Hampshire Safeguarding Adults Board

Accountability Statement 2012/14

A report of the activities and progress of the Hampshire Safeguarding Adults Board

September 2014

This report covers a two year period from (1st April 2012 to 31st March 2014) and highlights the board's progress in delivery its Strategic Plan.

Hampshire Safeguarding Adults Board

Accountability Statement 2012-2014

Foreword

This report provides the opportunity to demonstrate what the Hampshire Safeguarding Adults Board's (HSAB) has done to deliver its responsibilities regarding the strategic development of adult safeguarding across Hampshire. This report covers a two year period (1st April 2012 to 31st March 2014) and highlights the Board's progress and achievements in delivering its Strategic Plan. This report also outlines what each core HSAB member organisation has done to implement the Safeguarding Strategy as well as the areas requiring focus for the coming year. I would like to thank all members of the Board for their commitment and involvement over the past year, including the subgroups and their chairs for their important contribution. It is also important to acknowledge the contribution of other Boards and Partnerships which have been involved in supporting safeguarding adults work which includes the Community Safety Partnership, Health and Wellbeing Board and the Hampshire Safeguarding Children's Board. Over the two years covered by the annual report, there have been significant influences on the safeguarding adults' agenda both nationally and locally. The Board and all its partner agencies have been responsive to the opportunities and challenges these have presented. I am therefore, delighted to present this report to you and look forward to the new challenges and opportunities that the coming year will bring as we move towards Safeguarding Adults Boards being placed on a statutory footing and the introduction of a statutory framework within which to deliver safeguarding support to people at risk.

Pamela Charlwood

Independent Chair, Hampshire Safeguarding Adults Board

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1. Legal and policy context

1.1 A national framework for safeguarding adults was first introduced via *"No Secrets (2000): a national framework for providing better protection for people needing care and support"*. No Secrets was established under Section 7 of the Local Authority Social Services Act thus giving the guidance statutory status. Since 2000, safeguarding adults work has continued to gain ever increasing momentum and prominence. The Safeguarding National Framework published by ADASS in 2005 built on and updated No Secrets. In May 2013, the Government published its statement of policy on safeguarding adults (2013) which provides a legislative "bridge" between No Secrets and the Care Act due to come into force in April 2015. The Act will place adult safeguarding on a statutory footing and will introduce new safeguarding provisions.

1.2 Hampshire Safeguarding Adults Board has developed a multi-agency safeguarding adults' policy and procedures which outlines how the *No Secrets* framework is implemented locally. Published in 2013, the local multi-agency safeguarding adults' policy and procedures were developed as a joint initiative between Hampshire, Southampton, Portsmouth and the Isle of Wight local safeguarding adults' boards. Our local safeguarding procedures are aimed at supporting people with needs of care and support who are experiencing, or are at risk of, abuse or neglect, and as a result of those needs are unable to protect themselves against the abuse or neglect or the risk of it. Our local safeguarding arrangements are designed to ensure people at risk: are safe in the community and within mainstream and specialist service provision; are protected by crime prevention measures aimed at the whole community; can access mainstream criminal justice and victim support services; can access services and make decisions and if necessary and can get protection from statutory services if they do not have the mental capacity to decide whether to or how to protect themselves.

1.3 Local safeguarding policy and procedures reflect a number of key underpinning themes such as the importance of a person centred approach, prevention and early intervention work; application of robust risk management processes and the timely sharing of vital information to avoid delays in providing people at risk with safeguarding support. Local safeguarding arrangements recognise that there are three levels of safeguarding work comprising:

1) *Prevention*
2) Early Intervention and 3) Safeguarding Intervention

1.4 This approach highlights the need for work to be carried out within a 'business as usual' context by a wide range of agencies as part of their day to day contact with people at risk. This approach relies on risks being recognised and acted upon at an early stage in order to prevent issues escalating to the point of crisis into the safeguarding arena. It also reflects the principle 'safeguarding is everyone's business'.

2. National developments and local response

2.1 During the period covered by this report, safeguarding adults work has gained ever greater prominence. There have been significant national developments which have served to provide focus and to drive improvements in our local safeguarding adult arrangements. These developments are highlighted below:

- There have been major changes in the NHS landscape brought about by the abolition of Primary Care Trusts in 2013 and the introduction of Clinical Commissioning Groups (CCGs), area teams of NHS England, and commissioning support units. . The new NHS organisations have ensured that they are effectively represented on HSAB and engaged in its sub groups

- In December 2012, the new Disclosure and Barring Service was established replacing the Independent Safeguarding Authority and brought in new rules regarding the vetting and barring of people working with vulnerable groups.

- In December 2012, the Government published its response to the maltreatment of patients at Winterbourne View assessment and treatment unit, and set out its action plan for both Clinical Commissioning Groups (CCG) and local authorities. This plan centred on ensuring that the use of assessment and treatment centres is closely monitored and that joint plans are developed between CCG and local authorities to support people to receive support in their local community and in line with their wishes and best interests. In response, HSAB included follow up to Winterbourne View in its business plan and via reports to the board, monitors progress against the locally agreed action plan.

- In February 2013, the Final Francis Report was published, identifying failings at Mid-Staffordshire Foundation Trust which was shortly followed by the Government publishing its response to address poor quality care in NHS services. In response, HSAB included

follow up to Winterbourne View in its business plan and via reports to the board, monitors progress against the locally agreed action plan.

- In February 2013, the Home Office introduced a new definition of 'domestic abuse' which has been extended to include incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality.

- In April 2013, Health and Wellbeing Boards were established and became a statutory requirement. HSAB has established links with the Hampshire Health and Wellbeing Board and has developed a joint working protocol.

- In May 2013, the Government published its Statement of Policy on Safeguarding Adults which is designed to provide a legislative bridge with the Care Act which will be coming into law in April 2015. The Statement outlines six key principles against which local safeguarding boards and partner agencies should be using to measure both existing adult safeguarding arrangements as well as future improvements. These principles have been incorporated into the Hampshire Local Multi-Agency Safeguarding Policy and Procedures and also been included in the HSAB Memorandum of Agreement (or Constitution) thereby placing these principles at the centre of our safeguarding processes and governance arrangements. The six principles are outlined below:

Government Statement of Policy on Safeguarding Adults – Six Key Principles

Principle	Description	Outcome for Adult at Risk
Empowerment	Presumption of person led decisions and informed consent.	*"I am asked what I want as the outcomes from the safeguarding process and these directly inform what happens."*
Prevention	It is better to take action before harm occurs.	*"I receive clear and simple information about what abuse is, how to recognise the signs and what I can do to seek help."*
Proportionality	Proportionate and least intrusive response appropriate to the risk presented.	*"I am sure that the professionals will work for my best interests, as I see them and will only get involved as much as needed. I understand the role of everyone involved in my life."*
Protection	Support and representation for those in greatest need.	*"I get help and support to report abuse. I get help to take part in the safeguarding process to the extent to which I want and to which I am able"*
Partnership	Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.	*"I know that staff treat any personal and sensitive information in confidence, only sharing what is helpful and necessary. I am confident that professionals will work together to get the best result for me."*
Accountability	Accountability and transparency in delivering safeguarding.	*"I understand the role of everyone involved in my life."*

2.2 The Care Act 2014 will come into force in April 2015. In addition to significantly reforming the law relating to care and support for adults and carers, this legislation will introduce a number of provisions about safeguarding adults at risk from abuse or neglect. HSAB has been preparing for the implementation of the Care Act and has undertaken a range of activities to ensure local arrangements are fit for purpose and are compatible with new requirements such as the appointment of an independent chair and dedicated board manager, agreement of multi-agency funding, and an update of the serious case review process.

2.3 Clauses 42-48 of the Care Act provide the statutory framework for protecting adults from abuse and neglect from April 2015. Provisions include:

- A new duty for the local authority to carry out enquiries (or cause others to) where it suspects an adult is at risk of abuse or neglect.

- Local Safeguarding Adults Boards to carry out safeguarding adults reviews into cases where someone who is experiencing abuse or neglect dies or there is concern about how authorities acted, to ensure lessons are learned.

- New ability for Safeguarding Adults Boards to require information sharing from other partners to support reviews or other functions.

- Abolition of the existing power (under section 47 of the National Assistance Act 1948) for local authorities to remove people from their homes.

- Requirement for all areas to establish a Safeguarding Adults Board to bring together the local authority, NHS and police to coordinate activity to protect adults from abuse and neglect.

2.4 The government will be publishing draft regulations and statutory guidance setting out how it intend the legislation to be implemented including guidance on how social workers and other practitioners should use existing legal powers to safeguard vulnerable adults, after calls to introduce a new power of entry were excluded.

2.5 The implementation and extension of Personalisation has emphasised the importance of services relating to service users as individuals. In relation to safeguarding, this has highlighted the need for the agencies to work preventively to ensure service users are supported to protect themselves and make informed decisions about action when experiencing or likely to experience abuse or exploitation. In March 2014, guidance was published on 'Making Safeguarding Personal' (MSP). This represents a shift in culture and practice towards a more person centred approach in which the person at risk is at the centre of a safeguarding process driven by their views, decisions and outcomes sought. MSP echoes the key principles published by the Government in its Statement of Policy on Safeguarding Adults. Hampshire Adult Social Care has been involved in the national MSP pilot.

2.6 It is important to acknowledge the significant financial pressures experienced across partner agencies during the period covered by this report and to acknowledge that despite these, all HSAB partners have maintained their commitment to the safeguarding agenda and collectively, have made significant progress in achieving HSAB's strategic priorities and objectives.

3. About the Hampshire Safeguarding Adults Board

3.1 The HSAB was established in 2003 and is a statutory, multi-organisation partnership committee, co-ordinated by the local authority, which gives strategic leadership for adult safeguarding, across the Hampshire County Council area. The HSAB's remit is to agree objectives, set priorities and co-ordinate the strategic development of adult safeguarding across the county. The HSAB is the key mechanism for agreeing how relevant agencies will work together effectively to safeguard and promote the safety and well-being of adults at risk and/or in vulnerable situations.

3.2 The HSAB aims to promote awareness and understanding of abuse and neglect and works to generate community interest and engagement in safeguarding to ensure "Safeguarding is Everyone's Business". The well-being and safety of local people is our main concern and we adopt a zero tolerance stance on the abuse, neglect or discrimination of any person but particularly people at risk or in vulnerable situations in whatever setting. We make sure there is good partnership working at the local level when concerns are raised and agencies work together effectively to ensure a co-ordinated approach. We have worked proactively with care providers to address any concerns raised about their service to ensure that local people have access to good quality and safe care when they need it.

3.3 In 2012, the Board appointed an independent chair who commenced in January 2013. The chair is responsible for ensuring that all organisations contribute effectively to the work of the Board; she also provides accountability for the work undertaken by the HSAB by way of reports to relevant strategic committees and boards. The HSAB is made up of wide range of organisations as follows:

Hampshire Safeguarding Adults Board Membership

Board Management

- Independent Chair
- HSAB Board Manager
- Business Support

Core Members

- Adult Social Care
- Clinical Commissioning Groups
- Hampshire Constabulary
- NHS England, Wessex Area Team

Associate Members

- Advocacy provider
- Ambulance Service
- Children's Services
- Community Safety Partnerships
- Hampshire Fire and Rescue Service
- HM Prison Winchester
- Housing Services
- Independent care provider
- NHS providers
- Probation Service
- Subgroup chairs
- Trading Standards

Advisory

- Care Quality Commission
- Carer organisation
- Community Action Hampshire
- Director of Adult Services
- Executive Member, HCC
- HealthWatch
- Public Health
- Service user representative

4. Governance and accountability

4.1 Over the past year, the HSAB has undertaken a root and branch review of its governance arrangements in order to ensure these are consistent with current requirements and the organisational changes that have occurred within member organisations. When the Care Act passes into law next April, this will place the Board on a statutory footing requiring it to fulfil specific statutory responsibilities. The review of our governance arrangements has formed part of our preparation for the implementation of the new legislation. The following activities have been undertaken to improve governance and accountability arrangements:

- Review and revision of the HSAB Memorandum of Agreement (MOA). This document describes the framework that underpins the working of the Board and outlines the role, responsibilities, authority and accountability of member organisations represented.

- Review and revision of Board membership the result of which has been the addition of representatives from HealthWatch, Public Health, HMP Winchester and Trading Standards. The Board has responded effectively to the challenges created by the new NHS organisational structure and has Hampshire's five CCGs and the NHS Local Area Team are involved in the Board and its subgroups either directly or through agreed representation. In terms of service user participation, the Board has a service user representative. However, the Board recognises the need to develop a range of approaches to achieve meaningful involvement of service users (and other stakeholders) on the board and to ensure that the Board is informed by the voice of service users in general. This has been highlighted as an area for development for 2014/15.

- Development of clearly defined links with a range of other Boards and Strategic Partnerships including the Local Safeguarding Children's Board, Safer Communities, Domestic Violence, MAPPA, Honour Based Violence, Health and Wellbeing Board and the NHS Vulnerable Persons Committee. Links have also been established with the Police and Crime Commissioner's Office. These links are maintained either through representation at the HSAB and/or through participation by HSAB members on strategic forums and working groups.

- Publication of the HSAB Safeguarding Strategy in 2012. The priorities and objectives contained in it were informed by national and local developments as well as the previously discussed government statement of principles and policy objectives. HSAB has also developed a business plan to support implementation of its Safeguarding Strategy.

4.2 HSAB has been supported by a number of sub groups focusing on the delivery of specific business plan objectives. There are currently five subgroups covering Communication, Workforce Development, Quality Assurance, Learning and Review and finally, a Business Subgroup which manages and co-ordinates the Board's meetings, work programme and governance arrangements.

4.3 Each subgroup operates to agreed terms of reference and work plan and regular progress reports provided to the Board. HSAB has also set up short term task and finish groups focusing on specific areas of safeguarding work such as Fire safety and safeguarding in Winchester Prison. Progress and achievements against stated objectives are reported in the Accountability Statement which is then presented to the Health and Wellbeing Board in order to ensure alignment of activities within the broad health and well-being agenda and to deliver accountability to the wider local strategic partnership.

4.4In recognition of the importance of partnership working with neighbouring Local Safeguarding Adults Boards (LSABs), HSAB is an active member of the "4LSAB" management group (comprising the managers and operational safeguarding leads from Hampshire, Portsmouth, Southampton and Isle of Wight) the purpose of which is to share and disseminate good practice and to agree areas of strategic development the LSABs will undertake jointly in order to establish as great a level of consistency as possible.

4.5 In addition to the joint safeguarding adults' policy and procedures published in 2013, joint work has also been undertaken with the neighbouring LSABs to develop a shared Communication Protocol, Workforce Development Strategy, Learning and Review Framework and Fire Safety Protocol. To promote this approach, the Hampshire 4LSAB independent chairs also meet on a regular basis.

4.6 In March 2014, multi-agency funding of HSAB was agreed with costs shared between core members (local authority, CCGs and Police) according to an agreed formula. The budget required for 2014/15 is £109,000. The other HSAB member organisations have agreed to contribute 'in kind' for example by providing free venues for meetings and other events, training services of staff, etc. in order to keep HSAB running costs as low as possible. The HSAB budget and respective member contributions will be reviewed annually (in line with the production of the HSAB Annual Report and the publication of the following year's Strategic Plan) to take account of inflation and any additional costs arising from implementation of the Care Act and revised HSAB business plan objectives and priorities.

5. Monitoring

5.1 Hampshire County Council Adult Services are the lead agency which records all the safeguarding information on behalf of the Hampshire Adults Safeguarding Board. Over the last few years Hampshire County Council Adult Services have continued to make improvements to the capture and reporting of safeguarding information; as a result of these changes it may not always be possible to directly compare activity between years. It is recognised that current monitoring arrangement are single agency orientated with the information provided focusing in the main, on safeguarding activity with little or no information available about the effectiveness of safeguarding services or outcomes. As a result, HSAB has developed an integrated monitoring and quality assurance framework that will be implemented during 2014/16 and which will draw on a range of information and sources to enable the Board to make judgements about the effectiveness of safeguarding work locally. This work will be led and co-ordinated by the HSAB Quality Assurance Subgroup who will report regularly to HSAB on the outcomes of these processes.

5.2 The key findings from the HSAB Safeguarding Performance Report are summarised below with more detailed and comparator information available in **Appendix A** HSAB Safeguarding Performance Report. As will be seen, these figures raise a number of questions and suggest the need for further analysis as to the policy and practice implications. This work will be led by the HSAB Quality Assurance Subgroup.

5.2.1 The overall number of safeguarding referrals has continued to increase in 2013/14 with 3,197 being reported. This represents a 27% increase on 2012/13 (2,516) and is an increase of 49% over the last 3 years.

5.2.2 Referrals are up across all client groups, compared to 2012/13, although there are variations across clients groups. Monitoring to date shows that over the last 3 years:

- Learning disability referrals have remained at a fairly constant number although they now represent a lower percentage of the total.

- Physical disability referrals have increased by 32% over the last year, although they only account for 10% of all referrals.

- The increase within Mental Health referrals is largely as a direct result of the work that has been undertaken over the last 2 years to improve referral recording in the Integrated MH Teams; as extensive training has been undertaken with teams along with improvements to the accessibility of Adult Services IT systems (for recording safeguarding) from a Health setting.

- Older people referrals still make up the majority of referrals, accounting for 57%, and have increased in number by 36% over the last year.

5.2.3 Safeguarding referrals from staff working in social care, which includes residential, day care and domiciliary care staff as well as social workers, remains the highest source for referrals; although the percentage they account for has reduced slightly over time. In this group staff working in a residential setting accounted for typically around 50% of these referrals. The second main source is Health who account for between 17-19% of referrals, of which in 2013/14 50% came from hospitals (secondary health), 32% from GP and community health staff (primary health) and the remaining 18% from mental health staff.

5.2.4 Neglect remains the most frequently reported type of abuse in 2013/14 linked to 39% of referrals (up from 33% in 2011/12) followed by physical abuse (26%), although the percentage of referrals relating to physical abuse has reduced over the last 3 years. The decline in 'Institutional' abuse can be explained partly by the reduction in the prevalence of cases relating to residential or nursing settings and changes in recording as any large scale investigation concerning a provider will be dealt with as a Level 4 safeguarding incident.

5.2.5 In 2011/12 and 2012/13 the most frequently reported location for abuse to occur was within a residential or nursing home accounting for 43% and 46% of the referrals respectively. In 2013/14 however, incidents in residential and nursing homes reduced overall to 38%, with abuse occurring in residential homes dropping by 10% from 34% to 24%. A person's own home became the most frequently reported location for where abuse occurred.

5.3 An important aspect of HSAB's role is to hold local agencies to account for their safeguarding work and a mechanism for achieving this is by requesting management reports from partner agencies on current and emerging issues both locally and nationally. During the period covered by this report, HSAB has commissioned a wide range of management reports to help it understand the current issues influencing the local safeguarding agenda and their impact on front line services. These include:

- HSAB report of the Mr A Serious Case Review highlighting failures in the co-ordination between health and social care services to meet this individual's needs and in effective risk assessment (June 2012).
- CCG briefing regarding a major safeguarding investigation regarding a Hampshire based independent sector provider (June 2012).
- Briefing on Winterbourne View Serious Case Review and the local response required (September 2012).
- Hampshire Constabulary report on its use of Vulnerable Witness Intermediaries (September 2012).
- Joint presentation of the local multi-agency action plan in response to Winterbourne View (December 2012).
- Hampshire Fire and Rescue Service report on fire deaths of adults at risk which highlighted that people with needs of care and support have a significantly higher risk of death by fire than the rest of the population (December 2012).
- Southern Health Foundation Trust report outlining the application of safeguarding procedures in its mental health and learning disability services after monitoring of safeguarding activity highlighted a low referral rate regarding mental health service users (December 2012).
- Briefing on the Mid Staffordshire Inquiry and the local response required (March 2013)
- Trading Standards report highlighting its role and work linked to adult safeguarding (March 2013)

- Hampshire County Council report on Reducing the Incidence of Choking regarding People with a Learning Disability following a number of choking incidents (March 2013).

- Hampshire Fire and Rescue Service report of fire deaths involving Hampshire residents known to be accessing housing, health and/or social care services (March 2013).

- Children's Services report outlining the Multi-Agency Service Hub (MASH) service model and its transferability to an adult safeguarding context (June 2013).

- Care Quality Commission report outlining its role and responsibilities regarding safeguarding adults (June 2013).

- Hampshire County Council report outlining its Mate Crime Strategy (June 2013).

- Hampshire County Council report on the introduction of the new Disclosure and Barring Service (June 2013).

- Hampshire County Council report outlining the response to the failure of Southern Cross independent sector provider (June 2013).

- Domestic violence report outlining the work of the inter-agency Domestic Abuse Steering Group and to clarify the corporate position regarding the commissioning of Hampshire County Council funded services. The paper summarised the national and local context and position with regard to domestic abuse services, set out present commissioning and funding arrangements within Hampshire and provided a comparison for Hampshire, using data supplied by CAADA (Co-ordinated action against domestic abuse) current developments (December 2013).

- Hampshire County Council Choking Action Plan update (December 2013).

- Southern Health Foundation Trust report into the use of restraint in mental health services (December 2013).

- Children's Services report of the Joint Working Protocol for safeguarding children and young people whose parents or carers have problems with mental health, substance misuse, learning disability and emotional r psychological distress (March 2014).

5.4 In December 2013, HSAB introduced a 'Real Life' case presentation as the first agenda item of each Board meeting in order to ensure it is informed about and by, the experiences of service users and professionals. This item is presented by front line practitioners and is designed to place immediate focus on front line working and how good partnership working makes a difference to outcomes. Similarly, HSAB has also introduced the Safeguarding Policy and Practice Bulletin as a standard agenda item. This is a 'horizon scanning' designed to enhance the Board's scrutiny role by highlighting current and emerging issues on the national level and how these might impact on local services.

6. Business Plan Review

6.1 The following Table provides a summary of HSAB's activity over the two year period covered by the report and highlights the progress achieved against the key priorities and objectives outlined in the current HSAB Strategic Plan and Business Plan:

What we said we'd do	What we did
Raise awareness of safeguarding across all sectors of the community	• A new HSAB Website has been developed and launched. Aimed at the local community, service users and carers, it seeks to promote awareness of abuse, keeping safe and how to report concerns. There is a dedicated section for professionals with access to a comprehensive policy and guidance. • Launch of the 'Mate Crime' Strategy raising awareness of exploitation and abuse carried out on the part of 'friends'. • HSAB has developed a multi-agency Safeguarding Communication Protocol which all agencies across Hampshire and the Isle of Wight have signed up to. This ensures consistency in the messages provided about adult safeguarding. • HSAB has set up a multi-agency Safeguarding Communication Leads Network across Hampshire and Isle of Wight which will focus on advising the LSABs of activities to promote community engagement in safeguarding and the work of the LSABs. • HSAB has agreed a communication plan for safeguarding adults which highlights a wide range of activities to promote awareness and community engagement in safeguarding. This will be brought forward for inclusion in next year's HSAB Business Plan.

What we said we'd do	What we did
Actively engage all stakeholders in safeguarding adults at risk	• HSAB has held 'stakeholder events' aimed at the public and grass roots organisations across a number of locations to promote awareness of adult safeguarding and the work of the HSAB. These events were supported by a wide range of organisations who promoted their 'keeping safe' schemes. A range of publicity material was produced to support these events including a survey on safeguarding the results of which will inform the coming year's Strategic Plan.
Work to reduce the number of avoidable fire deaths of vulnerable people in Hampshire	• Hampshire Fire and Rescue Service has been added to the adult social care 'consent to share form'. • Partner agencies include Fire safety in induction training and safeguarding adults training programmes • Partner agencies include Fire safety in needs assessment. Domiciliary care providers are required to include fire safety in their generic risk assessment • HFRS and HSAB set up a 4LSAB working group to develop a multi-agency risk management process to respond to people at significant fire risk. This work is on-going and will be brought forward to the coming year's business plan.
Develop robust governance arrangements in and across agencies	• HSAB has introduced a multi agency Learning and Review Framework which enables shared learning to complement single agency governance arrangements. Lessons learned are used to improve front line practice and partnership working. • HSAB has introduced multi-agency reflective workshops to review cases falling below criteria for a Serious Case Review. This approach engages front line staff, managers and commissioners to identify potential learning and to develop recommendations for change. • In 2012, HSAB carried out a serious case review (SCR) of the Mr A case. The multi agency action plan developed following the review has led to improvements in the way health needs of people at risk managed and continuity of care maintained in hospital.

What we said we'd do	What we did
Develop robust governance arrangements in and across agencies (continued)	• The SCR policy has been revised to reflect the new terminology and criteria included in the Care Act (its title has been changed to safeguarding adult review process). The updated version provides a much clearer and manageable process and gives the flexibility to use a range of approaches. • HSAB has introduced Impact Analysis Reports which local agencies use to evidence how learning from serious cases with poor outcomes has been applied in practice and the difference made from a service user perspective • In 2012, HSAB commissioned an audit on choking incidents following a number of incidents involving people with a learning disability locally and nationally. The report and resulting multi agency action plan have brought about improvements in the management of people at high risk of choking. • HSAB has developed and launched a 'Learning from Experience' Database which contains links to national and local serious case reviews, reports and inquiries and for each, a summary of the case is provided together with professional learning points. It aims to support the dissemination of the learning arising from these across Hampshire and by doing so to promote evidence based practice. Four key themes have emerged from the analysis of SCRs which are: institutional abuse or neglect; self neglect; disability hate crime and familial abuse or neglect. In the coming year, HSAB will be setting up a programme of learning workshops and a 4LSAB conference to explore a sample of cases in order to improve frontline practice and partnership working. • HSAB has, and continues to explore a range of methodologies to carry out safeguarding adults reviews. In 2012, it commissioned 'systems learning training' from the Social Care Institute of Excellence. NHS England commissioned a further course in 2014 targeted at NHS designated safeguarding adult's nurses and doctors. HSAB is considering another approach which is Serious Incident Learning Process (SILP) with an accredited course taking place in September 2014.

What we said we'd do	What we did
Response to Winterbourne View and Mid Staffordshire Enquiry Reports	• HSAB has monitored the local multi- agency action plans to respond to these national events. As part of its scrutiny role and responsibility to hold local agencies to account, the Board has requested regular updates and progress reports from local agencies.
Develop a Quality Assurance Framework which HSAB will use to hold local agencies to account for their safeguarding work	• HSAB has introduced a multi-agency Quality Assurance Framework. This uses a range of complementary approaches to ensure that reliable and balanced information is gained. • A range of tools has been developed to support the implementation of the QA Framework including the Integrated Safeguarding Scorecard and an Organisational Self Audit Tool. • It is intended to develop an annual themed audit programme to provide information of a qualitative nature. This should reflect key priorities arising from the HSAB Safeguarding Strategy and Business Plan as well as topics flagged from quality assurance activity. • Regular reports on safeguarding adults' activity have been presented to the board which has enabled patterns and trends to be identified in the concerns raised. • The performance indicators reported to the Board have been revised so as to provide a better picture of the nature and extent of harm and risk of harm experienced by local people at risk. • Governance regarding Deprivation of Liberty Safeguards (DOLS) has been brought under the HSAB umbrella thus will improve the reporting and accountability for this critical area of service provision.

What we said we'd do	What we did
Develop effective partnerships	• Joint work between HMP Winchester and HSAB to produce a safeguarding adults' protocol. This work has ensured that the safeguarding needs of prisoners with needs of care and support are recognised and met within the prison environment and was cited as 'best practice' by HMIP in a recent inspection of the prison. On-going work is planned to implement safeguarding arrangements. • Launch of the Multi Agency Service Hub (MASH) which will improve information sharing, triage and partnership working. • Links have been established and maintained with HealthWatch, Police and Crime Commissioner, Health and Wellbeing Board, CCG's, ADASS SE Regional and National Safeguarding Adults Network and the national Independent Chairs' Network. • A joint working protocol has been developed between the HSAB and Health and Wellbeing Board. • HSAB has established a 4LSAB Workforce Development Group to develop a multi- agency safeguarding learning and development strategy across the area. This will ensure that safeguarding learning and development equips respective organisations and their staff to meet the standards outlined in the pan Hampshire safeguarding adults policy and procedures. • The Workforce Development Group is developing a quality assurance framework for safeguarding learning and development which will provide training standards to inform in house training. • Active involvement from HSAB, local authority and partner agencies in the 4LSAB Management Group so as to ensure joint strategic development of safeguarding work across the area. Regular meetings have been held of the 4LSAB independent chairs to develop a shared approach. This group jointly reviewed and updated the Local Multi-Agency Safeguarding Adults Policy and Procedures published in 2013.

What we said we'd do	What we did
Establish effective links between safeguarding and personalisation	• In 2013, HCC participated in a Making Safeguarding Personal (MSP) study in order to understand what works well in supporting adults at risk of harm and abuse and how the council can support individuals to achieve their desired outcomes from the safeguarding process. MSP is a change in approach to safeguarding work and the intention is to facilitate a move away from safeguarding being process driven to person-centred, outcomes focused responses to adult safeguarding. The pilot ran between October to December 2013 and Hampshire provided 20 cases for the study.
Develop service user involvement	• A Safeguarding Service User Forum has been maintained. A key priority has been to develop its training function. A number of service users have been identified to carry out training and awareness raising using standardised presentation materials. • The HSAB aims to promote the involvement and contribution of service users on the Board. The HSAB continues to explore a range of approaches to achieve meaningful involvement of service users on the board and also that the Board is informed by the voice of service users in general. This is a priority for the coming year.

7. HSAB Core Member Reports

7.1 This section of the report contains a brief report from each of the core members of the HSAB (Adult Services, CCGs and Police) outlining specific safeguarding adults' work and developments in their agency and the improvements they have achieved as a result. Other associate member organisations have provided an outline of how their work contributes to adult safeguarding work and as well as a 'Making a Difference' case study illustrating how safeguarding has supported people at risk to be safe and to achieve the outcomes they want.

7.1.1 Hampshire County Council Adult Services Department (ASD)

Hampshire County Council Adult Services Department have two responsibilities conferred upon it through the 'No Secrets' guidance which are to put in place services which act to prevent abuse of vulnerable adults and provide assessment and investigation of abuse and to co-ordinate the multi-agency partnership through the mechanism of the Hampshire Safeguarding Adults Board. The Adult Services Department has undertaken the following pieces of work during this period in order to strengthen and improve the safeguarding services offered to the people of Hampshire by adult social services:

- A Mate Crime Strategy was developed and launched during 2012-13 through work with multi-agency partners and service users;
- Continued work with service users, including the provision of training and support to take part in ASD staff training around safeguarding;
- Joint work with Trading Standards and appointment of a joint post to focus on financial abuse;
- Participation in the national pilot of Making Safeguarding Personal – an approach to improve involvement of service users in safeguarding;

- Internal review of contract arrangements with local care homes to ensure the standards expected are clear and the approach used when things do go wrong;

- Publication of practice guidance in 2012 for people providing care to people with a learning disability. This document was very well received, both locally and nationally, and compliance with the recommendations in the guide is currently being audited.

- Family Group Conference service commissioned to support adults and their families to address the abuse they may be experiencing.

- Family Group Conferences (FGC) are used to try and empower people to work out solutions to their own problems. A trained FGC coordinator can support the person at risk and their family or wider support network to reach an agreement about why the harm occurred, what needs to be done to repair the harm and what needs to be put into place to prevent it from happening again. This approach offers people a way to take control of their situation and resolve issues within the family unit – often in the context of strained relationships – in a safe and controlled environment. A three year contract to provide FGCs was awarded to Daybreak and began on 1st April 2013. The funding allows for 18 conferences and follow up reviews per year.

Making a Difference – Family Group Conferences

Brenda* has learning difficulties and general health problems. She had been living with her family but had chosen to move out and live with friends against her family's wishes. The relationship between her and a family member had become increasingly antagonistic and concerns had been raised about this. After Brenda left home communication broke down entirely. This was very upsetting particularly losing contact with her siblings but Brenda was adamant that she did not want to return. Brenda had mental capacity to decide where she wanted to live, but she needed support to help her with this situation. She was offered a Family Group Conference (FGC) by Daybreak to try to resolve the situation. As a result a FGC was organised and Brenda accepted the offer of an advocate to support her at the meeting to say what she really wanted. Members of the extended family attended and other family members, who could not be present, sent letters offering help. Brenda was supported to make a plan which helped her work towards her goal of achieving independence. Other family members agreed that they would help her to see her siblings outside of the family home, as they had also expressed the wish to stay in contact with her. Following the conference, Brenda was able to meet up with her siblings and spend time with other family members. In a subsequent review, Brenda reported that all the support she felt she needed to begin her new life was now in place.

* Name and some details changed to protect the identity of the service user

Making Safeguarding Personal (MSP) is a change in approach to safeguarding work and aims to move away from safeguarding being process driven and instead, to place the person at risk at the centre of the process and work with them to achieve the outcomes they want.

MSP also provides benefits for practitioners as it allows more in depth work at an early stage leading to better decision making. Staff are encouraged to use their social work skills, knowledge and judgement to improve outcomes for people. Early engagement of service users produces better outcomes and a simple approach is all that is needed.

Studies show that service users feel more empowered and in control of their safeguarding process when they and/or their representative were involved from the start and appreciated being involved even if their outcomes were not fully achieved.

Safeguarding can involve supporting people with very complex needs. The following case study provided by Southern Health Foundation Trust illustrates how good partnership working enabled the complex needs of a service user and her carer to be met safely whilst respecting her wishes and life style decisions:

What is Mate Crime?

Mate Crime occurs when a person is harmed or taken advantage of by someone they thought was their friend. There is limited information on the prevalence of Mate Crime nationally, however there has been an increase in the number of safeguarding alerts that involve Mate Crime across Hampshire in recent years.

In 2012, a family in Hampshire became concerned about how their daughter (who had a learning disability) had been exploited by someone she thought was a friend. The family talked to their local County Councillor, and as a result, Hampshire Adult Services were asked to develop a strategy to address this increasing problem. A working group was set up who collaborated on developing a strategy and a resource pack for service users and staff to use to help raise awareness of Mate Crime and encourage people to feel more confident to recognise and respond to Mate Crime. The resource pack includes good practice guidance, posters and a DVD of the Blue Apple Theatre Company performing a scene from their play "Living Without Fear" which highlights the dangers and consequences of Mate Crime.

The Mate Crime Strategy was launched in November 2013 supported by the Blue Apple Theatre Company who performed their play which highlights the issue. The launch event generated some excellent ideas and many of those present signed up to become local Mate Crime Champions and to raise awareness in their own organisations. For more information about Mate Crime including power point presentations, good practice guidance and the DVD go to Mate Crime or the Hampshire Safeguarding Adults website www.hampshiresab.org.uk

Making a difference – safeguarding people with complex needs

Mrs H is an elderly lady living in a flat with a family member who provides care for her along with community services. Staff were concerned at Mrs H's deteriorating health and mobility, and her frequent refusal to accept the care and advice offered, as well as her carer's own health and increasing inability to cope with her care needs. Consequently, a safeguarding alert was raised by one of the Community Nurses.

The subsequent safeguarding investigation found a number of issues, which included unwillingness to accept advice and care from the professionals involved such as her GP, and difficulty looking after the property. This meant that Mrs H and her relative were felt to be living in an 'unsuitable' home environment. A safeguarding plan was put in place to help both family members which respected Mrs H's decision to stay in her home, as well as the needs of her carer. While both declined a move to more suitable accommodation, Mrs H has now accepted a care at home plan which ensures she gets the additional support she needs while recognising that both she and her relative wish to remain living together with some care still provided by the relative. The joint working in this case between the NHS, Adult Services, Housing and the Police enabled the risks to Mrs H to be managed safely whilst respecting her wishes and lifestyle decisions

* Names and some details changed to protect the identity of the service users

7.1.2 Hampshire Constabulary

During the period covered by the report, Hampshire Constabulary has been undergoing a complete reorganisation of its business structures and processes in order to improve efficiency and cost effectiveness. The adult safeguarding role previously undertaken by the Vulnerable Adult Investigation Team is now undertaken by the CID department with the Head of the Public Protection Department having overall operational lead responsibility and who also represents Hampshire Constabulary on the HSAB. Hampshire Constabulary has continued to develop and implement appropriate internal policies and procedures to ensure its internal policy framework and practice is consistent with Local Multi- Agency Safeguarding Adults Policy and Procedures (2013) and also the requirements of the Care Act when it passes into law in April 2015.

- A significant development during the period covered by this report is the launch in 2014 of the Multi-Agency Safeguarding Hub (MASH). This has enabled the v Public Protection Department to standardise the process for adult safeguarding referrals, assessment of risks and allocation to an appropriate investigation and/or safeguarding team.

- Hampshire Constabulary has recently started a new Specialist Interview Team dedicated to professionalising our response to Vulnerable Victims and Witnesses in serious and complex cases and focuses on vulnerability and Achieving Best Evidence, working closely with the investigation team and partner agencies.

What is MASH?

Multi Agency Safeguarding Hub or MASH is a joint service made up of Police, Adult Services and the NHS. Information from different agencies is collated and used to decide what action to take. This means the agencies will be able to act quickly in a co-ordinated and consistent way, ensuring that the person at risk is kept safe. The MASH is a new way of working and will bring a range of benefits including:

- a faster, more co-ordinated and consistent response to safeguarding concerns;
- a greater emphasis on early intervention and better informed services provided at the right time;
- greater ability to identify potential vulnerability, enabling more preventative action to be taken, dealing with cases before they escalate;
- a clearer and more responsive process for alerters;

- Hampshire Constabulary is currently undertaking a joint project with adult social care and NHS services in Southampton which if successful, will be rolled out to other police teams across Hampshire. This project is exploring the use of assisted technology (GPS) for adults with dementia and Alzheimer's to ensure they stay safe and independent longer, as well as giving family /carers peace of mind in knowing that if they do go missing then this assisted technology will help in a fast and safe reunion.

- All front line officers are given basic awareness training which will be ongoing and offered via Front Line Training. These officers will also receive input in relation to Self Neglect, Legal Powers and Remedies, FGM and Honour Violence, Domestic Abuse, Hate Crime, Human Trafficking and Prevent. All Officers working within the Public Protection Department are also offered the enhanced Hampshire County Council "Making Connections" six day training course.

- Hampshire Constabulary has been involved in a wide range of safeguarding work. The following case study illustrates the importance of effective prevention and early intervention in order to stop risks escalating to the point of crisis. Joint work between Hampshire County Council Adult Services, NHS and the Police enabled the needs of service users to be met safely whilst the criminal investigation took place. Safeguarding meetings enabled all agencies to share vital information and to discuss concerns about risks to service users and how these would be managed.

Making a difference – safeguarding people in residential care

A whistle blower employed in a residential care home contacted Hampshire County Council Adult Services to raise concerns about the neglect of service users witnessed whilst working in the care home. The care home was already under scrutiny by the Care Quality Commission and was working towards an agreed action plan. The care home had also been receiving support from Adult Services to rectify the problems identified and to improve the quality of the care provided. The information given by the whistle blower indicated that problems in the home had escalated. Adult Services held a safeguarding strategy planning meeting which the Police attended. It was agreed that the Police would start an investigation into the concerns raised. During the police investigation, a safety plan was put in place to ensure that the residents remained safe in the care home. This approach enabled the registered manager to get extra support and resources needed to help ensure the care provided to the residents was safe. The joint investigation resulted in all the residents moving to alternative care homes which were able to meet their needs. Eventually, the care home was closed for business.

7.1.3 NHS Commissioning

- Clinical commissioning groups (CCGs) were formally established on 1 April 2013 and are responsible for the planning and commissioning of local health services for the local population. There are five CCGs aligned to Hampshire County Council, who are Fareham & Gosport CCG, North Hampshire CCG, North Eastern Hampshire and Farnham CCG, South Eastern Hampshire CCG, and West Hampshire CCG. West Hampshire CCG hosts the safeguarding adults services on behalf of the five CCGs. Area Teams were also formally established on 1st April 2013 as the local representation of the NHS England, which is an executive non-departmental body working under its mandate from the Government to improve the quality of NHS care and health outcomes, reduce health inequalities, empower patients and the public and promote innovation.

- CCGs have a clear role and responsibilities for regarding adult safeguarding. They commission services for their local population and are responsible for ensuring that the organisations from which they commission services provide safe care and systems to protect adults at risk. They must ensure that there are effective safeguarding arrangements in place within the local health community. CCGs are an integral part of the local safeguarding adults' strategic partnership and are core members of the HSAB. CCGs work with HSAB to ensure robust processes are in place across the care system to learn lessons where serious abuse or neglect has occurred. Specific safeguarding responsibilities for CCGs include:

1. *Plans to train their staff in recognising and reporting safeguarding issues:* All staff in CCGs undertake mandatory training in safeguarding adults as part of their induction and via mandatory training programmes. Face to face sessions are also delivered. All members of the Continuing Healthcare (CHC) team and vulnerable adult's team attend the Hampshire Six day safeguarding training programme due to the nature of their clinical roles.

2. *A clear line of accountability for safeguarding adults which is reflected in their governance arrangements:* The five Hampshire CCGs have established the Vulnerable Persons Committee for both adults and children, which reports to the CCG Boards through established structures. The committee receives the minutes from the Hampshire Adults Safeguarding Board and sub-groups, both of which have senior representation from the CCGs.

3. *Arrangements to co-operate with local authorities in the operation of the safeguarding adult's board and health and well-being boards:* The CCGs work in close partnership with the local authority on a daily basis when safeguarding concerns arise, ensuring advice and guidance on health matters is shared. Where there are concerns in relation to services the CCGs commission, full and proactive co-operation is provided to ensure good outcomes for patients. The Consultant Nurse for Safeguarding Adults meets monthly with the Strategic Lead for Safeguarding in the local authority, and attends joint meetings.

4. *Ensuring effective arrangements for information sharing:* The CCGs work within the Hampshire Multiagency Safeguarding Policy in partnership with other agencies in relation to information sharing.

5. *Having a safeguarding adult's lead and a lead for the Mental Capacity Act, supported by the relevant policies and training:* Each CCG has a named lead for the Mental Capacity Act.

6. *Have effective systems to respond to abuse and neglect and effective interagency working with local authorities, the police and third sector organisations:* The five Hampshire CCGs have a dedicated safeguarding adult's team which is hosted by West Hampshire CCG. The team is led by the Consultant Nurse for Safeguarding Adults and supported by the Specialist Nurse and two Safeguarding Adults Nurses. The team provides training to the CCGs and advice on all matters related to safeguarding adults and responds to all safeguarding concerns within NHS providers of care and where patients care is funded by the NHS. This is undertaken in partnership with the local authority and other agencies. The five CCGs have also adopted a standardised approach to health provider contract requirements for safeguarding adults, ensuring consistency across our patch. The team also leads on the Prevent agenda for the CCGs and the safeguarding adults contract requirements for NHS and private sector large care providers.

Specific safeguarding responsibilities for the Wessex Area Team include:

1. *Statutory duty with CCGs to be fully engaged with Local Safeguarding Adult's Boards, working in partnership with local authorities to fulfil their safeguarding responsibilities:* The Wessex Area Team is represented at all SABs across Wessex including Hampshire SAB. Where possible this includes representation at pan-Hampshire sub-groups to the Board such as the Pan-Hampshire workforce group

2. *Ensuring that robust processes are in place to learn lessons from cases where adults die or are seriously harmed or abuse or neglect is suspected:* The Area Team works closely with CCG safeguarding teams across Hampshire to monitor serious incidents, alerts and safeguarding concerns. A key priority is to share the lessons learned from such events to improve outcomes across services we directly commission.

3. *Contributing fully to Serious Case Reviews (SCRs) commissioned by SABs and where appropriate conducting IMRs and providing information relevant to SCRs:* The Area Team works closely with health partners to contribute fully to investigations and a team of named GPs across Wessex undertakes this liaison and training role alongside designated nurses from the CCGs. The NHS CB via its Area Team is responsible for co-ordinating and funding safeguarding training for GPs and other primary care professionals.

4. *Responsible for ensuring that the health commissioning system is working effectively to safeguard and improve outcomes for adults at risk and their families:* Wessex Area Team provides oversight and assurance of CCGs' safeguarding arrangements and supports CCGs in meeting their responsibilities. This includes working with the Care Quality Commission, professional regulatory bodies and other national partners.

Good Practice

- The importance of the culture of organisations and clinical teams has been highlighted in recent high profile investigations, which can result in safeguarding adults concerns. These issues may be related to leadership capability, team dynamics, and communication. The safeguarding adults team supports providers to specifically look at this, helping them to draw through the root causes of some of the issues in order that they can develop action plans to address these concerns. This approach has already been used on several occasions and although resource intensive, providers have reported that this approach has been especially useful.

- The safeguarding adult's team work closely with NHS England and provides advice in relation to safeguarding concerns. The team also belong to the Wessex Safeguarding Forum and Adults sub-group for safeguarding which works jointly with NHS England on a range of developments, such as home fire safety in primary care.

- 'Safeguarding Vulnerable people in a Reformed NHS (2013) sets out the requirements for the establishment of a Wessex-wide Safeguarding Forum led by each Area Team. The Wessex Safeguarding Forum provides an opportunity for the sharing of best practice in safeguarding adults and children and has met on a quarterly basis this year. It has been successful in bringing together designated safeguarding professionals from the NHS to work in support of commissioning for effective safeguarding, shared learning and providing professional support. This year the Forum has worked closely with NHS Education England to support the provision of SCIE (Social Care Institute for Excellence) multi-agency safeguarding training across Wessex for SABs and plans are underway to provide further training in the form of SILP (Significant Incident Learning Process).

Future developments

The Consultant Nurse for Safeguarding Adults chairs the Hampshire NHS reference group for safeguarding leads. A similar group is being established for independent hospitals to support them with the safeguarding adult's agenda. In partnership with the local authority, the safeguarding adult's team has also developed threshold groups, which have been implemented in independent hospitals to support clinicians to consider safeguarding concerns and appropriate reporting. This work has been developed further with the trial of safeguarding care plans for patients in one independent hospital setting. The safeguarding adult's team is developing processes to ensure a continuum between safeguarding adult's processes and quality functions to ensure sustainability of improvements. The team has been established as a placement for undergraduate nursing students and students will join the team from June 2014. The Wessex Area Team is developing the Wessex Safeguarding Strategy to align with the latest national guidance from NHS England and local priorities determined through audit and review of lessons learned. Objectives include the ongoing development of safeguarding capacity and capability in primary care and liaison with CCGs and CQC to provide assurance that appropriate governance and practice is in place to protect adults from harm.

8. HSAB Associate Member Reports

8.1 The following reports have been contributed by Associate Members of the Board and these highlight their contribution to the work of the HSAB.

8.1.1 Choices Advocacy

Choices Advocacy works together with people with learning disabilities and older people in Hampshire, providing independent advocacy and person centred planning. It provides issue based advocacy for individuals involved in Safeguarding processes, and work to help people to understand and access their rights to support them to stay safe. Choices Advocacy has people who have experienced using services involved in all areas of its work including on the governance board. This involvement provides inclusion, empowerment and co production that shapes the organisation and its work.

- In 2007 a self advocacy group member talked at a group about the murder of Steven Hoskins. Group members shared their experiences of being bullied and some had experiences of crimes being committed against them. The group decided that they wanted to do something about it. This work continues ,self advocates have been involved in making and presenting a DVD, training people who work to support people with learning disabilities, talking to people with learning disabilities to ensure they know their rights, producing easy read information and working with other organisations to set up local Safe Places Schemes. This work has been in partnership with other organisations but the leadership role of people with learning disabilities has shown that people with learning disabilities are empowered citizens.

  "It's inspirational; I have never seen people with learning disabilities so confident" (social work student 2013)

- Choices Advocacy, Speakeasy Advocacy and Just Advocacy work together to support members of the Hampshire Learning Disability Partnership Board in their roles. This year the Board has worked to develop a Learning Disability Plan for Hampshire. The plan is co produced, by people with learning disabilities, family carers, Adult Services, Health Services, Hampshire Police, Advocacy and other community services. The board members and members of self advocacy groups have given a clear message that "Being Safe" is important.

  "We want to be able to live our lives not being scared" (Hampshire Learning Disability Plan, p49).

- The Learning Disability Plan shows people with learning disabilities in a leadership role, speaking out and having their views valued. This active self advocacy is a powerful message to all people with a learning disability that may be struggling to find a voice to report abuse or crime that has been committed against them.

8.1.2 Hampshire Fire and Rescue Service

- Over the past year, Hampshire Fire and Rescue Service has been leading a joint working group set up for the purpose of developing a consistent multi agency process to manage risks relating to people whose fire safety is significantly compromised. The overall aim of this approach is to reduce avoidable deaths and 'near miss' fire incidents which have resulted in serious injury. There has been continued focus on fire safety awareness, prevention and early intervention, This has resulted in:

- Universally accessible fire safety information in a range of formats
- A clear on-line referral pathway has been established
- Delivery of training for front line staff
- Fire safety awareness training and inclusion in other training
- HFRS being included on 'permission to share forms'
- Fire safety needs are addressed in assessments and reviews
- An increase in referrals for a fire safety check
- HFRS staff invited to safeguarding meetings where appropriate
- Revision of referral forms to better reflect vulnerability factors
- An audit being carried out to identify at risk population
- 'Outreach' with 400 at risk people to offer advice and support
- Fire included as a priority within partner agencies and strategic boards
- Domiciliary care assess fire safety when doing their initial risk assessment
- Telecare and fire resistant materials considered as part of care plans

Risk of Fire Deaths

An analysis of fire deaths in Hampshire carried out by HFRS in 2011 showed that the average fire fatality rate for accidental fires amongst people with needs of care and support is approximately **thirty times greater** than the fire fatality rate for the entire population of Hampshire.

Some factors lead to people being at a higher risk from death in a fire than others such as:

- Physical factors such as impairments linked to age/frailty, physical disability, mental health, dementia, memory loss, sensory loss, reduced physical mobility.
- Behavioural factors linked to alcohol and drug use, cigarette smoking, self neglect, hoarding, fire setting, etc.
- Environmental factors such as ignition sources, cigarette or naked flame, absence of smoke alarm.
- Historical factors such as previous fire incidents.

The findings of this study has been the impetus for setting up a joint pan Hampshire working group involving Fire and Rescue Service, Adult Services and the NHS.

- Opportunities for alignment of prevention agendas with partners
- Quality Improvement officer being part of Improving Home Safety project
- HFRS included as a virtual partner on the MASH.

- The *Improving Home Safety Project* has been set up to meet the needs of both people at risk as well as the wider community. A *Home Safety Visit* resource and tools have been developed including technology and literature that enable station based personnel and other staff to carry out effective visits.

8.1.3 Hampshire Probation Trust

Hampshire Probation Trust (HPT) has worked closely with the HSAB to ensure vulnerable offenders and/or victims are assisted through a multi-agency approach. During July-September 2013 an interactive awareness raising exercise was undertaken to launch the revised multi-agency Safeguarding Vulnerable Adults Policy and Procedures at a team level. Senior Probation Officers familiarised themselves with the HPT Safeguarding Vulnerable Adults Policy and Practice Guidelines 2012 prior to facilitating the session to staff. They were supported by the Learning and Development Manager and Training department who produced the materials for the briefing exercise which was successfully delivered to all teams. As an active member of the HSAB, HPT has been represented at the Board meetings and staff have been notified of and encouraged to use the new comprehensive HSAB Website. The Probation Service has changed under the Government's Transforming Rehabilitation agenda from 1st June 2014. The Service now consists of the National Probation Service to manage high risk offenders and the Hampshire and Isle of Wight Community Rehabilitation Company (CRC) to deliver rehabilitation to medium and low risk offenders. Protocols for interaction with the HSAB will be worked out accordingly.

8.1.4 Hampshire Trading Standards

Trading Standards works in closely with the Adult Services Department to support vulnerable people experiencing financial abuse and exploitation and Trading Standards Officer is based within the Safeguarding Unit to lead on and support investigations involving this form of abuse. Hampshire Trading Standards has developed a range of schemes designed to protect local people.

- *Making Money Matter:* This accessible resource provides advice and guidance for adults with learning disabilities on avoiding becoming victims of scams and unscrupulous doorstep callers. It helps people understand their rights as consumers when buying goods or having work done in their homes. There are useful sections on bank accounts; internet shopping; how budgets with information about managing loans and debts. The booklet can be read independently or with the support of carers and has a helpful list of organisations that advise on consumer and money matters. For more information about this resource go to www.hants.gov.uk/tradingstandards-makingmoneymatter

- In January 2014 Trading Standards Safeguarding work was recognised as mainstream and a team of 12 specialist officers was created to address cases of financial abuse that vulnerable residents experience when buying goods and services or becoming victims of scams. Now receiving 60+ complex referrals a month Trading Standards have established excellent relationships with a wide variety of partner agencies, make direct referrals and work effectively together to improve the lives of those they come into contact with.

Making a difference - safeguarding people from financial exploitation

A Trading Standards officer visited Peter*, an 81 year old gentleman who had signed up to a call blocker that he did not want and could not remember how he paid for it. The officer spoke to him and it became clear that since his wife died several years ago Peter had not managed his finances very well at all as his wife had previously done all of this. Peter agreed for the officer to look through the piles of paperwork he had received over the past few years and had not dealt with. Paperwork was found from a bank that he had no recollection of having an account with. The current account with his usual bank was slightly overdrawn. The officers made an appointment to attend the two banks with Peter to do a financial health check. He was then delighted to discover that he had over £150,000 in the previously unknown account. Trading Standards, the Community Independence Team and the banks are now all working with Peter to ensure he is fully aware and able to deal with his finances for the future.

* Name changed to protect the identity of the service user

- Since 2009 Trading Standards has intervened through negotiation and mediation to retrieve one million pounds. This has been handed back to the vulnerable adults involved. This impressive amount of money does not tell the whole story though - many isolated victims have been unsupported until the time of the Trading Standards intervention. As one victim told us "I had a good nights sleep last night for the first time in 4 years. I felt sheer relief that I had finally confided in someone who will support me".

8.1.5 Healthwatch Hampshire

Healthwatch is the new independent consumer champion created to gather and represent the views of the public. It exists in two distinct forms - local Healthwatch and Healthwatch England at a national level. The aim of local Healthwatch is to give citizens and communities a stronger voice to influence and challenge how health and social care services are provided within their locality. Local Healthwatch has taken on the work of the Local Involvement Networks (LINks) and also:

- represents the views and experiences of people who use services, carers and the public on the Health and Wellbeing Boards set up by local authorities
- provides information and signposting to people about local health and care services, how to access them and how to find their way round the system
- reports concerns about the quality of health and social care services to Healthwatch England, which can then recommend that the Care Quality Commission take action
- responds to members of the public raising concerns about their care or treatment

8.1.6 South Central Ambulance Service NHS Foundation Trust

- During the period covered by this report, South Central Ambulance Service NHS Foundation Trust (SCAS) has been working with partner agencies to strengthen the processes for sharing information and receiving and delivering individual feedback to referrers.

- The organisation has gained new services over this period which has seen the SCAS grow in size particularly in workforce, with the integration of the 111 services and the acquisition of new Patient Transport Service contracts. This has led to significant strengthening of the corporate safeguarding functions to enable the increase in referrals made by the service, which has risen by 83%, (697 - 12/13 to 1278 - 13/14 whole of Hampshire) managed at a time of increasing demands for input into Serious Case Reviews and requests for involvement in case meetings. In addition to the recruitment of two additional support staff within the Safeguarding Team, key work undertaken includes:

- Training of all patient facing frontline staff to level two via face to face delivery with case studies and discussion groups featuring personal experiences to share learning including MCA, DOLS and PREVENT.

- The NHS England Safeguarding Adults pocket book issued all frontline patient facing staff the covering responsibilities, categories of abuse, role of the Alerter, information sharing, capacity and consent, pressure ulcer grading, MCA/DOLS and PREVENT.

Making a difference – responding to changing needs

An ambulance crew attended an elderly man following a fall. The crew arrived and found that Tony hadn't been coping very well and that he needed support with personal care and maintaining his home environment. The ambulance crew found that in addition to his home being infested with insects, there was also a fire hazard due to poor electric cabling and hoarding. Tony didn't want to leave his home to go to hospital and so a GP was called to visit him at home and a referral was sent to adult social care services. This referral resulted in:

- Tony's domiciliary care package being increased from 4 to 14 hours per week
- A deep clean of the property being carried out and including the provision of a new mattress and carpet
- the installation of vital equipment to help Tony with his personal care needs.

* Name changed to protect the identity of the service user

9. Moving Forward

9.1 As this Report shows, HSAB and its partners have made a significant contribution in strengthening local safeguarding arrangements and in holding local agencies to account for the quality of their safeguarding work. The Board has continued to benefit from the excellent commitment and engagement of partner agencies in the strategic development of adult safeguarding locally. This, together with the comprehensive changes the Board's operating arrangements will stand the HSAB in good stead to meet the challenge of operating within a statutory framework when the Care Act 2014 comes into force in April 2015.

9.2 HSAB has produced Safeguarding Adults Strategic Plan which highlights the Boards priorities for adult safeguarding over the next two years. A number of factors have helped to shape and influence the priorities in the 2014/16 Safeguarding Adults Strategic Plan. Firstly, it has been informed by the review of the HSAB Business Plan reflected in this report as well as the need to respond to national developments such as implementation of the Care Act 2014 and other initiatives such as Making Safeguarding Personal. Secondly and of equal importance, is the feedback received from the public, service users and grass roots organisations as part of the 'Stakeholder Events' organised by HSAB in May. These events were attended by over 140 local people and provided an opportunity for people to share their views about the key issues within adult safeguarding that they feel HSAB should be responding to. Common concerns highlighted included quality of local care services, disability hate crime and access to information about where and how to get help. A Business Plan will be developed which will give the detail about how the HSAB Strategic Plan will be implemented including our measures of success.

9.3 2014/16 Safeguarding Adults Strategic Plan

"Safeguarding is everyone's responsibility"

Introduction

This document outlines the vision for Safeguarding Adults in Hampshire. The Hampshire Safeguarding Adults Board (HASB) is a partnership committed to working together to ensure local safeguarding services are effective. Its remit is to lead the strategic development of adult safeguarding and to hold agencies to account for their safeguarding work.

Principles

The ethos and work of the HSAB reflects the following principles:

- Living a life that is free from harm and abuse is a fundamental right of every person.
- All organisations and local communities have a responsibility to ensure that they foster a culture which takes all concerns seriously, and enables transparency, reporting of concerns and whistleblowing.
- Safeguarding adults at risk and their carers, from abuse is everyone's business and responsibility.
- All staff and volunteers in whatever the setting have a key role in preventing abuse or neglect occurring and in taking prompt action when concerns arise.
- Adults at risk and their families, carers or representatives have access to information regarding the standards, quality and treatment they can expect to receive from any individuals (paid or unpaid), services or organisations involved in their lives

- A person led approach is used so that the support provided is person centred and focused on the outcomes identified by the individual.

- Supports are in place to prevent abuse from occurring in the first instance and to enable interventions at an early stage.

- People at risk are supported to access mainstream community and crime prevention measures aimed at the rest of society

- When abuse does take place, it is dealt with swiftly, effectively and in ways that are proportionate to the issues presented.

- The person at risk at the centre of any safeguarding concern must stay as much in control of decision making as possible.

- Personalised support is for everyone, but some people will need more support than others to make choices and manage risks. Making risks clear and understood is crucial to empowering and safeguarding adults and in recognising people as 'experts in their own lives'.

- People working or involved in supporting vulnerable adults and/or their carers have the appropriate level of skills, knowledge and training to safeguard adults from abuse

The Department of Health set out the Government's statement of principles for use by Local Authority Adult Social Services, Health, Police and other agencies for both developing and assessing the effectiveness of their local adult safeguarding arrangements. It also describes, in broad terms, the desired outcomes for adult safeguarding, for both individuals and agencies. These principles will be used by the Hampshire Safeguarding Adult Board and partner agencies with safeguarding responsibilities to benchmark their existing adult safeguarding arrangements. These principles are outlined in the table located on page 6 of this report. To read the full document please click here:

Statement of government policy on adult safeguarding

Safeguarding work in Hampshire aspires to the standards expected by the 11 good practice standards set out in the Association of Directors of Social Services "Safeguarding Adults" framework (2005) and complies with the Care Act 2014 and the mandatory guidance to be published by the Department of Health later this year.

Priorities for 2014 -2016

The HSAB Safeguarding Adults Strategic Plan highlights the Boards priorities for adult safeguarding over the next two years. A number of factors have helped to shape and influence the priorities in the 2014/16 Safeguarding Adults Strategic Plan. Firstly, it has been informed by the review of the HSAB Business Plan reflected in this report as well as the need to respond to national developments such as implementation of the Care Act 2014 and other initiatives such as Making Safeguarding Personal. Secondly and of equal importance, is the feedback received from the public, service users and grass roots organisations as part of the 'Stakeholder Events' organised by HSAB in May. These events were attended by over 140 local people and provided an opportunity for people to share their views about the key issues within adult safeguarding that they feel HSAB should be responding to. Common concerns highlighted included quality of local care services, disability hate crime and access to information about where and how to get help. The Hampshire Safeguarding Adults Board will achieve its vision through the working out of the following strategic objectives:

Priority	Actions
Clear policy framework for safeguarding work - robust policies and procedures are in place to enable staff in all agencies work to an appropriate policy context.	Update of local multi-agency safeguarding policy and procedures Ensuring compliance with Care Act requirements Development of financial abuse guidance Development of Human trafficking and Modern Slavery guidance Development of safeguarding toolkits for the wider workforce
Prevention and early intervention – acting before harm occurs and robust shared risk management approaches	Development of a prevention and early intervention strategy Development of a multi-agency risk management process Fire safety and fire death prevention work Strategies to address disability hate crime Framework for disengagement or refusal of support Framework for managing self neglect Initiatives to address isolation e.g. friendship circles, support groups Strong links with Community Safety Partnerships to ensure adult safeguarding is included in current and new processes being developed to deliver the reduction of anti-social behaviour focussed on both perpetrators and victims/witnesses
Wide awareness of abuse, its impact and engagement of the local community in the adult safeguarding agenda	Implementation of the HSAB Communication Plan Development of a Schools Awareness Programme Developing community engagement initiatives Stakeholder events (public, service users, grass roots organisations and staff) Raising awareness of disability hate crime and its impact

Priority	Actions
Safeguarding services improved and shaped by the views of service users, carers and other stakeholders	Development of a Stakeholder Subgroup Participation of service users at HSAB meetings Involvement in the strategic development of safeguarding Use of "expert partners" or "experts by experience" Service user involvement in the safeguarding process Gaining feedback from users of safeguarding services Stakeholder events
Quality Assurance and governance - implementing clear and robust inter-agency monitoring and review arrangements adult safeguarding	Implementation of the integrated quality assurance framework Implementation of the Integrated Scorecard and Self Audit Tool Publication of a 2014/16 audit programme Use of the 6 safeguarding government principles for benchmarking Management reports to board and annual report Robust board governance arrangements
Learning from experience - putting in place mechanisms to promote learning from serious cases and promoting evidence based practice.	Learning from Experience Database Activities to ensure lessons from serious cases are learned and applied Learning workshops and an annual conference
Skilled, competent workforce - shared workforce development strategies to ensure all staff are able to respond appropriately to adults at risk and that practice is safe and reflects the highest professional standards.	Development of a pan Hampshire safeguarding learning and development strategy Development of a pan Hampshire and learning and development programme Sharing of expertise and resources Development of a safeguarding practitioner network

10. Glossary

10.1 This glossary is not an exhaustive list, but explains some of the key words or terms that have been used in this report.

4LSAB Four Local Safeguarding Adults Boards covering Hampshire, Portsmouth, Southampton and the Isle of Wight.

Abuse includes physical, sexual, emotional, psychological, financial, material, neglect, acts of omission, discriminatory and institutional abuse.

ACPO (Association of Chief Police Officers), an organisation that leads the development of police policy in England, Wales and Northern Ireland.

ADASS (Association of Directors of Adult Social Services) is the national leadership association for directors of local authority adult social care services.

Adult Services arrange social care and support for adults who need extra support. This includes older people, people with learning disabilities, physically disabled people, people with mental health problems, drug and alcohol misusers and carers. Adult social care services include the provision by local authorities and others of care homes, day centres, equipment and adaptations, meals and home care Adult social care also includes services that are provided to carers.

Advocacy is taking action to help people say what they want, secure their rights, represent their interests and obtain services they need.

Alert is a concern that a person at risk is or may be a victim of abuse, neglect or exploitation. An alert may be a result of a disclosure, an incident, or other signs or indicators.

Alerter is the person who raises a concern that an adult is being, has been, or is at risk of being abused or neglected. This could be the person themselves, a member of their family, a carer, a friend or neighbour or could be a member of staff or a volunteer.

Assessment is a process to gather information, assess the health and social care needs of an vulnerable person at risk of abuse, or of an adult who may have caused harm.

Care Act 2014 comes into force in April 2015 and it significantly reforms the law relating to care and support for adults and carers. This legislation also introduces a number of provisions about safeguarding adults at risk from abuse or neglect. Clauses 42-48 of the Care Act provide the statutory framework for protecting adults from abuse and neglect.

Care Setting/Services includes health care, nursing care, social care, domiciliary care, social activities, support setting, emotional support, housing support, emergency housing, befriending and advice services and services provided in someone's own home by an organisation or paid employee for a person by means of a personal budget.

Carer refers to unpaid carers, for example, relatives or friends of the person at risk. Paid workers, including personal assistants, whose job title may be 'carer', are called 'staff' within this document.

Central Referral Unit is where all adult safeguarding referrals to the police are received, risk assessed, graded and allocated for action by the most appropriate police team and/or partner agency.

CCGs (Clinical Commissioning Groups) were formally established on 1 April 2013 to replace Primary Care Trusts and are responsible for the planning and commissioning of local health services for the local population.

Clinical Governance is the framework through which the National Health Service (NHS) improves the quality of its services and ensures high standards of care.

Community Safety Partnerships bring agencies and communities together to tackle crime within their communities. Community Safety Partnerships (CSPs) are made up of representatives from the responsible authorities, these are Police, police authorities, local authorities, Fire and Rescue authorities, Clinical Commissioning Groups and Probation.

Consent is the voluntary and continuing permission of the person to the intervention based on an adequate knowledge of the purpose, nature, likely effects and risks of that intervention, including the likelihood of its success and any alternatives to it.

CPA (Care Programme Approach) was introduced in England in the joint Health and Social Services Circular HC(90)23/LASSL(90)11, *The Care Programme Approach for people with a mental illness, referred to specialist psychiatric services*, published by the Department of Health in 1990. This requires health authorities, in collaboration with social services departments, to put in place specified arrangements for the care and treatment of people with mental ill health in the community.

CPS (Crown Prosecution Service) is the government department responsible for prosecuting criminal cases investigated by the police in England and Wales.

CQC (Care Quality Commission) is responsible for the registration and regulation of health and social care in England.

DASH (Domestic Abuse, Stalking and Harassment and 'Honour'- Based Violence) risk identification checklist (RIC) is a tool used to help front-line practitioners identify high risk cases of domestic abuse, stalking and 'honour'-based violence.

Disclosure and Barring Service (DBS) was established in 2012 through the Protection of Freedoms Act and merges two former organisations, the Criminal Records Bureau and the Independent Safeguarding Authority. The DBS is designed to help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable adults. The DBS search police records and barring lists of prospective employees and issue DBS certificates. They also manage central barred lists of people who are known to have caused harm to vulnerable adults.

DOLS (Deprivation of Liberty Safeguards) are measures to protect people who lack the mental capacity to make certain decisions for themselves. They came into effect in April 2009 using the principles of the *Mental Capacity Act 2005*, and apply to people in care homes or hospitals where they may be deprived of their liberty.

Domestic Violence and Abuse is any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to psychological, physical, sexual, financial and emotional abuse. Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour. Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim. Family members are defined as mother, father, son, daughter, brother, sister and grandparents, whether directly related, in-laws or step-family (Home Office 2012).

Domestic Homicide Reviews are commissioned by local Safer Communities Partnerships in response to deaths caused through domestic violence. They are subject to the guidance issued by the Home Office in 2006 under the *Domestic Violence Crime and Victims Act 2004*. The basis for the domestic homicide review (DHR) process is to ensure agencies are responding appropriately to victims of domestic abuse offering and/or putting in place suitable support mechanisms, procedures, resources and interventions with an aim to avoid future incidents of domestic homicide and violence.

FACS (Fair Access to Care Services) is a system for deciding how much support people with social care needs can expect, to help them cope and keep them fit and well. It applies to all the local authorities in England. Its aim is to help social care workers make fair and consistent decisions about the level of support needed, and whether the local council should pay for this.

Family Group Conferences (FGC) are used to try and empower people to work out solutions to their own problems. A trained FGC coordinator can support the person at risk and their family or wider support network to reach an agreement about why the harm occurred, what needs to be done to repair the harm and what needs to be put into place to prevent it from happening again.

HealthWatch is the new independent consumer champion created to gather and represent the views of the public. It exists in two distinct forms - local Healthwatch and Healthwatch England at a national level. The aim of local Healthwatch is to give citizens and

communities a stronger voice to influence and challenge how health and social care services are provided within their locality. Local Healthwatch has taken on the work of the Local Involvement Networks (LINks).

Health and Well-being Board a statutory, multi-organisation committee of NHS and local authority commissioners, co-ordinated by the local authority which gives strategic leadership across Hampshire regarding the commissioning of health and social care services.

HSAB (Hampshire Safeguarding Adults Board) is a statutory, multi-organisation partnership committee, co-ordinated by the local authority, which gives strategic leadership for adult safeguarding, across the Hampshire County Council area. SAB's remit is to agree objectives, set priorities and co-ordinate the strategic development of adult safeguarding across the county.

IMCAs (Independent Mental Capacity Advocates) were established by the Mental Capacity Act 2005. IMCAs are a legal safeguard for people who lack the capacity to make specific important decisions, including making decisions about where they live and about serious medical treatment options. IMCAs are mainly instructed to represent people where there is no one independent of services, such as a family member or friend, who is able to represent the person.

Making Safeguarding Personal (MSP) is a change in approach to safeguarding work and aims to move away from safeguarding being process driven and instead, to place the person at risk at the centre of the process and work with them to achieve the outcomes they want.

MAPPA (Multi-agency Public Protection Arrangements) are statutory arrangements for managing sexual and violent offenders.

MARAC (Multi-agency Risk Assessment Conference) is the multi-agency forum of organisations that manage high risk cases of domestic abuse, stalking and 'honour'-based violence.

MASH (Multi Agency Safeguarding Hub) is a joint service made up of Police, Adult Services and the NHS. Information from different agencies is collated and used to decide what action to take. This means the agencies will be able to act quickly in a co-ordinated and consistent way, ensuring that the person at risk is kept safe.

Mate Crime occurs when a person is harmed or taken advantage of by someone they thought was their friend. There is limited information on the prevalence of Mate Crime nationally, however there has been an increase in the number of safeguarding alerts that involve Mate Crime across Hampshire in recent years.

Mental Capacity refers to whether someone has the mental capacity to make a decision or not. The Mental Capacity Act 2005 and the code of practice outlines how agencies should support someone who lacks the capacity to make a decision.

NHS (National Health Service) is the publicly funded health care system in the UK.

OPG (Office of the Public Guardian), established in October 2007, supports the Public Guardian in registering enduring powers of attorney, lasting powers of attorney and supervising Court of Protection appointed deputies.

PALS (Patient Advice and Liaison Service) is an NHS service created to provide advice and support to NHS patients and their relatives and carers.

PREVENT is a Government strategy, launched in 2007, which seeks to stop people becoming terrorists or supporting terrorism. It is the preventative strand of the government's counter-terrorism strategy and aims to respond to the ideological challenge of terrorism and the threat from those who promote it; prevent people from being drawn into terrorism and ensure that they are given appropriate advice and support and work with sectors and institutions where there are risks of radicalisation that need to addressed.

Public Interest - a decision about what is in the public interest needs to be made by balancing the rights of the individual to privacy with the rights of others to protection.

Referral - an alert becomes a referral when it is passed on to a safeguarding adults referral point and accepted as a safeguarding adults referral.

Safeguarding Adults Process refers to the decisions and subsequent actions taken on receipt of a referral. This process can include a strategy meeting or discussion, an investigation, a case conference, a care/protection/safety plan and monitoring and review arrangements.

Safeguarding Adults Work is used to describe all work to help adults at risk stay safe from significant harm.

Safeguarding Assessment is the process to gather information to assess the health and social care needs of a person at risk experiencing abuse, neglect or exploitation or of an adult who may have caused harm.

Safer Neighbourhood Teams are local police working with local people and partner agencies to identify and tackle issues of concern in their area to make neighbourhoods safer.

SCR (Serious Case Review) is undertaken by a Safeguarding Adults Board when a serious case of adult abuse takes place. The aim is for agencies and individuals to learn lessons to improve the way in which they work. From April 1st 2015, these will become known as 'safeguarding adult reviews).

Significant Harm is not only ill treatment (including sexual abuse and forms of ill treatment which are not physical), but also the impairment of, or an avoidable deterioration in, physical or mental health, and the impairment of physical, intellectual, emotional, social or behavioural development.

SIRI (Serious Incident Requiring Investigation) is a term used for serious incidents in the NHS requiring investigation. It is defined as an incident that occurred in relation to NHS-funded services resulting in serious harm or unexpected or avoidable death of one or more patients, staff, visitors or members of the public.

Strategy Meeting is a multi-agency face-to-face meeting, with a chairperson and the relevant individuals involved, including the person at risk where appropriate, to agree how to proceed with the referral.

Vital Interest is a term used in the *Data Protection Act 1998* to permit sharing of information where it is critical to prevent serious harm or distress, or in life threatening situations.

Wilful Neglect or Ill Treatment is an intentional or deliberate omission or failure to carry out an act of care by someone who has care of a person who lacks capacity to care for themselves. *Section 44* of the *Mental Capacity Act 2005* makes it a specific criminal offence to wilfully ill-treat or neglect a person who lacks capacity