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# 1. Message from the Chair of Southwark Safeguarding Adults Board

Welcome to the Southwark Safeguarding Adults Board (SSAB) annual report, the production of which is one of the statutory requirements of the Care Act 2014 and covers the period April 2022 to March 2023. The purpose of the report is to set out what we have done in Southwark in the last 12 months in order to help and protect adults at risk of abuse and neglect.

Progress has been made during the last year with ongoing work to address the more complex safeguarding cases including themes of homelessness and self-neglect. There has also been positive cross partnership working to consider thematic areas such as domestic abuse and cuckooing. There is still much to do in order to raise greater awareness of what constitutes abuse and neglect, how to report it and the risk factors associated with it, in order to minimise the risk of it happening.

A significant and critical part of the Safeguarding Adults Board role relates to assurance, learning and development, which is coordinated through the work of the Learning Network, the Safeguarding Adult Review sub-group, and the Quality and Effectiveness sub-group. We have seen through the work of this infrastructure, a plethora of work to support developments and improvements in practice. In particular the work that has been undertaken to understand the current position of cuckooing, has informed the development of an innovative learning package for the year ahead that evidences wider community engagement with residents and frontline workers.

The annual multiagency audit of practice yielded rich information that has helped to set the priorities for next year. In particular, there is further work to be done to enhance our quality assurance and data analysis from across the partnership, to build on the data provided by the local authority. During 2023, the Care Quality Commission will begin the assessment of the quality of care at a local authority and Integrated Care Board level. The new assurance regime will shine a light on adult safeguarding and hopefully open the door to further local collaborative and partnership work, which will benefit adults who are at risk of abuse and neglect. The work of the SAB will continue to align with the CQC framework.

This annual report articulates the breadth of work undertaken by the Safeguarding Adult Board during 2022/2023 and has prompted a robust priority setting consultation to inform the year ahead. I would like to acknowledge the work and commitment of our front line practitioners in Southwark, and the significant contributions to the work of the SAB by all of its member agencies. I would like to finish by extending my thanks and appreciation to the Board Business Manager, the Board members and members of our various sub groups, for their continued support to developing and promoting the work of protecting adults.

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



### 2. Our Vision & Purpose

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.

2.1 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?
- 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?

Adults Partnership

## 3. Membership of the SSAB

- 3.1 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.
- 3.2 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.

Southwark Council	ICB/NHS		
Independent Chair, SSAB	Chief Operating Officer, Southwark, SELICB		
Strategic Director of Children's and	Designated Nurse for Adult Safeguarding		
Adults Services	(ICB)		
Strategic Director of Housing and	Named GP for Adult Safeguarding (ICB)		
Modernisation			
Strategic Director of Environment and	Head of Safeguarding Adults (GSTT)		
Leisure	Trodd or Caroguaranig Additio (CCTT)		
Director of Adult Social Care	Safeguarding Adults Lead (KCH)		
Director of Communities	Safeguarding Adult and Child Lead (SLaM)		
Director of Public Health	Police		
Director of Resident Services	Chief Superintendent Southwark and		
Director of Resident Services	Lambeth BCU		
Director of Commissioning, Children	Detective Superintendent - Head of Public		
and Adults' Services	Protection		
Assistant Director, Community Safety	Other Organisations		
and Partnerships			
Principal Social Worker for Adults	Borough Commander, London Fire Brigade		
Cabinet Member for Community	Head of Drobation Carriage Courthwest		
Safety	Head of Probation Service, Southwark		
Cabinet Member for Council Homes	Community Southwark		
and Homelessness	Community Southwark		
Cabinet Member for Health &	Provider Representatives		
Wellbeing	1 Toridor Representatives		



#### 4. Governance Structure

# Southwark Safeguarding Adults Board Independent Chair

Safeguarding Adult
Review Subgroup (SAR)

DCI Public Protection & Designated
Nurse Adult Safeguarding (Southwark)

Quality & Effectiveness
Subgroup
Independent Chair

Learning Network

Independent Chair / Scrutineer

Communication, engagement (frontline and voice of the child, young person, family and adult), learning events, Domestic Homicide Reviews, Safeguarding Adult Reviews, Child Safeguarding Practice Reviews, learning reviews, training, resources, briefings:

## 5. Communication & Engagement

- 5.1 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 2022-23 we began to develop a Communication and Engagement strategy
- 5.2 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.

#### 5.3 Looking ahead to 2023 - 24;

- 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.



## 6. Work of the Subgroups

#### **6.1 The Learning Network**

The Learning Network is a joint subgroup of the Safeguarding Children's Partnership and the Safeguarding Adults Board and focuses on the partnership training offer, the implementation of learning and developing communication and seeking assurance. The Learning Network continually strives to strengthen the 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 2022/23 this network has focused 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.

#### **6.2 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, which all partners complete annually. This group identifies the key themes from the assessments which informs the priorities for the forthcoming year.

Other areas of assurance included undertaking a self-assessment in preparation for forthcoming CQC visits, the ICS safeguarding accountability framework and LeDer



In addition, this subgroup drives forward the priorities of the SSAB, such as the strengthening of our local support services for older victims of domestic abuse and the embedding of the complex case pathway. Development and roll out of the complex case pathway and the domestic abuse deep dive took place during 2022/2023.

Although work is ongoing to review and develop the existing performance dashboard and align it with the Board's agreed priorities, annual safeguarding reports, including data were received from the Metropolitan Police Service and Adult Social Care which the group scrutinised.

Looking ahead to 2023/24 this group will continue to monitor the CQC inspection readiness of the partnership, will roll out and embed the pending new Department of Health pressure Ulcer guidance and will support the local LeDer 3 year strategy 2023-26.

#### 6.3 Safeguarding Adults Review (SAR) Subgroup

During 2022/23 the group has strengthened its referral process as a direct result, seen a significant increase in the number of cases referred for consideration. In addition to making decisions whether the SAR threshold has been met, this group also reviews and implements recommendations regarding learning from the National SAR Analysis and takes forward priorities for sector led improvement. Most importantly, this subgroup seeks assurance from across the partnership on progress of SAR recommendations and action plans with a focus on impact on practice.

## 7. Safeguarding Adults Partnership Audit Tool (SAPAT)

7.1 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 2022/23 SAPAT include:

#### 1. Management of complex cases

The complex case pathway is being utilised but further consideration needs to be given to how the process could link with existing pathways in Southwark

#### 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. <u>Dissemination of learning from SARs</u>

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 2023/24.

## 8. Financial Arrangements

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

Money received in 2022/23 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



## 9. Core Adult Safeguarding Data

- 9.1 During 2022/3, Adult Social Care (ASC) addressed a total of 1145 concerns, with 252 of these necessitating a S42 (2) enquiry. The conversion rate from concerns to enquiries was 22%, demonstrating a 7% decline from the previous year and a 7.5% deviation from the national average, presently standing at 29.5% (NHS digital).
- 9.2 Notably, all completed enquiries successfully identified and mitigated risks, achieving a 100% risk reduction rate. Furthermore, 77% of citizens, when prompted, expressed a desired outcome, indicating a noteworthy 10% improvement from the preceding year. Of these expressed outcomes, 98% were perceived as fully or partially achieved in concluded inquiries.

Concerns and Enquiries	2021/22	Change	2022/23	S42	Other
Safeguarding concerns received	1400	-18%	1145	-	-
2. Safeguarding enquiries commenced	401	-37%	252	206	46
3. Rate of Concerns to Enquiries	29%	-6.63%	22%	-	ı
4. Safeguarding enquiries concluded	401	-37%	252	206	46
5. Safeguarding enquiries concluded within 30 days	277	-34%	183	141	42
%	69%	3.92%	73%	68%	91%
6. Concluded enquiries where the individual assessed as lacking capacity	100	-33%	67	60	7
7. Safeguarding enquiries concluded where risk was identified	401	-40%	241	198	43
%	100%	-4.00%	96%	96%	93%
8. Where risk identified - risk reduced or removed	377	-36%	241	198	43
%	94%	1.99%	100%	100%	100%
9. Safeguarding enquiries for which the individual expressed desired outcomes	268	-27%	195	161	34
%	67%	10.17%	77%	78%	74%
10. Safeguarding enquiries for which the individual's expressed outcomes were fully or partially achieved	263	-27%	191	157	34
%	98%	0%	98%	76%	74%

- 9.3 There is a marked 18% decrease in the volume of concerns received during this period. Looking ahead to 2024, strategic initiatives are planned to enhance the front door of the Older People and Physical Disabilities (OPPD) service, optimizing the pathway for citizens. Additionally, enhancements to the Safeguarding pathway are on the agenda, starting with a comprehensive revision and streamlining of the S42 (1) Safeguarding concern and S42 (2) Safeguarding enquiry processes.
- 9.4 Continued efforts are underway to refine the Safeguarding training program, ensuring that the workforce is equipped with the requisite skills for their roles. Throughout 2023/24, attendance rates will be closely monitored, and adjustments to the nature and frequency of courses offered will be considered, aligning with the commitment to ongoing improvement and efficiency in Adult Social Care.

#### 10. Our Priorities

10.1 In March 2022 a consultation and engagement session was held for all SSAB partners to agree the priorities for 2022/23. The partnership acknowledged that significant work has been done to build strong foundations for the current priority areas which are all still very relevant with continuing progress. It was therefore agreed to maintain the existing priorities and continue to embed existing learning whilst focusing on effectiveness.

#### 10.2 For 2022/2023 the focus would be to:

- Embed the ongoing priorities work into frontline practice by driving forward learning
- Test the effectiveness, impact and parity of partnership ownership
- To strengthen data and intelligence which will tell us where we may need to focus
- Be flexible to take forward emerging areas robustly

#### **10.3 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, we are seeing an increase in the number of older victims coming the attention of services. As a direct result, Southwark have been engaging with Hourglass, a safer ageing organisation who specifically support older people who are affected by Domestic Abuse.

With the recent introduction of the new Domestic Abuse Act, the partnership have also 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.



#### **10.4 Managing Complexity**

Findings from local and national 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

Following the launch of the pathway the previous year, 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. Extensive efforts have been made across there partner agencies to embed the use of the pathway but this has identified a number of challenges, namely how it aligned with existing policies, procedures and pathways and this will be strategically explored as we move into 2023/24.



#### **10.5 Homelessness**



A Homelessness task and finish group was established in 2022/23 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 which was adopted by the partnership in the latter part of the year.

## 11. Learning from Reviews

#### 11. 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 2022/23 six referrals were received for SAR consideration, of which it was agreed in the latter part of the year that two met the criteria and should progress to a SAR. The progress and findings from these SARs will be reported on in 2023/34.

#### 11.2 Thematic Review - Cuckooing

The SSAB also commissioned a thematic review into the prevalence of cuckooing in the borough. 'Cuckooing' occurs when the home of an individual is taken over within the context of exploitation, usually for the use, supply, storage and/or production of drugs and other criminal activities. It exposes the individual to harm and risk. Cuckooing is a safeguarding area of concern in Southwark.

The purpose of the review was to:

- 1. Review the work undertaken by the Cuckooing Forum; to identify the key drivers and characteristics present for those subject to cuckooing and review the effectiveness of the actions that are undertaken to resolve cuckooing.
- 2. Review the Cuckooing Forum processes, including referral process, data collection and storage, recording of actions and outcomes.

#### 11.3 Learning Disability Mortality Reviews (LeDeR)

LeDeR is a service improvement programme which aims to improve care, reduce health inequalities and prevent premature mortality of people with a learning disability (LD) and autistic people by reviewing information about the health and social care people received



Approximately 2.16% of adults in the UK are believed to have a learning disability and approximately 1% of the population is autistic. Locally, our figures under represent the national picture, with Southwark having a population of 356,056 in 2022/23, and of that, the learning disability population was 1,294.

Evidence shows that people with learning disability and autistic people experience health inequalities, leading to preventable mortality compared to the general population.

On average, the life expectancy of women with a learning disability is 18 years shorter than for women in the general population (Mencap, 2023). The life expectancy of men with a learning disability is 14 years shorter than for men in the general population (Mencap, 2023).

Whilst we have some insight about the themes of health inequalities experienced by Black, Asian and Minority Ethnic communities. However, we still do not know enough about the lives and deaths of people with autism and the health inequalities they face.

Therefore, we have ensured focused reviews are undertaken for all notified deaths of autistic people and people who have a minority ethnic background. This will provide more detailed data to support a greater understanding of need and inform our work streams as we move into 2023/24.



## 12. Looking Ahead to 2023/24

- 12.1 As we move into 2023/24, the SSAB has agreed to five thematic priority areas to focus on which are represented in the yellow sections in the diagram below.
- 12.2 In addition, there will continue to be a focus on strengthening the current arrangements, including the alignment with other partnerships together with gaining assurance on the progress of these priority work streams to demonstrate the positive impact on front line services.



### 13. 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 <a href="mailto:OPPDContactteam@southwark.gov.uk">OPPDContactteam@southwark.gov.uk</a>.

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.

