Southwark Safeguarding Adults

Annual Report 2009-2010

Southwark Council

Southwark NHS Primary Care Trust

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Foreword by the Chair of the Southwark Safeguarding Adults Partnership Board

This will be the last time that I write a foreward to the annual safeguarding report as, following a number of changes to the governance structures within both Children's and Adult's safeguarding in Southwark, the Safeguarding Adults Partnership Board (SAPB) will now be chaired by an independent person.

This is the right change and provides a level of independent scrutiny to the SAPB which will provide a strong voice to those working to ensure that vulnerable people in Southwark are safeguarded. I am very pleased to announce that Terry Hutt has now been appointed to this post. Terry is an experienced adults social services manager, and has a background which includes inspectorate and safeguarding experience with the Commission for Social Care Inspection (CSCI). I am looking forward to working alongside Terry as we ensure that the changes we put in place in 2009-10 are embedded, and that we build on the enthusiasm and knowledge that was so apparent at the partnership stakeholders event in March 2010 to continue to ensure that people in Southwark are kept safe.

The annual safeguarding report contains but a few examples of the many safeguarding interventions and outcomes that those in the sector deal with every day. Many relate to financial abuse, which remains a key local issue. A number of the case studies in this report relate to people trying their best to manage their money, but - for whatever reason - having a friend or relative who is misusing that money. However we have also included a case study about a nursing home where the Council, in partnership with an NHS Trust and the Police undertook a priority safeguarding investigation following allegations of abuse and neglectful practices. It is hoped that this type of action will not be needed, however where it is necessary I am grateful to staff for the urgency and dedication with which they bring to often very difficult and challenging circumstances.

This report also sets out how it is only by working in partnership, social workers, housing officers, the voluntary sector, NHS trusts and others, that we are able to ensure that vulnerable people in Southwark are safeguarded. It is with this in mind that we continue to work together to improve our joint practices and processes, and I look forward to working with everyone involved in safeguarding to accomplish our shared vision of a Southwark that is excellent at safeguarding.

Yours sincerely

Susanna White
Strategic Director of Health and Community Services, Southwark Council and Chief Executive of Southwark Primary Care Trust (PCT)

Executive summary

1. Southwark is a borough where there is an increasing number of safeguarding alerts being raised, with an increasing number of alerts being raised by the vulnerable person on whom the abuse is alleged to have been committed, their friends or family.

2. With an increased number of alerts, there is also an increased number of safeguarding investigations. More people in Southwark have been kept safe.

3. The majority of safeguarding alerts in Southwark relate to financial abuse, usually committed within the victim's own home and often by members of their own family or by friends. It is within this particularly challenging and personal space that safeguarding investigations usually take place and social workers and others have to take actions to ensure that any abuse is stopped.

4. There has also been a major safeguarding investigation in 2009-10 related to institutional abuse within a nursing home. Whilst this type of investigation is unusual in Southwark, it demonstrated the strengths of partnership working in Southwark with a joint operation taking place between Southwark Council, Guy's and St Thomas's Hospital and the police.

5. With an additional number of safeguarding alerts, Southwark has also worked to refresh its governance arrangements. A new independent chair of the safeguarding and partnership board has been appointed, and the role and function of the sub-groups has been changed.

6. A partnership stakeholders event also took place in March 2010 which reaffirmed Southwark's vision to be excellent in safeguarding.

Introduction

1. During the last year in Southwark there has been a substantial increase in the levels of safeguarding activity. A changing context has also involved the review and implementation of an improved governance framework in safeguarding, with a refreshed board and sub-group structure and a new independent chair of adult safeguarding being appointed.

2. Many of these changes have been implemented following recommendations by the CQC Independence Wellbeing and Choice Assessment in April/May 2009. The report set out that Southwark had excellent safeguarding policies and procedures; however the report also noted a need to strengthen compliance at an operational level.

3. The CQC report also noted the strength of the Safeguarding Adults Partnership Board (SAPB) in achieving a strong level of inclusivity with carers, the voluntary sector and other stakeholders engaged in safeguarding work. The quality of the work that was jointly undertaken between the local authority and the local NHS Hospital Trusts was also highlighted. However the CQC recommended that the number and role of board sub-groups should be reviewed.

4. Following the inspection, the SAPB set in place a review to strengthen safeguarding governance arrangements and to improve the performance management and workings of teams involved in safeguarding.

5. This report describes the activities for adult safeguarding during 2009-10 in Southwark and highlights the changes to the governance arrangements, key outcomes achieved, and actions that are now being taken towards achieving an excellent service.

Governance Arrangements

6. The Care Quality Commission (CQC) made a number of recommendations related to safeguarding in May 2009. Whilst the SAPB was considered inclusive and included a wide range of representatives including carers and service users, it was suggested that the board's capacity for leading the safeguarding agenda in Southwark could be improved through a refocusing of efforts in a number of areas. The board considered proposals for change in the autumn of 2009 and, following a board awayday in February 2010, new safeguarding governance arrangements have been developed.

7. The refreshed framework includes a streamlined board which is chaired by an independent person who has now been appointed. The board was previously chaired by the Council's strategic director for health and community services and the appointment of an independent person provides an improved level of independent scrutiny and accountability over the adults safeguarding agenda. The new chair is an experienced adults social services manager, and has a background which includes inspectorate and safeguarding experience with the Commission for Social Care Inspection (CSCI). The board has also agreed new terms of reference which includes a commitment for more regular meetings.

8. The SAPB formally reports to the Health and Social Care Board, which is a joint leadership body comprising of the Council's Cabinet and the Southwark Primary Care Trust (PCT) Board. The Council and PCT have a history of close cooperation and joint working and this was developed into formal partnership arrangements between the two organisations. The Health and Social Care Board considers the Safeguarding Adults Annual Report each year, oversees implementation of the safeguarding action plan, and considers specific issues that may have an adverse impact on vulnerable adults.

9. The SAPB is also recognised as a thematic partnership group within Southwark's Local Strategic Partnership (LSP), with the Assistant Director, Adult Social Care meeting regularly with lead

officers from the other LSP partnership groups to address cross-cutting issues. Assistant Directors responsible for Community Safety and Adult Social Care attend both the SAPB and the Safer Southwark Partnership (SSP) thematic partnership group to ensure that the leadership of the safeguarding agenda is strongly led by organisations involved in crime prevention and community safety.

10. The SAPB receives safeguarding monitoring reports on a quarterly basis. These reports highlight the number of referrals received, updates on progress of current safeguarding investigations, and provides the board with information on the outcomes of completed investigations.

11. The refreshed board also has representation from a number of senior safeguarding practitioners whose role is to take forward work and drive forward safeguarding improvements on behalf of the board.

12. One of the strengths of the previous model was the enthusiasm and energy that was brought by the carer, voluntary sector and service user board representatives. Whilst the review aimed to rationalise membership of the board and the number of board sub groups that existed in order to have an improved governance system, it was important to ensure that the commitment of those involved in the system was maintained. The review therefore set out to improve clarity over the role of sub groups and the role of carer and other representatives on these.

13. The refreshed framework set up the following five sub-groups, and an additional "task and finish" financial fraud sub-group was also set up to oversee a short-term project. These groups were developed to take on specific safeguarding workstreams and to oversee the completion of these:

    - Practice Quality and Audit
      A sub-group to look at supporting improvements in safeguarding agencies and teams with the development of effective audit practices and other improvement measures. The group has a particular remit to embed processes, oversee the management of cases and to ensure that processes for the evidencing of work are in place. The Deputy Director of Adult Social Care chairs this sub-group.

    - Learning and Development
      A sub-group to support training and other development requirements in relevant organisations. The group has a specific project to take forward the development of core competencies across the partnership. The Council's Head of Organisational Development chairs this sub-group.

    - Human Resources
      This is a joint sub-group with the Children's Safeguarding Board to support recruitment and to maintain and embed workforce standards across partnership agencies. The Council's Head of Human Resources chairs this sub-group.

    - Stakeholders
      This group supports engagement and involvement by key stakeholders, including carers, service users and representatives from the voluntary sector. It is envisaged that the independent chair and a service user or voluntary sector representative will co-chair this group.

    - Health Providers
      This sub-group is currently taking forward a project looking at the prevention and treatment of pressure sores and the development of transfer of care protocols related to this.

    - Financial Fraud

This "task and finish" sub-group was set up to oversee a short term project which is undertaking work to improve understanding of the levels of financial fraud in the borough. This is particularly significant at this time as 2009-10 has seen an increase in the number of safeguarding alerts relating to financial abuse, which is already the highest are from which safeguarding alerts are raised in the borough.

14. In addition to regular attendance at the SAPB, statutory organisations such as Guy's and St Thomas's Foundation NHS Trust, King's Foundation NHS Trust, NHS Southwark provider services, and South London and Maudsley Mental Health Foundation Trust all have their own internal safeguarding boards to oversee compliance with the multi-agency policy and procedures and with CQC standards.

Partnership Stakeholders Event

15. In March 2010 over one hundred delegates representing the customers and agencies that form Southwark Safeguarding Adults Partnership attended a stakeholders' event to learn about, discuss and develop ideas about how excellent practice in safeguarding vulnerable adults can be achieved in Southwark.

16. Delegates were welcomed by Councillor David Noakes, the Executive Member for Health and Adult Care, who affirmed the Council's commitment to making Southwark a safer borough and its determination to safeguard vulnerable adults. Susanna White, Strategic Director of Health and Community Services and Chief Executive NHS Southwark, then spoke about the CQC Independence, Wellbeing and Choice Inspection that took place in 2009 and the improvements that have been put in place in response to the recommendations made by the inspectors. In particular, she outlined the developments to the SAPB that would make it a more focused and effective body. She also restated that it is Southwark's ambition to become excellent in safeguarding.

17. Excellence in safeguarding was the key theme developed in the presentations given by the main conference speakers. DC Maria Gray of the Metropolitan Police outlined the new standard operating procedures adopted by the police to ensure a consistent approach to investigations of alleged crimes against vulnerable adults. Jonathan Lillistone from Southwark Adult Care Commissioning Service also spoke about work to ensure robust safeguarding standards are maintained.

18. The stakeholders event was also provided with a presentation by Terry Hutt, an independent social care consultant, who provided delegates with an overview of how excellence in safeguarding is achieved and outlined ten steps that Southwark should take to achieve excellence. These included: ensuring that safeguarding and self directed support systems are integrated; regular audits of practice; strong partnership working; and an agreed work programme with accountability with the Safeguarding Board.

19. Throughout the day delegates were actively involved through question and answer sessions and table discussions and many suggestions were made for achieving excellence. These included further developing and maintaining strong audit processes, creating virtual safeguarding teams to progress investigations, everyone owning the safeguarding process, and regular information campaigns to keep the public aware of the safeguarding message. The SAPB has subsequently agreed to integrate these ideas into their work programme for the year forward.

20. Feedback from the event was extremely positive and many delegates mentioned how much they had learned. A number of people said they had found the conference inspirational and wanted additional events to raise awareness of abuse of vulnerable adults.

Statistical Overview

21. Safeguarding data and information is available in appendix 1.

Number of safeguarding alerts and investigations

22. In 2009/10 a total of 377 safeguarding alerts were received. This represents an increase of 31% on the previous year. 88% (332) of alerts led to safeguarding investigations compared with 86% (248) in the previous year. There has been an increase in the number of safeguarding alerts in each of the previous three years and, compared to 2007-08, there were an additional 35% (133) safeguarding alerts in Southwark.

Who is raising alerts of abuse?

23. In 2009-10 41% of safeguarding alerts originated with the vulnerable adult themselves, or a family or friend. This is particularly significant as it shows a rise of 11% in such alerts compared with 2008-2009 and is thought to be related to an increased awareness in recognising abuse and how to report it. Over the last three years whilst there has been a steady increase in the number of safeguarding alerts from the vulnerable person themselves, a family or friend, safeguarding alerts coming from social care workers and service providers has fallen by 14% compared to the previous year.

24. The increase in the number of alerts, and in the number of alerts originating from the vulnerable person themselves, or from their family or friends, follows the dissemination of refreshed multi-agency policy and procedures throughout Southwark. There has also been an ongoing training programme and publicity campaigns to support the embedding of these procedures, and the highlighting of safeguarding to relevant agencies and stakeholders.

25. Referrals from statutory agencies other than the local authority have increased in the past year with an 18% rise compared to 2009-10. A marked increase in referrals from the police must also be noted from 5 in 2008-9 to 17 in 2009-10. This is also reflected in an increasingly close working relationship between the police and other statutory agencies.

Who are the individuals who are having alleged abuse committed to them?

26. As in previous years, most safeguarding alerts progressing to investigation were for elderly people making 59% of the total (and a quarter of alerts were from those between the ages of 75-84). This is in line with national levels (AEA Prevalence Report 2007) that highlights that people over 75 years of age were most likely to be abused. 166 or 84% of investigations involved people in this age group.

27. Whilst the number of safeguarding alerts has increased overall, the proportion of alerts to gender has stayed relatively constant over the last three years (43% of alerts relating to a vulnerable adult who is male, 57% to a female person) with a nominal increase of the proportion of alerts relating to a vulnerable person who is male. The majority of safeguarding alerts at 68% related to a vulnerable person who had an ethnicity of being white. These figures are consistent with the demographics of the elderly people age group in Southwark, being predominantly white and with a greater proportion of female to male, which is the group where the majority of safeguarding alerts are raised.

28. 58 safeguarding alerts progressing to investigation related to people with a learning disability with a further 46 for people with sensory and physical disabilities. 9% or alerts progressing to investigation were for people with known to have mental health needs.

29. No safeguarding alerts were received for people whose major presenting problem was substance misuse. The SAPB recognises that this may not be an accurate reflection of the level of abuse

experienced by this group and that further work is required to understand the role of safeguarding in substance misuse cases in Southwark. One issue discussed by the SAPB related to the chaotic nature of the lifestyles of some service users in this group which may be reflected in lower safeguarding reporting of this type of abuse.

30. As with the previous year only one formal safeguarding alert was raised concerning someone regarded to be funding their own care. However during the year safeguarding investigations were undertaken regarding the care being received by older people in three local care homes, including five people who were funding their own care in the home. Individual safeguarding alerts were not raised for each resident, resulting in an under-reporting of safeguarding activity. This will be addressed in 2010/11. Nevertheless the need to ensure that people funding their own care know how to seek help about any possible abuse remains an area of concern that the SAPB will be taking forward.

Alerts not progressed to investigation

Type of abuse alleged	Number not progressed to investigation during 2009-10
Financial	13
Multiple	4 (1 x Physical and Financial, 2 x Neglect and Physical, 1 x Financial and Psychological)
Neglect	11
Other	1
Physical	11
Psychological	2
Sexual	3
Total	**45**

31. Further work is being undertaken to understand what actions were taken despite the decision not to progress the alert as a safeguarding inspection.

Types of abuse

32. In line with the previous years' data on safeguarding, the most common type of alleged abuse was financial with 136 investigations carried out. This represents 41% of all investigations. The SAPB is concerned about this volume of abuse relating to finance and also the slight proportionate increase. This will be a major area of work which the SAPB will take forward in the coming year.

33. The majority of safeguarding investigations at 58% related to alleged abuse that had taken place in the vulnerable person's own home. This is consistent with the levels of financial abuse that was reported as this type of abuse is generally perpetrated in the vulnerable adults own home.

Financial Abuse

34. An analysis of safeguarding alerts and investigations has determined that financial abuse is the most common form of abuse reported in Southwark. The Council's fraud team works closely with Adult Social Care and the police in conducting investigations, pursuing proven perpetrators and in putting effective protection plans in place. A police officer is seconded into the team to assist with this work. Where vulnerable adults are unable to manage their own money the Council provides both an appointee and a deputyship service. The number of people being supported in this way

has increased from 325 appointees and 55 deputyships at the end of 2008/09 to 380 appointees and 65 deputyships by the end of 2009/10.

Case Study 1

Mrs A is an elderly lady in her 80s and was living in Peckham with one of her sons, who was in his 50s. Mrs A had a physical disability and was receiving benefits that supported her to remain living in her own home. A safeguarding alert was raised by Mrs A though as she was upset and concerned about her son who would ask her for money which he would use to buy alcohol. It was later discovered that the son had an alcohol addiction problem. Mrs A felt disempowered and felt unable to stop providing her son with money however she was also aware that this meant that she was not able to access the support she required. Mrs A was also worried about approaching a social worker, however, as she understandably did not want her son to get into trouble, and talked about how she did not want him to end up homeless. She was keen to ensure that whatever happened her son was not prosecuted. Assuring Mrs A that she was there to help resolve the problems, the social worker organised a family conference at Mrs A's home. The meeting was very difficult for the family, as many of the issues raised had never been discussed before. A good outcome was produced though with all parties agreeing that Mrs A's money would be managed by her daughter and that her son would therefore no longer have access to it. The social worker has since checked to ensure that the agreed plan has been put in place and has found that Mrs A is able to use her money to access the support that she requires.

Case Study 2

Social workers received a referral from a housing officer in Peckham who was concerned about a tenant he worked with, Mr H. There were allegations that Mr H's brother had bullied him, both with physical assault and also through financial exploitation which he claimed had taken place on several occasions. The situation was difficult – as it was important to understand Mr H's situation and to provide a safe space where he could discuss the situation away from his brother. Social workers made arrangements with the police to be present when Mr H visited the housing office. Following the meeting, alternative accommodation was arranged immediately which was necessary due to the severity of the situation. Social workers and the police officers interviewed Mr H and deduced that he was clearly fearful of his brother. It transpired that he indeed did not want to return to the accommodation he currently resided in. Mr H was taken to alternative accommodation and requested possessions were collected on his behalf. Police are now investigating the brother, and Mr H is now happily living in a different one bedroom flat.

Physical abuse

35. Physical abuse with 90 investigations carried out represents approximately 27% of all cases investigated. 78 investigations were carried out which is a small reduction in overall incidence from the previous year.

Case Study 3

31 residents lived in a privately owned nursing home, 23 of whom were from Southwark. The home had a history of poor or patchy performance and had been rated by CQC inspectors as an adequate home at the time of the safeguarding investigation. In the summer of 2009 the safeguarding lead at Guy's and St. Thomas's Hospital was alerted to a number of serious concerns about practice at the home. This included allegations of assaults, neglectful practices and that records of members of staff had been falsified. An investigation was set up between Guy's and St Thomas's Hospital, Southwark Council and the police. The investigation involved an immediate visit to the home to check on the

safety and wellbeing of the residents and verify the claims that had been made. The investigation revealed a large number of serious issues which the team had to tackle. Following the investigation, the Council's adult social care service concluded that the home not providing the quality of care that Southwark's residents should expect to receive. The Council therefore decided to cease funding placements at the home and met with residents and their relatives to explain that they would be helped to find better homes to live in. There were some positive outcomes from this very difficult work. One resident, who wanted to be more independent, was helped to move into a flat of his own in an extra care sheltered scheme. After relocating to a new home, a resident who had been non-verbal whilst in the home, began to respond to questions with appropriate sentences and can now communicate to a degree with carers and other residents. This investigation into physical and institutional abuse demonstrated strong joint working between the Council, an NHS acute trust and the police.

Case Study 4

Ms G is a lady in her 50s with learning disabilities. She lives with her elderly mother and is her sole carer. Ms G attends a local day service. One Friday afternoon staff noticed she was visibly distressed. Upon questioning she remarked that her mother had been attacking her with a walking stick. Ms G appeared visibly concerned and did not want to go home to her mother. As this incident was reported as an assault, the police were contacted and this situation was flagged as a safeguarding alert. The police referred the case to social workers due to the situation. Duty social workers on call visited the same day for a discussion before Ms G returned home. The mother was evidently frail - and said that she was at the end of her tether due to what she called Ms G's attention seeking behaviour (i.e. knocking on the door to come in at 5am in the morning). Duty social workers facilitated a family conference that afternoon, and Ms G returned home to a tearful reunion. Ten days later, the situation was reviewed and Ms G was discovered to be calmer and much more positive. She was offered more support in the future if needed, but stated she was more than happy with the service provided.

Sexual abuse

36. The incidence of allegations of sexual abuse showed both an absolute fall in numbers and a corresponding relative fall in incidence with 15 cases investigated in 2009-2010 compared with 25 in 2008-2009 representing 10% and 4.5% of the totals respectively.

Outcomes of Investigations

37. During 2009-2010 252 cases were closed of which 51, approximately 20%, were substantiated with a further 26, approximately 10%, partially substantiated. This number includes cases that may have been referred in 2008-9 but not closed that year.

38. Whilst these figures for case conclusions may appear low they are typical for a London borough and reflect the difficulty in fully investigating allegations of adult abuse where the victim often lacks capacity to appreciate that they may have been abused and is unable to provide reliable information, or may feel intimidated or reluctant to provide information because the alleged perpetrator is a friend or family member. This situation is reflected in some of the challenging case studies cited in this report.

39. For 25% of cases, following a safeguarding investigation, no further action was required or the issue was resolved. This reflects often immediate issues which are alerted, can be resolved quickly and sometimes do not require further intervention. 22% of cases required some form of increased monitoring of the vulnerable adult. A number of the case studies in this report reflect

this type of situation in which the social worker remains in contact with the vulnerable adult and their family following a safeguarding intervention to ensure that there are no further issues or a repeat of the type of abuse that prompted the original safeguarding alert. 13% of investigations involved an outcome in which a different system was put in place for the management of the vulnerable adults finances. This is consistent with the levels of safeguarding investigations relating to financial abuse, and also an area of increased interest for the SAPB with the roll-out of personal budgets for a wider group of people in Southwark.

40. Prior to closing a safeguarding investigation the social worker completes a protection plan with the service user to determine what actions have been, or will continue to be taken in order to minimise future risks of abuse. This frequently includes the ongoing involvement of providers in monitoring the service user's well-being. Feedback from service users during subsequent reviews is that the protection plan and the post investigation support has helped them to feel safe.

41. As part of protection plans social workers inform people about the community alarm services available in the borough, including the Southwark monitoring and alarm response team (SMART), which provides community alarm and telecare services and a home visiting service 24 hours a day in response to emergencies.

Outcome for alleged perpetrator

42. In the majority of cases, at 57%, no further action was taken against the perpetrator of the alleged abuse following a safeguarding investigation.

43. This area remains a challenge for Southwark and is similar to other local authorities that have a comparable population and environment nationally. It has been notoriously difficult to prove allegations of abuse in cases and taking further action, including criminal action, can often be a challenge for the individuals, on whom the abuse has been committed, many of whom find it difficult to put forward their case without additional support.

44. With regard to perpetrators, when they are family members, as they often are in cases of financial abuse, the victims of abuse often do not want to bring forward prosecutions but rather wish for a resolution that does not unduly punish the perpetrator. This often results in a change in the way in which the vulnerable adult's finances are managed, either through management by the Council or by another family member, which resolves the situation without stigmatising the family member involved.

Deprivation of Liberty Safeguards

45. From 1st April 2009, Mental Capacity Act 2005 Deprivation of Liberty Safeguards (MCA DOLS) legislation was introduced for people who are unable to make decisions about their care or treatment. The European Court of Human Rights has said that the rights of people who cannot make these decisions and who may have their liberty taken away in hospitals and care homes must be strengthened. The MCA DOLS has been developed to protect these people.

46. Southwark Council has responded to this legislation by developing policies and procedures to ensure that the Council is capable of meeting the requirements dictated by the new Act.

47. Prior to implementation, training was arranged for provider organisations to identify service users who may require a potential DOLS assessment. For the period from April 2009 to March 2010 30 requests for DOLS assessments have been received with 17 authorised. This is comparable for figures across London.

48. The Safeguarding Adult Team now manages the Deprivation of Liberty Safeguards (DoLS) for both Adult Social care and Southwark PCT and close working with colleagues in commissioning

have aided the development and focus of the local advocacy provider Cambridge House to provide IMCA services. For 12 months up to March 2010 there have been a total of 8 IMCA referrals involving safeguarding concerns. Feedback has shown that people who have used the IMCA services felt that they were supported, listened to and their views were championed by their IMCA.

Working together – NHS Southwark

49. Southwark PCT established an adult safeguarding steering group in January 2010 to oversee the development of safeguarding adults work, make decisions in consultation with the Southwark NHS Provider Services (SPS) Board and operational Board, sign off safeguarding policy and move forward strategic objectives and priorities. The group operates under the auspices of Southwark's multiagency safeguarding adults partnership board.

50. The group membership includes clinicians and managers across health and social care and meetings take place 6 weekly.

51. The group has responsibility for ensuring that quality assurance arrangements are in place for the Safeguarding activity, and for the monitoring and development of procedures on the basis of lessons learnt.

52. The group workplan is in place and includes:

- Developing an adult safeguarding adults policy specific to community health services
- Ensuring staff have the required skills and competencies to safeguard adults, recognise potential safeguarding issues and undertake risk assessments
- Overseeing compliance with the requirement of core standards and CQC registration
- Developing systems for activity reporting
- Developing related practice guidelines

53. A comprehensive SPS adult safeguarding policy has been developed and is widely available. The policy was formally launched at the SPS nurse and Allied Health Profesionals leadership meeting in March 2010 and a safeguarding introduction and briefing undertaken with the 40 attendees from a range of services across the organisation.

Working Together - Community Safety

54. At the heart of Southwark's partnership approach are the principles of identifying and reducing the risk of harm and identifying and supporting vulnerable people. To support the clear links between the work of the Council's community safety team and other safeguarding agencies, the Head of Community Safety is a member of the SAPB and the Deputy Director of Adult Social Care is a member of the Safer Southwark Partnership (SSP) which includes representation from the police and fire service.

55. The Head of Community Safety is accountable for ensuring that the Safeguarding Adult Team and the adult social work services receive early notification of critical incidents that occur and may have impact on vulnerable adults.

56. All of the agencies working within the SSP are committed to these principles and the SSP recognises the strong links to both the adult and Children's Safeguarding Boards in Southwark

57. The SAPB also works very closely with Community Safety Partnership Services to address domestic abuse issues, including regular and active attendance by the Safeguarding Adults Co-

Ordinator at MARAC (Multi-Agency Risk Assessment Conferences), which ensures co-ordinated action by partner agencies to safeguard people at serious risk from domestic violence.

Working together – housing

58. Southwark Council is the largest local authority social landlord in London with 45,000 tenants and homeowners. With such a high level of social housing in the borough there is an additional importance to safeguarding in housing services.

59. Housing officers' visits to known vulnerable tenants have been a great success. Last year the housing service carried out over 5625 visits to check on known vulnerable tenants. The Council also has a tenancy check programme which helps to identify tenants whose vulnerability was previously unknown. This programme is ongoing and is aimed at making sure that tenants are receiving adequate help and support from either the Council or other agencies and are living free from abuse.

Building Safeguarding Capacity within Southwark

60. A range of Safeguarding Adults courses are commissioned and co-ordinated by the Council and are advertised on the Southwark website for council staff and are available for staff from partner organisations. The Alerter and Investigation Officer courses are provided regularly, with more specific courses being provided as required. These include courses on safeguarding for chairs of case conferences, investigation managers, commissioners, providers and case conference minute takers. During 2009/10 84% of Adult Social Care staff received safeguarding training, as did 75% of staff in independent sector registered care services.

61. Three half day workshops were arranged in January 2010 and attended by 45 Adult Social Care and PCT commissioners to improve their knowledge of safeguarding and improve their skills when working with providers and applying contract monitoring processes. Evaluation of the effectiveness of the training demonstrated a significant improvement in participants' knowledge of their commissioning role in relation to safeguarding and how to support providers to improve the quality of safeguarding.

62. Since January 2010 Safeguarding Awareness training has been incorporated into induction training for all staff joining the Council and NHS Southwark. During 2009/10 Safeguarding Alerters training was targeted at all service providers including housing, community safety and leisure. In addition during the year an e-learning training programme for safeguarding adults and children's awareness was introduced. This will be available for all council staff from early 2010/11 and rolled out to external partner agencies, including the voluntary sector during the year.

63. In addition to participating in the training commissioned by the Council, providers also organise their own internal safeguarding training based on the multi-agency policy and procedures and the safeguarding adults competency framework. For example in 2009/10 Kings College Foundation NHS Trust provided safeguarding training to 1756 staff whilst 3340 from Guys and St Thomas's Foundation NHS Trust received such training.

Quality Assurance

64. The established Adult Social Care safeguarding case file audit programme has three levels; monthly audits completed by social work team managers (two audits per team identified by the Safeguarding Adult Team); quarterly audits conducted by the Safeguarding Team, and (at least annually) an externally commissioned audit by an independent auditor. The findings of these audits are considered by the Adult Social Care Senior Management Team (SMT) in order to both recognise good work and outcomes and to identify further actions required to improve and standardise good practice. Following feedback from staff and managers, in 2009 the

safeguarding audit tool, that had been in use since November 2008, was reviewed and simplified. A revised audit tool was piloted in September 2009 and launched in November 2009. Further improvements to the Audit Tool have been identified with changes to be implemented from May 2010.

65. Findings from recent level one and two audits include:

- improvements in the standard of recorded management oversight of investigations
- improved recording of mental capacity and referrals to IMCAs
- a faster response to alerts with most cases being allocated from duty (which commences the initial investigation and protection planning) to social workers within 48 hours.

66. The variability in practice standards that was identified by the CQC inspection in April 2009 has been addressed. Specific experienced social workers have been identified and these conduct the majority of the safeguarding investigations and provide targeted safeguarding training for managers.

Safeguarding and Personalisation

67. The Putting People First agenda provides an opportunity to develop more personalised services and give service users and carers more choice and control. However, striking a balance between empowerment and protection poses challenges for local authorities and Safeguarding Adult Partnerships.

The recent Department of Health consultation on the review of no secrets highlighted these comments from Safeguarding Adult Partnerships about personalisation.

- A balance needs to be established between empowerment and protection and between the rights for self determination and the duty to ensure safety of people and safety of public money.
- We want to support people to be citizens and take risks that they understand.
- Empowerment in all aspects of life is a protective factor against abuse

68. The Personalisation Programme is well established, with lead officers and a project team implementing the programme plan to ensure that Southwark continues to meet the Putting People First milestones. Ensuring that people are safeguarded whilst exercising choice and control over how they live their lives is an integral part of the new operating model that was developed during 2009/10 and is currently being implemented.

69. A service user and carer panel was established in September 2009 and meets monthly to work with the personalisation team to co-produce the new operating model. As each stage of the new model, i.e. Access and Information, Re-ablement, Outcome Based Assessment and Support Planning has been developed, presentations have been made to the panel, workshops conducted providing the opportunity for challenge and questioning, and user and carer feedback incorporated into the model. Panel members advised about the wording of easy to read advice for users about personalisation assessment processes and their comments about ways to ensure that service users are enabled to manage their personal budgets were included in the staff guidance about managing risks.

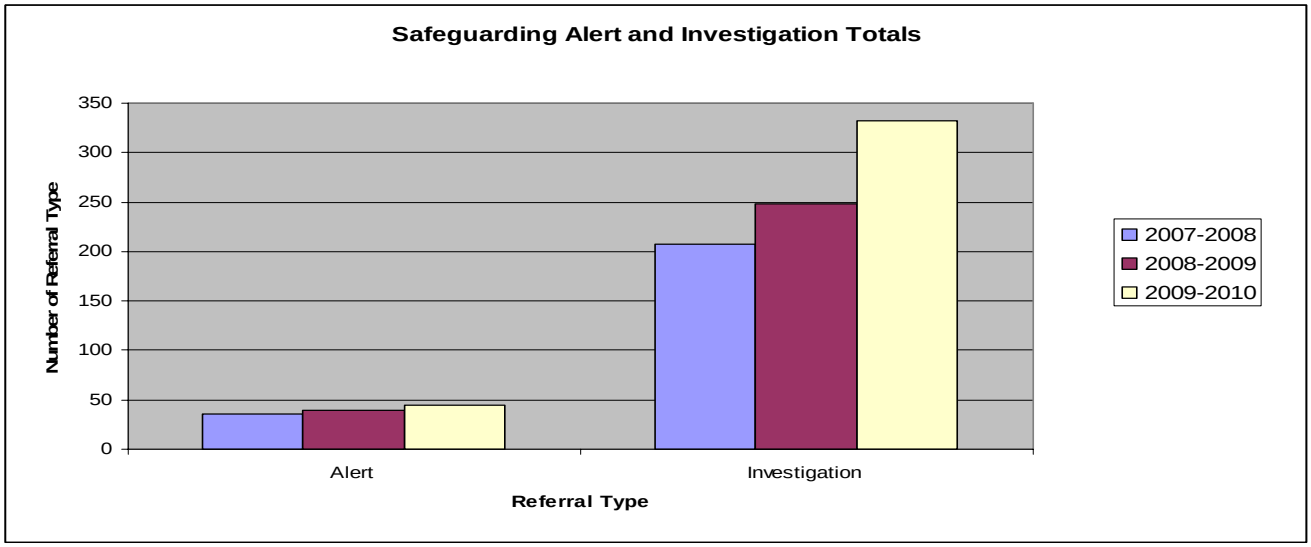
70. The Council is aware that there are concerns about how individuals will be safeguarded outside of regulated services and that there may a greater risk of financial abuse, in particular. But it is

already the case that many people who are referred for a safeguarding investigation are living in regulated, institutional care and for reasons of financial abuse.

71. Following the introduction of personal budgets more widely, the Council will retain its legal duty of care. But in agreeing the support plans the Council will need to be more open to people choosing to manage the risks in their lives differently, whilst also ensuring that individuals are safeguarded and that support is in place in areas of concern.

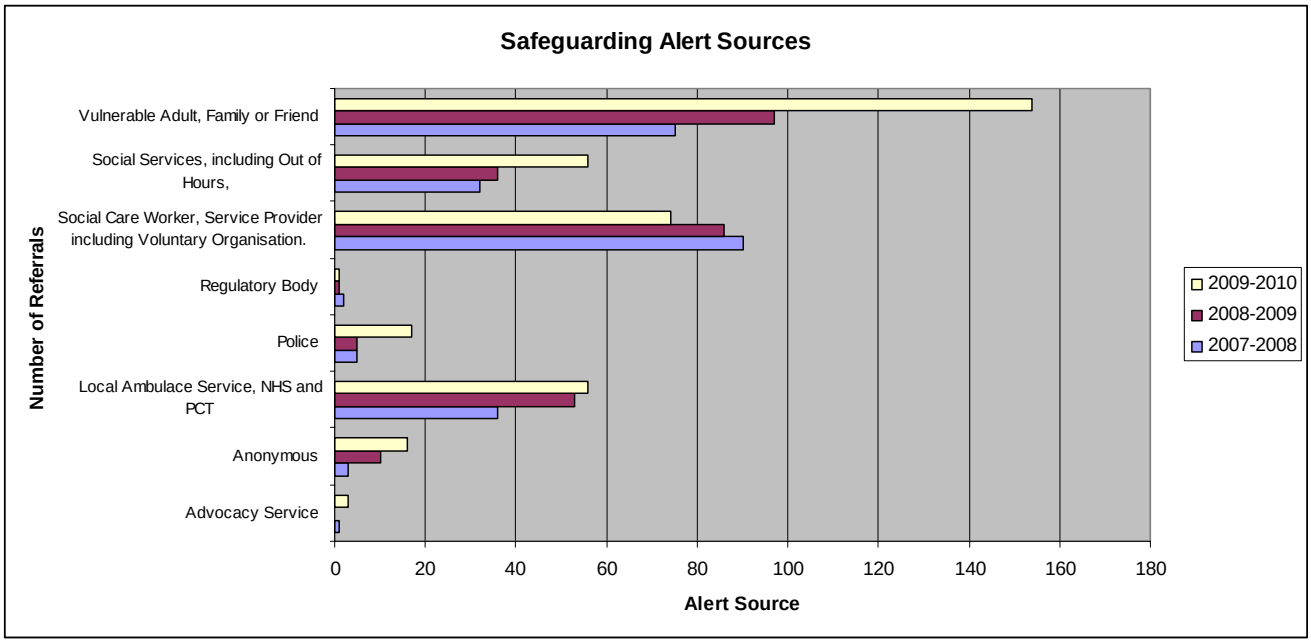
APPENDIX 1

Table 1. Number of Safeguarding Alerts and Investigations



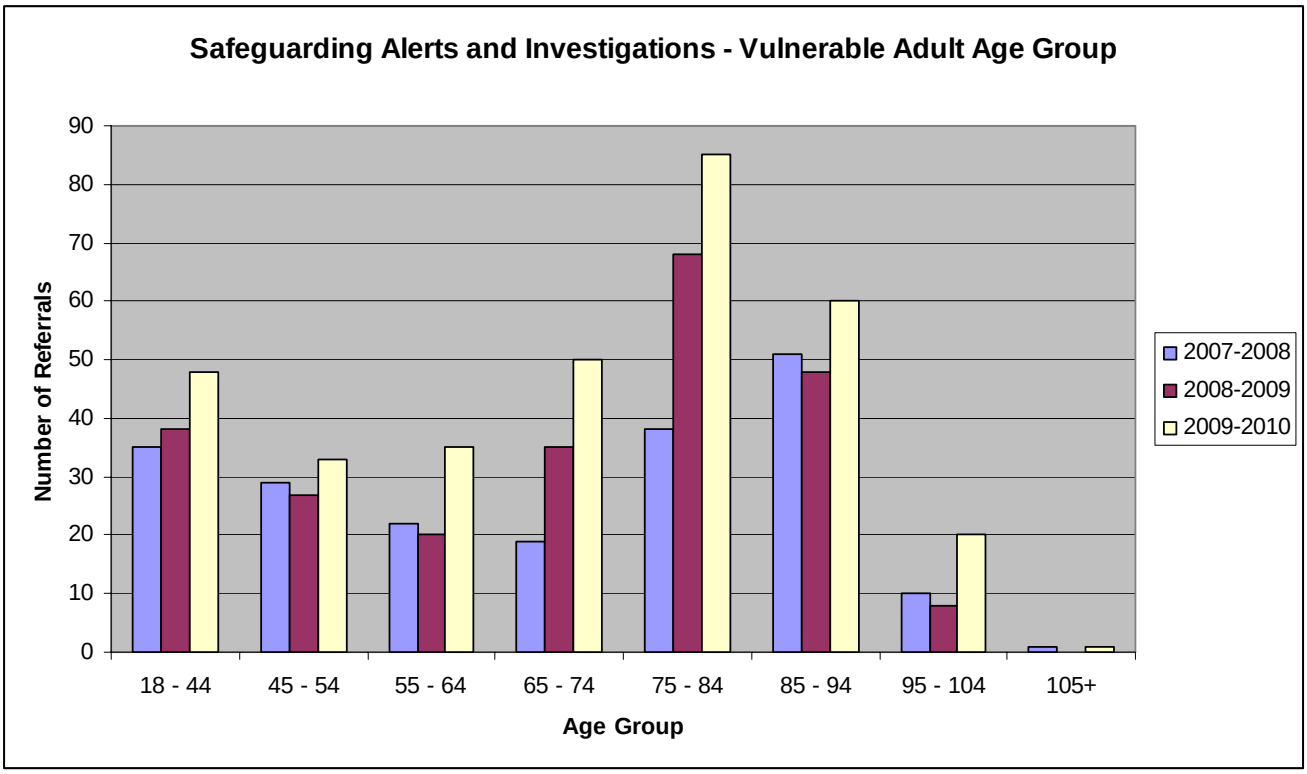
Safeguarding Alert and Investigation Totals			
	2007-08	**2008-09**	**2009-10**
Alert for which a safeguarding investigation is not required	36	40	45
Investigation	208	248	332
Total	**244**	**288**	**377**

Table 2. Safeguarding Alert Sources



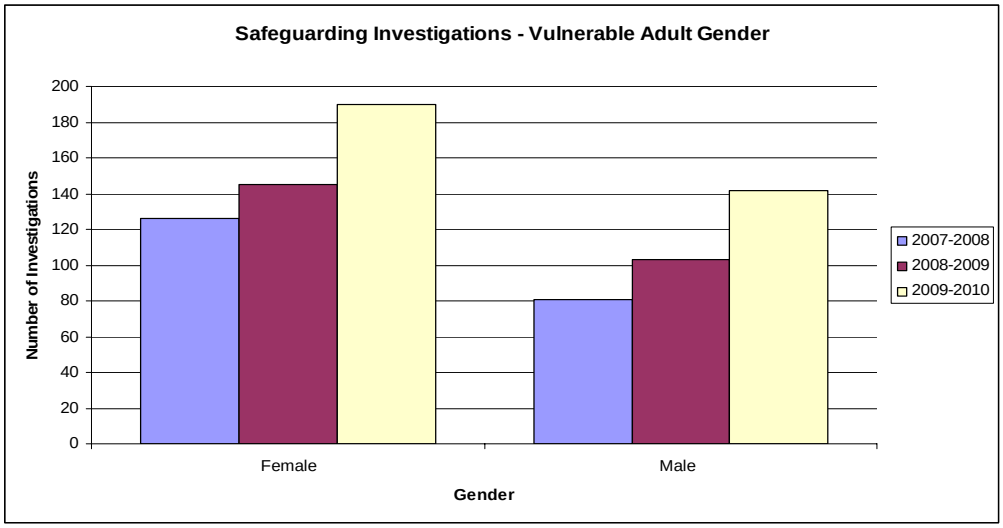
Safeguarding Alert Sources	2007-08	2008-09	2009-10
Advocacy Service	1	0	3
Anonymous	3	10	16
Local Ambulance Service, NHS and PCT	36	53	56
Police	5	5	17
Regulatory Body	2	1	1
Social Care Worker, Service Provider including Voluntary Organisation.	90	86	74
Social Services, including Out of Hours,	32	36	56
Vulnerable Adult, Family or Friend	75	97	154
Total	**244**	**288**	**377**

Table 3. Safeguarding Alerts by Vulnerable Adult Age Group



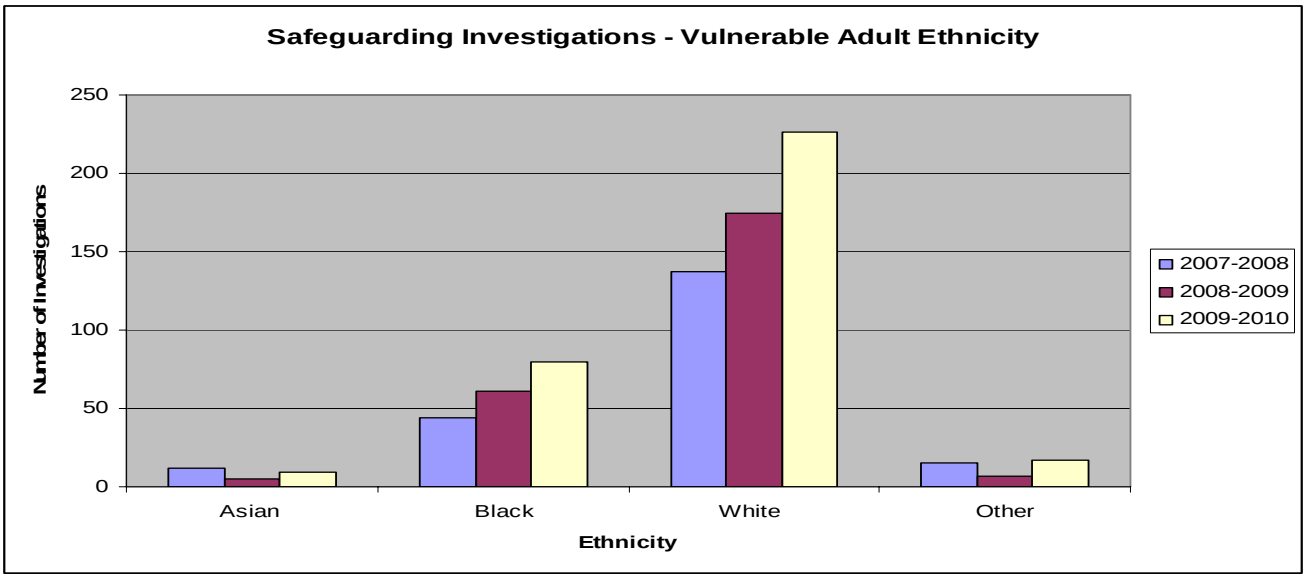
Safeguarding Alerts and Investigations - Vulnerable Adults Category			
	2007-08	**2008-09**	**2009-10**
18 - 44	35	38	48
45 - 54	29	27	33
55 - 64	22	20	35
65 - 74	19	35	50
75 - 84	38	68	85
85 - 94	51	48	60
95 - 104	10	8	20
105+	1	0	1
Total	**205**	**244**	**332**

Table 4. Safeguarding Investigations - Vulnerable Adult Gender:



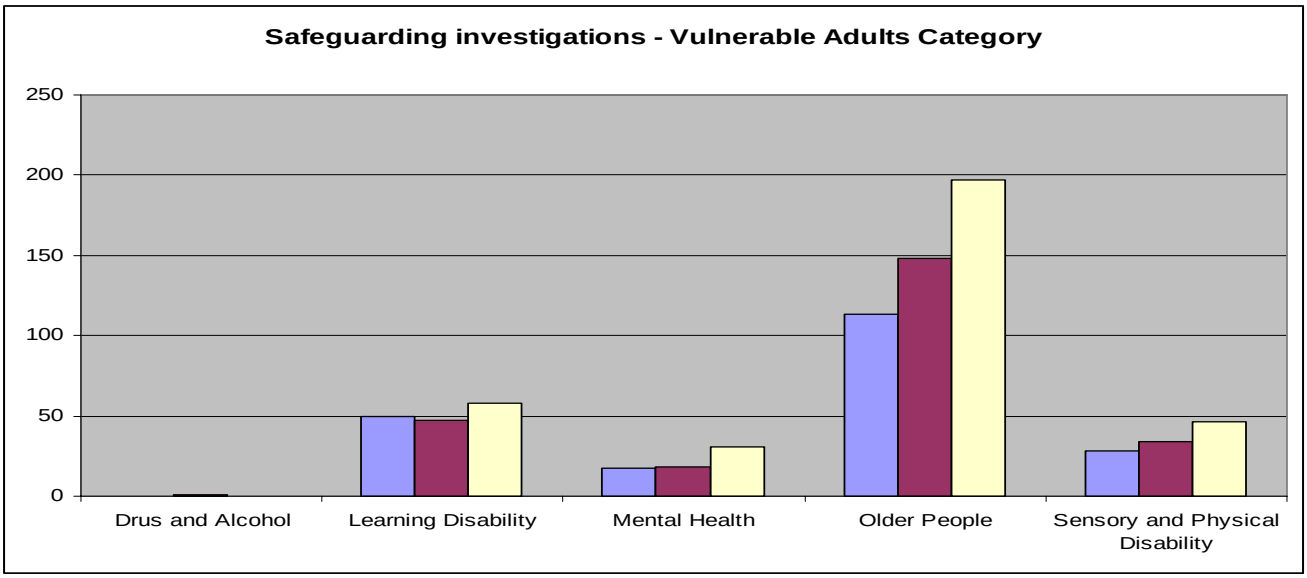
Safeguarding Investigations – Vulnerable Adults Gender			
	2007-08	**2008-09**	**2009-10**
Female	126	145	190
Male	81	103	142
Total	**208**	**248**	**332**

Table 5. Safeguarding Alerts raised by Ethnicity



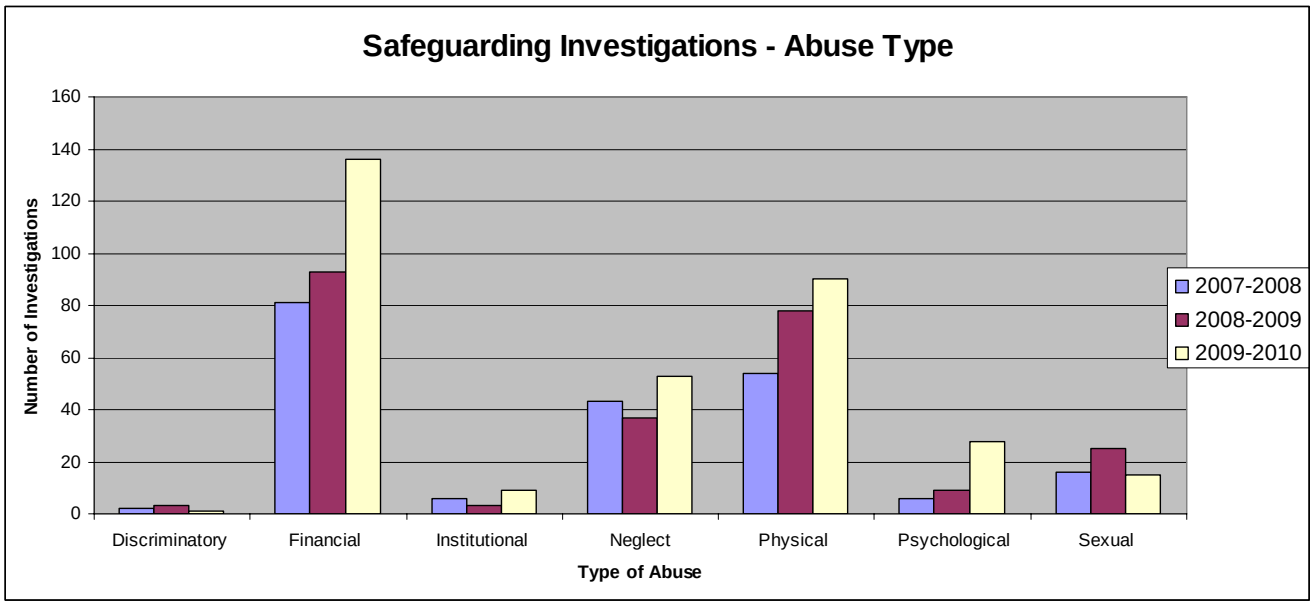
Safeguarding Investigations – Vulnerable Adult Ethnicity			
	2007-08	**2008-09**	**2009-10**
Asian	12	5	9
Black	44	61	80
White	137	175	226
Other	15	7	17
Total	**208**	**248**	**332**

Table 6. Safeguarding Alerts - Vulnerable Adults Category



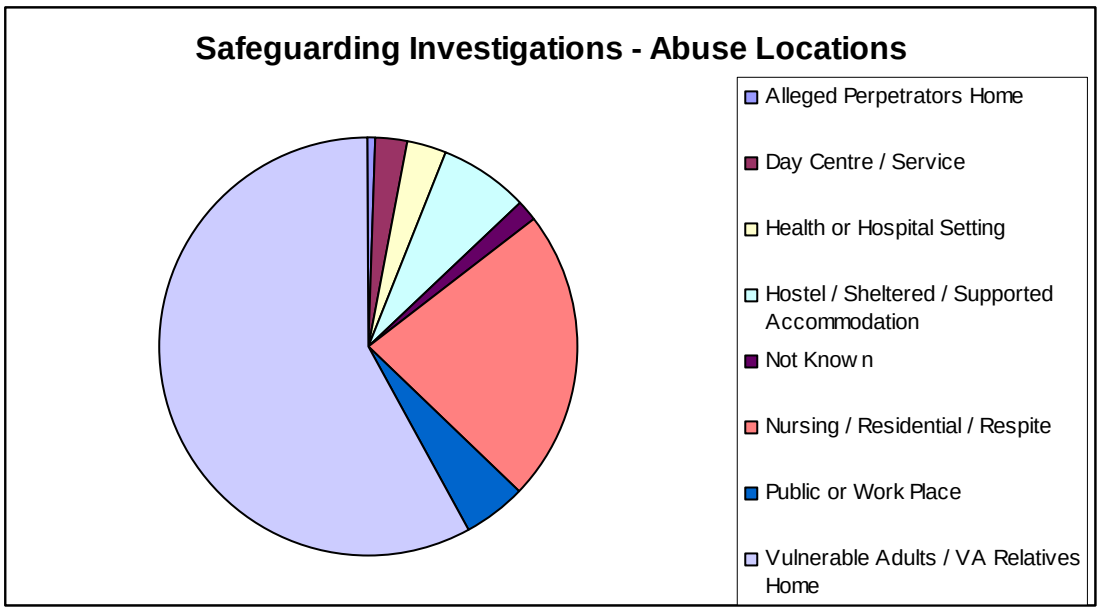
Safeguarding Investigations – Vulnerable Adults Category			
	2007-08	**2008-09**	**2009-10**
Drugs and Alcohol	0	1	0
Learning Disability	50	47	58
Mental Health	17	18	31
Older People	113	148	197
Sensory and Physical Disability	28	34	46
Total	**208**	**248**	**332**

Table 7. Types of Abuse Investigated



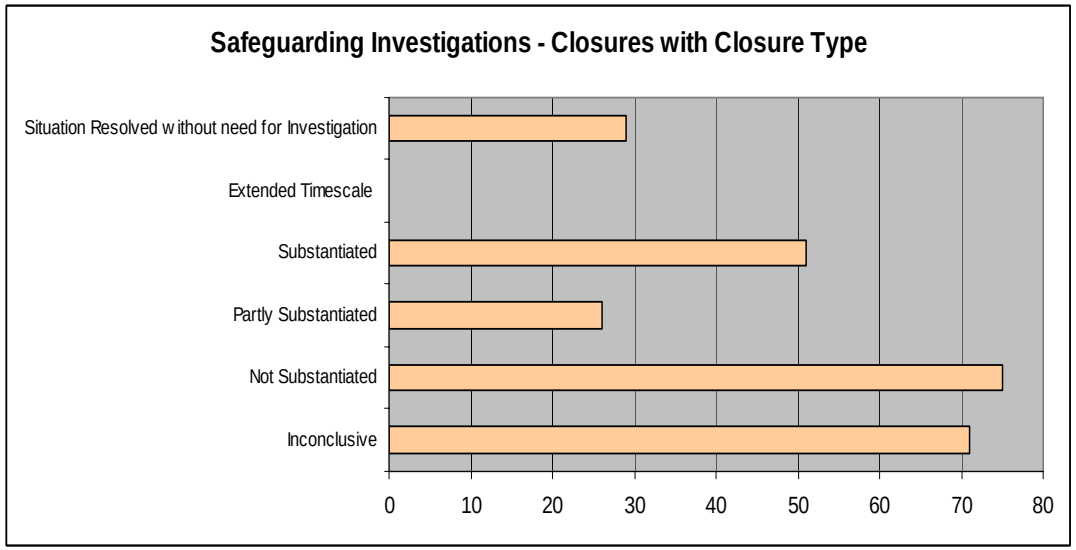
Safeguarding Investigations – Abuse Type	2007-08	2008-09	2009-10
Discriminatory	2	3	1
Financial	81	93	136
Institutional	6	3	9
Neglect	43	37	53
Physical	54	78	90
Psychological	6	9	28
Sexual	16	25	15
Total	**208**	**248**	**332**

Table 8. Location of Abuse



Safeguarding investigations – abuse locations	2009-10
Alleged Perpetrators Home	2
Day Centre / Service	8
Health or Hospital Setting	10
Hostel / Sheltered / Supported Accommodation	23
Not Known	6
Nursing / Residential / Respite	75
Public or Work Place	15
Vulnerable Adults / Vulnerable Adults Relatives Home	193
Total	**332**

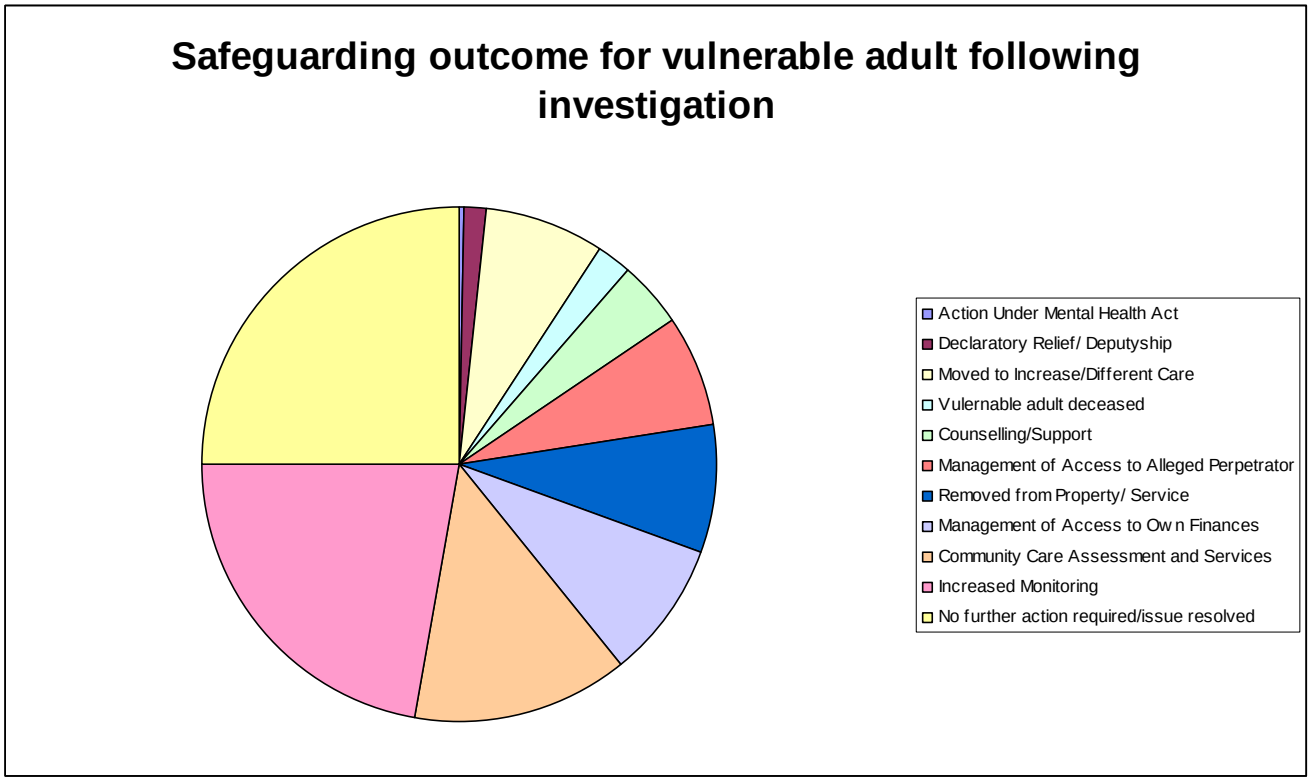
Table 9. Case Conclusions



Safeguarding investigations – closure with closure type	
	2009-10
Inconclusive	71
Not Substantiated	75
Partly Substantiated	26
Substantiated	51
Extended Timescale	0
Situation Resolved without need for Investigation	29
Total	**252**

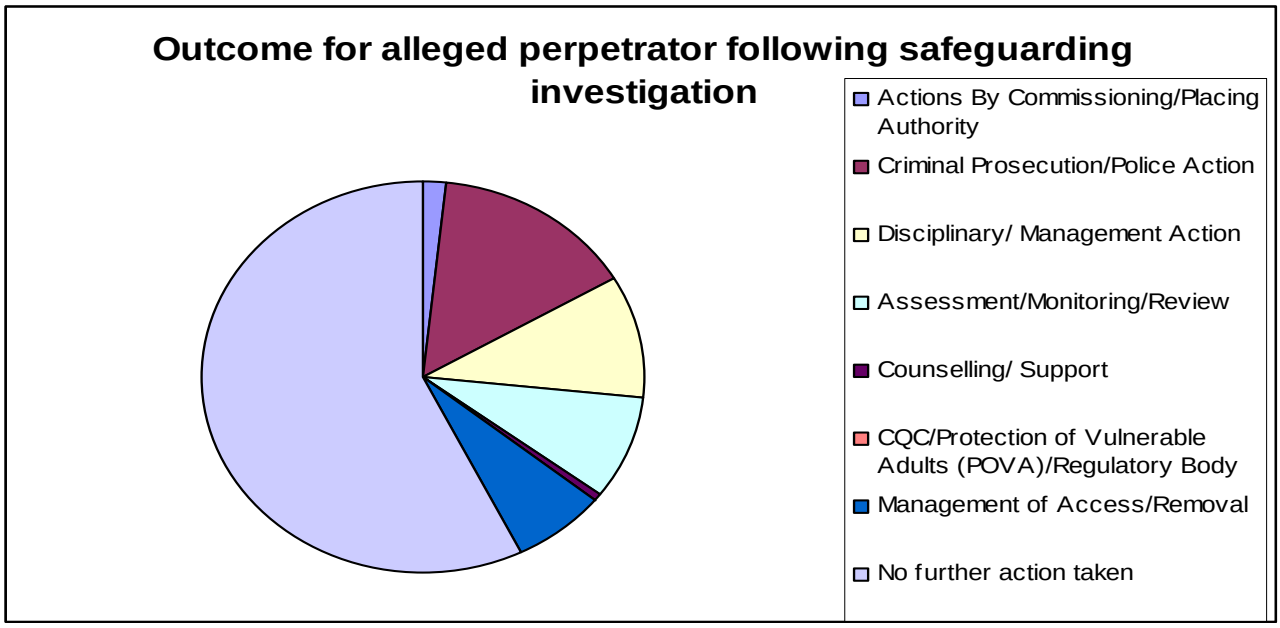
Item:	Conclusion:	Definition:
1.	Substantiated:	All of the allegations of abuse are substantiated on the balance of probabilities
2.	Partly Substantiated:	This would apply to cases where it has been possible to substantiate some but not all of the allegations made on the balance of probabilities. For example '*it was possible to substantiate the physical abuse but it was not possible to substantiate the allegation of financial abuse*'.
3.	Not Substantiated:	It is not possible to substantiate on the balance of probabilities any of the allegations of abuse made.
4.	Not Determined / Inconclusive:	This would apply to cases where it is not possible to record an outcome against any of the other categories.
5.	More Likely than not to have occurred:	

Table 10. Outcome for Vulnerable Adult:



Safeguarding outcome for vulnerable adult following investigation	2009-10
Action Under Mental Health Act	1
Declaratory Relief/ Deputyship	3
Moved to Increase/Different Care	19
Vulnerable Adult Deceased	6
Counselling/Support	10
Management of Access to Alleged Perpetrator	18
Removed from Property/ Service	20
Management of Access to Own Finances	22
Community Care Assessment and Services	34
Increased Monitoring	56
No further action required/issue resolved	63
Total	**252**

Table 11. Outcome for Alleged Perpetrator



Safeguarding outcome for vulnerable adult following investigation	2009-10
Actions By Commissioning/Placing Authority	4
Criminal Prosecution/Police Action	38
Disciplinary/ Management Action	25
Assessment/Monitoring/Review	22
Counselling/ Support	1
CQC/Protection of Vulnerable Adults (POVA)/Regulatory Body	0
Management of Access/Removal	18
No further action taken*	144
Total	**252**