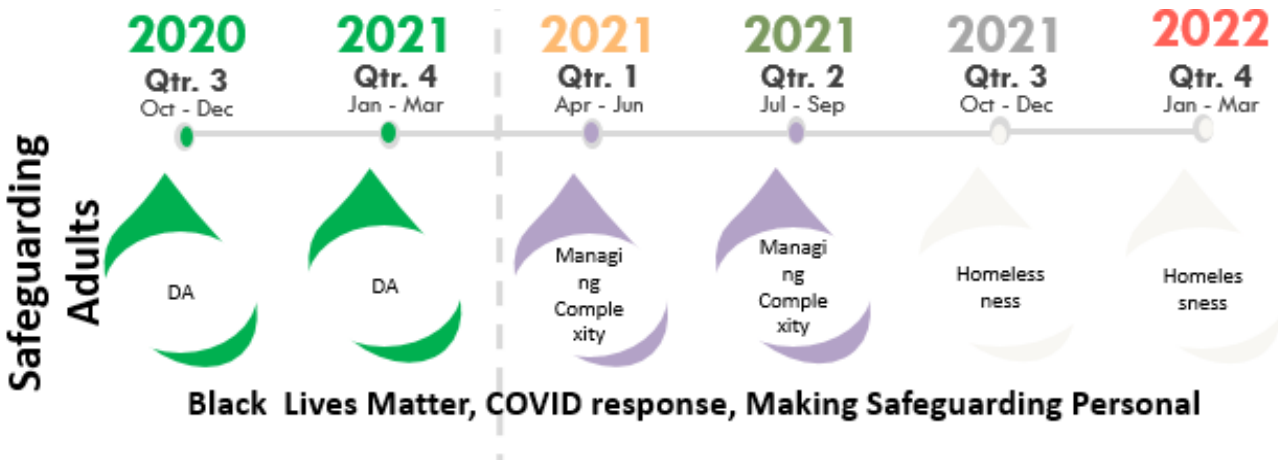
In 2020/21 the outgoing PSW and Safeguarding Lead planned to take deep dives in to specific areas in order to inform further analysis of practice and process review. The intention was to gain further understanding of the types of cases that constitute 'non-statutory' enquiries. As aforementioned this piece of work has been delayed until 2023/24 to allow for a review of the current safeguarding pathway. The review will initially focus on simplifying the workflow and changes to ASC forms. It is anticipated that the knock-on effect of these changes may have an impact on the percentage conversion rate of concerns to enquiries.

Concerns and Enquiries	2020/21 (Cleansed data)	2021/22	S42	Other
1. Safeguarding concerns received	1458	1400	-	-
2. Safeguarding enquiries commenced	398	401	326	75
3. Rate of Concerns to Enquiries	27%	29%	-	-
4. Safeguarding enquiries concluded	398	401	326	75
5. Safeguarding enquiries concluded within 30 days	285	277	220	57
% of enquiries	*72%*	*69%*	*55%*	*14%*
6. Concluded enquiries where the individual assessed as lacking capacity	94	100	91	9
7. Safeguarding enquiries concluded where risk was identified	398	401	326	75
% of enquiries	*100%*	*100%*	*81%*	*19%*
8. Where risk identified - risk reduced or removed	365	377	308	69
%	*92%*	*94%*	*77%*	*17%*
9. Safeguarding enquiries for which the individual expressed desired outcomes	325	268	217	51
% of enquiries	*82%*	*67%*	*54%*	*13%*
10. Safeguarding enquiries for which the individual's expressed outcomes were fully or partially achieved	244	263	213	50
%	*75%*	*98%*	*79%*	*19%*

2. Our Priorities

Due to the pandemic, the priorities for the previous year (2020/21) were not formally agreed until September 2020 to enable sufficient time to implement, and therefore it was agreed that the SSAB priorities would remain the same in 2021/22. While the partnership will work on all the priorities during this period, there will be a quarterly focus on particular priority areas as detailed below.

Quarterly areas of focus



2.1 Domestic Abuse

Sadly, domestic abuse affects thousands of people in Southwark every year. It is often hidden but its impact spans generations. Despite the successful work already undertaken locally, the Covid 19 pandemic and the imposed lockdowns had a negative effect on the number of domestic abuse incidents. During 2021/22 anecdotally partners were reporting an increase in family members abusing other family members within the home. In light of this, the SSAB, in conjunction with the SSCP undertook a thematic review to establish locally if there was there a noticeable trend of intergenerational abuse during Covid.

Although the review did highlight an increase, this increase was not as significant as predicted. It is possible that this could be attributed to an under reporting of such abuse. The vast majority of cases reviewed involved adult children abusing their parent and the findings highlighted that the parent often minimised the level of abuse and were reluctant to report to the police for fear of criminalising their child and / or making them homeless. Furthermore, the victim parent (usually the mother) and parenting ability was often the focus of the assessment and subsequent intervention, not the perpetrator of the violence and abuse. Responsibility was therefore, not being rightfully placed, with the focus being on the victim / survivor as opposed to the perpetrator. Following this identification, work is being undertaken to ensure this position is improved and our support offer is strengthened.

With the introduction of the new Domestic Abuse Act during 2021/22, the partnership focused on raising awareness and understanding about the devastating impact of domestic abuse on victims and their families and the implications the Act will have on everyday practice. There was a specific emphasis that domestic abuse is not just physical violence, but now also includes emotional, controlling or coercive and economic abuse. Partners of the SSAB, together with the SSCP and the Community Safety Partnership are working collaboratively to ensure all aspects of the Act are understood and implemented.

2.2 Managing Complexity

Findings from our recent Safeguarding Adults Reviews (SARs) have identified concerns about how agencies worked together effectively to support adults at risk of self-neglect, where the risks (both known and unknown) are increasing, and where providing support for the person is either challenging or those support pathways are unclear.

These risks and challenges can often be compounded as the adult may not meet the criteria for a formal adult safeguarding response, or the person may not be in receipt of a service with clear responsibility for overall care co-ordination that takes into account the entire well-being of the person, or the person may fall outside eligibility criteria for statutory services.

In response to this, the SSAB have developed a Complex Case pathway, which seeks to;

- promote a *pro-active responsibility to act* on the agency that identifies the concern,
- encourage the facilitation of multi-agency conversations about risk
- develop on-going consideration of risk and actions through the identification of a lead agency

During 2021/22 this pathway was launched and whilst it is still in its infancy, its use has demonstrated that the complex case pathway is a helpful tool in bringing agencies together to assess and manage risk in complex situations relating to self-neglect. The facilitation of multi-agency discussions provided an effective space for professionals to focus and think creatively about managing risk. Looking ahead to 2022/23, the partnership will embed the use of this pathway, together with reviewing its effectiveness.

2.3 Homelessness

During 2021/22 Southwark Safeguarding Adults Board requested an update to the Joint Strategic Needs Assessment (JSNA) on the health and wellbeing needs of Southwark's rough sleepers (December 2018) to include the current picture and the impact of COVID-19. This highlighted that during 2020/21, Southwark had the 6th largest population of rough sleepers in Greater London, with our rough sleeping population increasing by 83% from 2017/18 to 2020/21. Furthermore, during 2020/21, three in four (72%) of the rough sleeping population in Southwark had at least one complex support need, confirming the decision for homelessness to be a priority of the SSAB.

A Homelessness task and finish group was established, to review the current homeless pathways for multiple disadvantage service users, with the aim of identifying gaps with the various partner agency 'touchpoints' and how this can be improved. The work also includes the development of a shared Risk Assessment toolkit to safeguard service users with multiple complex needs. This work commenced in September 2021and will continue into 2022/23.

3. Learning from Case Reviews

3.1 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.

During 2021/21 three referrals were received for SAR consideration. Whilst none of these have progressed to a SAR, one is being undertaken as a Domestic Homicide Review and due to two of the referrals intimating suspected cuckooing, the SSAB have commissioned a thematic review into the prevalence of cuckooing in the borough, and the findings of this review will be reported in 2022/23.

The two SAR's that commenced in 2020/21 have been locally completed but have yet to receive formal ratification and thus these are scheduled to published in 2022/23. The learning from these reviews included developing a pathway for cases where an adult with capacity, whose needs are not considered to be eligible for care and support but there is a risk of serious harm. As a direct result of this identified area for development, Managing Complexity was agreed as a priority for the SSAB in 2021/22 and progress on this is citied above.

3.2 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 SSAB Quality and Effectiveness subgroup. During 2021/22 the 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.

4. Looking Ahead 2022/23

It is evident that throughout the year and across the partnership, significant work has been undertaken on our priority areas. In addition, a new governance structure has been implemented. As we move into 2022/23, the SSAB has agreed to carry through the priorities from 2021/22, acknowledging that these areas of work do not fit neatly within a financial year framework. This will also provide the opportunity for the new governance structure to be fully embedded. Although the thematic priority areas remain the same, during 2022/23 there will be a specific focus on gaining assurance on the progress of these priority work streams to demonstrate the positive impact on front line services.

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.