Hampshire Safeguarding Adults Board

Annual Report 2014 - 2015

An interim report of the activities and progress of the Hampshire Safeguarding Adults Board

September 2015

This report highlights the Hampshire Safeguarding Adult Board's progress in the delivery of its Strategic Plan.

Hampshire Safeguarding Adults Board Annual Progress Report 2014/15

1. Introduction

1.1 In 2014, the Hampshire Safeguarding Adults Board (HSAB) published its Strategic Plan for the two year period 2014/16 setting out its vision safeguarding adults in Hampshire and within this, identified a number of key priorities and objectives. A number of factors helped to shape and influence these priorities most notably the implementation of the Care Act 2014 and the introduction of a new statutory framework for adult safeguarding. In addition, the HSAB undertook a major consultation exercise in 2014 with the public, service users and grass roots organisations in which local people were asked about the key issues within adult safeguarding that they felt HSAB should be responding to. The HSAB developed a business plan detailing the activities it would be undertaking over this two year period to deliver the priorities and objectives it had agreed.

1.2 Over the past year, the main focus of the HSAB has been on planning and preparation for the implementation of the Care Act 2014 which came into force on 1st April 2015. A wide range of activities have been undertaken by the Board and its member organisations to ensure local arrangements are fit for purpose and are compatible with the new statutory safeguarding arrangements. Throughout this period, the HSAB has continued to deliver its responsibilities regarding the strategic development of adult safeguarding across Hampshire with the necessary work being undertaken by the HSAB subgroups, each of which has focussed on specific objectives in the business plan.

1.3 Activities have been monitored throughout the year and progress reported on a regular basis to the HSAB. A full report covering the two year period of the Strategic Plan will be published in 2016. The purpose of this document is to provide an interim report outlining the progress made so far.

1.4 For more information about the work of the Hampshire Safeguarding Adults Board go to www.hampshiresab.org.uk
Click here to view the HSAB Strategic Plan and HSAB Business Plan

1.5 The HSAB Annual Report will be 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. It will also be shared with the Hampshire Safeguarding Children's Board in recognition of the links between the safeguarding agenda of the respective boards.

1.6 Board representatives will be requested to share the HSAB Annual Report with their senior executive and management teams as well as relevant governance boards and committees to ensure member organisations are sighted on the strategic priorities and issues for adult safeguarding across the area they serve.

2. Care Act 2014

2.1 The Care Act 2014 came into force in April 2015 and will be implemented between 2015 and 2017. This legislation establishes that safeguarding is everybody's business with the Local Authority, Police and NHS as key statutory partner agencies. The previous duty of partnership is replaced by a legal duty of co-operation. The new statutory framework for adult safeguarding is laid out in clauses 42-45 of the Care Act 2014 as follows:

- **Leadership by the local authority of a multi-agency local adult safeguarding system** that seeks to prevent abuse and neglect and stop it quickly when it happens

- **Making safeguarding enquiries, or causing enquires to be made** - this replaces the previous guidance in relation to investigations and allows the local authority to reasonably request that another agency carries out the enquiry and provide feed back to the safeguarding process

- **Establishing a Safeguarding Adults Board** with the Local Authority, Police and NHS as core members and develop, share and implement a joint safeguarding strategy

- **Carrying out safeguarding adult reviews** when someone with care and support needs dies as a result of abuse or neglect and there is concern that the local authority or its partners could have done more to protect them

- **Arranging, where appropriate, for an independent advocate** - this is a new requirement as it goes beyond the expectation in relation to the Mental Capacity Act 2005. The advocate must be engaged to represent or support an individual who is the subject of a safeguarding enquiry where the individual has 'substantial difficulty' in being involved in the process and where there is no other appropriate adult who can help them

- **Co-operation between relevant partners** - this has significantly strengthened previous arrangements in respect of partnership working. This new duty of co-operation between partners also establishes the importance of organisations sharing vital information related to abuse or neglect with the Local Safeguarding Adult Board.

3. Local Response to the Care Act 2014

3.1 The HSAB is in a strong position in respect of the Care Act 2014 as we have been working on developing new safeguarding arrangements with our partner organisations over the past year to ensure that the local 'safeguarding system' is Care Act 2014 compliant. The HSAB has undertaken this work with the other three neighbouring local safeguarding adult boards in Portsmouth, Southampton and the Isle of Wight to ensure that the new overarching safeguarding arrangements are not only in line with the requirements of the Care Act 2014 but are also as consistent as possible across the area as a whole. The key activities undertaken by the HSAB regarding implementation of the Care Act 2014 include the following:

- Leadership and coordination of the review and development of the 4 LSAB (Hampshire, Portsmouth, Southampton and Isle of Wight) Multi-Agency Safeguarding Policy and Guidance including the safeguarding enquiry process

- Development and publication of a wide range of 4 LSAB practice guidance covering Information Sharing, Prevention and Early Intervention, Managing Self Neglect and Safeguarding in Commissioned Services.

- Development of a number of Board governance processes which have now been adopted by all four LSABs thus providing consistency of approach for partner agencies. These include the Learning and Review Framework, Quality Assurance Framework and Communication Protocol.

- Development and publication of a Multi-Agency Adult Safeguarding Learning and Development Strategy to support implementation of the new Statutory Safeguarding Framework and the shift in culture and practice needed to achieve this. This was informed by a a safeguarding learning and development audit undertaken within LSAB member organisations across the 4 LSAB area and covering over 30,000 staff.

- Introduction of the Designated Adult Safeguarding Manager (DASM) role within HSAB member organisations and creation of the Hampshire and Isle of Wight wide DASM Network to support and develop good practice.

- Briefings and learning events held on the new Statutory Safeguarding Framework across a wide range of sectors including Adult Services, Hampshire Constabulary, Independent Providers, Voluntary Sector Organisations and District and Borough Councils.

- Implementation of the Safeguarding Organisational Self Audit process (akin to the children's sector Section 11 audit) to support the development of adult safeguarding arrangements in member organisations.

- Review of the HSAB structure and governance arrangements resulting in the revision of the Memorandum of Agreement and creation of the Stakeholder Subgroup and Health Subgroup.

- Strengthening of links with other strategic partnerships and plans including the Hampshire Domestic Abuse Partnership, the PREVENT Board, Human Trafficking Partnership, HealthWatch and the Crisis Care Concordat.

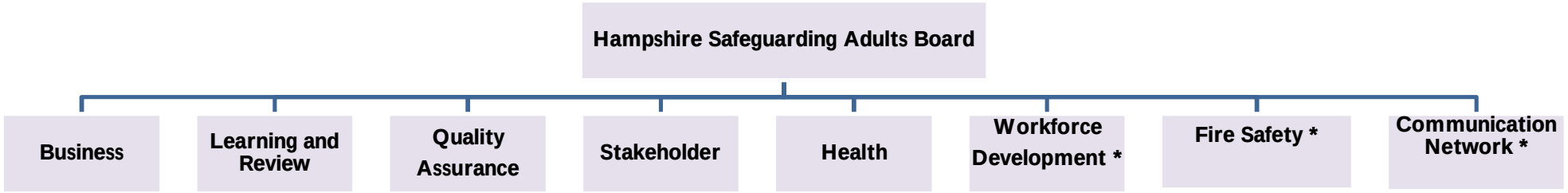
- Introduction of Stakeholder Events to support the development of the Strategic Plan and also engagement in the 'Sounding Board' initiative which uses a citizen panel model for gaining feedback.

- Publication of a range of HSAB information leaflets and continued development of the HSAB Website to promote awareness of abuse, keeping safe and how to report concerns and joint work with Hampshire County Council on the 'Engaging Hampshire Communities' initiative aimed at promoting wide awareness of adult safeguarding concerns.

- Contribution to the development of the National Competency Framework for Safeguarding Adults led by Bournemouth University.

4. HSAB membership and subgroup structure

4.1 HSAB is supported by a number of subgroups which focus on the delivery of specific business plan objectives which are illustrated below:



(* Denotes a pan Hampshire Group)

4.2 Each Subgroup operates to terms of reference and a work plan agreed by the Board which focuses on the delivery of HSAB strategic objectives and priorities. Each subgroup has a chair that is responsible for providing regular progress reports to HSAB.

4.3 The HSAB Manager has an overview of the work and activities of all the subgroups and is responsible for ensuring respective work programmes of the subgroups are co-ordinated and also consistent with the HSAB Safeguarding Strategy and Business Plan. Short term task and finish groups have also been set up as and these focus on the implementation of specific objectives or projects.

4.4 The HSAB has continued to maintain effective links with a range of other strategic partnerships and plans including the Local Children's Safeguarding Board, Community Safety Partnerships, Hampshire Domestic Abuse Partnership, Learning Disability Partnership, Health and Wellbeing Board, Healthwatch, Pjn REVENT and the Crisis Care Concordat. These links have emphasised the strong synergies between the work of the HSAB and many of these forums and have ensured that any duplication is reduced and efficiencies maximised, particularly as objectives and membership can overlap.

5 Performance and Activity

5.1 Hampshire County Council Adult Services are the lead agency who records all the safeguarding information on behalf of the multi-agency partnership and 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. New legislation introduced under the Care Act 2014 has also redefined how safeguarding is undertaken. HSAB partner agencies have responded to these changes and a number (such as Adult Services, Police, NHS providers, etc.) have made fundamental changes to organisational structures and allocation of resources to support safeguarding work both within their own agencies as well as across the local safeguarding system as a whole.

5.2 From 2011/12 the number of referrals made to Hampshire Adult Services have increased year on year, with the overall number of referrals increasing by 50% over the last 4 years (see Figure1, Appendix A). This increase in referral rates is due in part to much stronger engagement and awareness amongst professionals and the public, less tolerance of poor quality care and more high profile reporting in the media of cases of abuse and neglect both nationally and locally. There are now standard reporting forms across agencies such as Hampshire Fire and Rescue and much clearer referral processes, supported by the role of the Multi-Agency Safeguarding Hub (MASH) and much stronger interface with NHS governance processes. Overall referrals in 2014/15 were only very slightly higher than in the previous year at a total of 3223 referrals which is an increase of 26 on the previous year. Monitoring undertaken throughout the year has also identified that the number of monthly referrals being made has been reducing since October 2014. There are several reasons for this change - the majority of safeguarding referrals are now directed to the Multi-Agency Safeguarding Hub (MASH) where staff review them in relation to action required, multi-agency information sharing and appropriateness. This enables the service to ensure that referrals that require a different response, for example, a review of the care arrangements are dealt with by the social work teams and not through safeguarding. It is also anticipated that this new model of service has reduced duplication and over recording of safeguarding referrals. It is believed the MASH team is having an impact on safeguarding rates, taking the role of screening referrals, signposting or taking appropriate action. The new local multi-agency Safeguarding Adults Policy and Guidance introduced in response to the Care Act 2014 encourages proportionate responses and this has an information gathering stage built in which allows for professionals to consider the most appropriate course of action and more robust approaches to poor quality care. In terms of safeguarding referrals by client group, older people accounted for 58% of the total referrals made. Concerns about neglect and physical abuse were the most common reason for safeguarding referrals (37% and 28% respectively). The most common location for the abuse or neglect was the adult's own home followed by residential care. Further details about these figures can be seen in Tables 1, 2 and 3 of Appendix A.

5.3 As part of its continued drive to raise standards and to gain assurance about the quality and effectiveness of the outcomes of safeguarding work the Board has developed a new performance and quality review framework reporting against which will commence in September 2015. The framework consists of four key elements:

a) Safeguarding activity data
b) Feedback from "Making Safeguarding Personal" quality indicators
c) Feedback from local and national audits
d) Analysis of themes and trends from all of the above

6 HSAB Learning Summary

Learning and Review Framework:

6.1 The Hampshire Safeguarding Adults Board (HSAB) is committed to promoting a culture which values and facilitates learning and in which the lessons learned are used to improve future practice and partnership working to safeguard adults at risk. risk. A multi-agency Learning and Review Framework has been developed to support this approach. It is intended for use by all partner agencies and local organisations which work with adults with care and support needs across the area covered by the HSAB. The HSAB is confident that the approaches outlined in the Learning and Review Framework will drive improvements in the wider safeguarding system as well as in the outcomes experienced by users of services.

6.2 The Learning and Review Framework recognises that HSAB member agencies and organisations have their own internal governance and learning structures. The Framework seeks to complement and build on single agency arrangements by adding a multi-agency approach to enable partner agencies to work collaboratively to learn lessons from cases where there may have been multi agency failings and to use this learning to improve future joint working. The Learning and Review Framework is designed to support decision making regarding the use of multi-agency review processes and outlines the pathway for commissioning reviews and the governance arrangements underpinning these arrangements. The Framework comprises four key processes aimed at identifying learning, reducing future risk and driving improvements. The Learning and Review Subgroup reviews each referral received and, on the basis of scoping information provided, makes a decision about the most appropriate type of review to carry out, ranging from a Safeguarding Adult Review, multi-agency partnership review, multi-agency reflective workshop or multi-agency themed audit.

6.3 The Learning and Review Framework was revised in December 2014 to address the issues highlighted in the first year of implementation but also to ensure it is consistent with the requirements and the best practice outlined in the Care Act 2014 statutory guidance. Key changes included introduction of thresholds and considerations when making referrals; clearer links and interfaces between internal governance, multi agency review and statutory review processes; steps to ensure the voice of the service user and/or their family is heard as part of any multi-agency review undertaken and the recognition of appointing independent advocates where necessary; an escalation process to address concerns about a lack of engagement and/or poor quality of information on the part of involved agencies; clarity about the respective roles and responsibilities of HSAB, its subgroups and organisations; and a revised format for carrying out multi agency reflective workshops with facilitators working to a standard programme and materials. The Learning and Review Framework has now been adopted by all four local safeguarding adult boards in Hampshire, Portsmouth, Southampton and the Isle of Wight thus providing a consistency of approach for partner agencies.

Safeguarding Adult Review Policy:

6.4 HSAB has also introduced a new Safeguarding Adult Review Policy in order to bring local arrangements into line with the requirements of section 44 of the Care Act 2014. This Policy also provides guidance and templates for carrying out a Safeguarding Adult Review when someone with care and support needs dies as a result of abuse or neglect and there is concern that the local authority or its partners could have done more to protect them. In line with statutory guidance to the Care Act 2014, the HSAB has included in the Annual Report information about the Safeguarding Adult Review it has arranged. A learning summary has also been included which gives an overview of all the multi-agency review referrals the Board has received over the course of the year and the key themes emerging from these (please see paragraphs 6.7 – 6.11.

Reporting:

6.5 HSAB has established clear reporting arrangements and has introduced 'impact analysis reports' following a multi-agency review as a means of HSAB gaining assurance that learning has been applied to practice and that this has improved outcomes for service users. In addition to the Annual Learning Summary, HSAB has established key roles and responsibilities for a number of its subgroups in the dissemination and promotion of learning, for example through the Quality Assurance Subgroup, or in staff training through the Workforce Development Subgroup.

Learning from Experience Database:

6.6 HSAB has developed the Learning from Experience Database which is located on its website. This contains links to a wide range of national and local serious case reviews, reports and inquiries (both historic and current) and aims to support the dissemination of the learning arising from these and in doing so promote evidence based practice. The database contains 50+ cases and for each, has a case summary and professional learning points. In setting up the database five common themes emerged and these have helped to inform HSAB's strategic objectives and work programme:

a) Organisational abuse or neglect
b) Self neglect or refusal of support
c) Disability hate crime
d) Mate crime
e) Familial abuse or neglect

Learning Summary:

6.7 Since the launch of the Learning and Review Framework in January 2014, HSAB has received a total of 24 referrals for a multi-agency review. Of these, only one has met the criteria for a statutory safeguarding adult review. This review is in progress and is due to be completed by the end of October 2015.

6.8 Of the other 23 referrals, there were four cases which whilst falling short of the criteria for a statutory safeguarding adult review, the circumstances were sufficiently concerning for HSAB to commission a multi agency reflective workshop. Three reflective workshops have been completed over the past year and one is currently planned. The multi-agency reflective workshop approach has proved to be a very useful mechanism from which to gain learning about cases with a poor outcome but which do not meet the statutory criteria for a statutory Safeguarding Adult Review. HSAB has established a multi-agency pool of facilitators to support these workshops made up of a wide range professionals from a variety of organisations and areas of expertise. There were a number of referrals which the Learning and Review Subgroup referred back to agencies to review under internal governance arrangements and in a number of these cases, requested oversight by commissioners of the outcomes of these reviews so as to provide additional assurance of a robust process from which to capture learning for the organisation.

6.9 A range of practice issues have been highlighted in the multi-agency review referrals received and these include the following:

- Respecting the dignity of individuals
- Poor discharge planning and unsafe discharge from hospital
- Poor risk assessment and risk management in community settings including of service users refusing or disengaging from support
- Lack of continuity of care resulting from staff annual leave and sickness absence
- Poor clinical care and treatment which placed patients at risk
- Lack of access to mental health beds and management of mental health incidents in acute hospital settings
- Understanding and application of the Mental Capacity Act 2005 and other legal frameworks
- Poor access to places of safety and domestic abuse services for people with needs of care and support
- Managing deteriorating physical health of people with learning disabilities in community settings
- Managing deteriorating mental health in community settings
- Fire deaths of vulnerable adults receiving care and support

6.10 Joint work has continued with Hampshire Fire and Rescue Service (HFRS) and partners to develop a Fire Safety Framework outlining how partner agencies will be working together to safeguard adults who are at significant risk from fire. In addition to fire safety awareness, this work includes agreement of a process through which to review fire deaths involving vulnerable adults. HFRS internal fire investigation procedures have been reviewed to ensure continuity with the HSAB Learning and Review Framework and a trigger question has been included in the investigation template to indicate whether or not a referral for a multi-agency review may be needed.

6.11 Three of the 24 referrals received related to the fire death of people with care and support needs. These incidents had been examined under the safeguarding process and it was agreed that this had served as a review of the case from which relevant learning had been identified. A summary of key messages regarding fire safety has been compiled and shared with practitioners.

7 Review of the Business Plan 2014/15

7.1 The following Table provides a summary of HSAB's activity over the past year and highlights the progress achieved against the key priorities and objectives outlined in the HSAB Strategic Plan and supporting business plan and this highlights the further action planned for the current year, 2015/16:

HSAB Key Priorities and Objectives

Priority	What we said we'd do	What we've done	Focus for 2015/16
Provide a clear policy framework - robust policies and procedures are in place to enable staff in all agencies work to an appropriate policy context.	a) Produce multi-agency safeguarding policy and guidance in line with the Care Act 2014. b) Develop human trafficking and modern slavery multi-agency memorandum of understanding and practice guidance. c) Develop safeguarding toolkits for the wider workforce. d) Develop financial abuse practice guidance.	a) HSAB published the new multi agency Safeguarding Adults Policy in May 2015. This has been adopted by all local SABs in Hampshire thus providing consistency across the area. The Policy and related guidance is available on the HSAB website and member organisations' staff intranet sites. b) Guidance on Human Trafficking has been produced and added to the multi agency Safeguarding Adults Policy. c) HSAB and member organisations have held a number of events to raise awareness and understanding of the new statutory safeguarding framework and local multi-agency safeguarding policy. d) HSAB has developed frameworks on Learning and Review, Quality Assurance, Communication and Learning and Development and these have been adopted by the other local SABs. e) HSAB has developed a Designated Adult Safeguarding Manager framework which member organisations are using to manage allegations against staff. A DASM network has been created to enable effective information sharing and the development of best practice.	a) Multi agency workshops on the new Safeguarding Policy to gain feedback on the new approach in order to develop the evidence base needed for future updating. b) Review by HSAB member organisations of internal safeguarding policies, service plans and safeguarding training programmes against the new Safeguarding Policy to ensure consistency with its content and approach. c) Further work on the local authority DASM process including the creation of a reporting mechanism with the voluntary and independent sector. d) Develop guidance on new duties regarding PREVENT introduced under the Counter Terrorism and Security Act 2015. e) Develop financial abuse practice guidance.

Priority	What we said we'd do	What we've done	Focus for 2015/16
Prevention and early intervention – acting before harm occurs and robust shared risk management approaches	a) Develop a HSAB Prevention and Early Intervention Strategy b) Develop a multi-agency risk management process c) On-going fire safety and fire death prevention work d) Safeguarding is included in current and new processes being developed to reduce anti social behaviour and disability hate crime.	a) HSAB has developed a Prevention and Early Intervention Strategy which has been incorporated into the multi agency Safeguarding Adults Policy published in May 2015. This highlights the issue of social isolation and suggests a wide range of approaches. b) Hampshire Fire and Rescue Service (HFRS) have continued to lead a Hampshire wide group focusing on fire safety for adults with needs of care and support. This group has introduced a process for reviewing any fire deaths involving any adults with care and support needs in order to ensure lessons are identified. c) HSAB is involving district and borough council and community safety partners on the Board and its subgroups to ensure that there are links between the respective agendas of the strategic partnerships. d) The Hampshire Domestic Abuse Strategy now sits within the HSABs governance structure. e) A 'Model for Proportionate Responses' has been included in the multi agency Safeguarding Adults Policy. This clarifies the role of organisations with responsible for community safety in local safeguarding arrangements and the measures available.	a) Development of a multi agency risk management framework with this work undertaken by the PAN Hampshire Policy Development Group. A first draft is planned for September 2015 b) Implementation of the HSAB Communication Plan in order to coordinate activity across partner agencies aimed at raising awareness of abuse and neglect and how to report concerns. c) Member organisations to audit themselves against the HSAB Prevention and Early Intervention Strategy as a means of exploring further opportunities to promote wellbeing and prevention within their core activity.

Priority	What we said we'd do	What we've done	Focus for 2015/16
Wide awareness of abuse, its impact and engagement of the local community in the adult safeguarding agenda	a) Implement the HSAB Communication Plan b) Develop community awareness and engagement in adult safeguarding c) Raising awareness of disability hate crime and its impact d) Development of a Schools Awareness Programme	a) Given the importance of information and awareness in adult safeguarding HSAB has developed a Communication Plan. The management and oversight of this function sits with the Business Subgroup and joint work is undertaken with the Stakeholder Subgroup as required. b) HSAB has developed a suite of leaflets about the Board and adult safeguarding generally. These are also available in an easier to read format. All leaflets can be found on the HSAB website. c) HSAB has established a Communication Network made up of the communication and media leads from member organisations. This aims to ensure that communication about safeguarding are consistent and coordinated. d) HSAB has worked with HCC to develop publicity material and a phone APP to support the 'Engaging Hampshire Communities' initiative. e) HSAB continues to develop its website. This has recently been updated to include the new multi agency Safeguarding Adults Policy and related practice guidance. The website now has improved navigation and new sections have been introduced such as an area for DASMs and an area where visitors can view national and local consultation documents.	a) Regular reports to HSAB on the communication activity across member organisations. b) Development of a calendar of events relating to adult safeguarding. c) Launch of the' Engaging Hampshire Communities' products. d) Establish links with the Hampshire Disability Hate Crime Group. e) Links with the Crown Prosecution Service to raise awareness of disability hate crime and its impact. f) Links with the HCC Education Service to develop a Schools Awareness Programme.

Priority	What we said we'd do	What we've done	Focus for 2015/16
Service user involvement - safeguarding services improved and shaped by the views of service users, carers and other stakeholders	a) Development of a Stakeholder Subgroup b) Use of "expert partners" or "experts by experience" c) Service user involvement in the safeguarding process d) Gaining feedback from users of safeguarding services	a) A Stakeholder Subgroup has been established consisting of a wide range of people who have a role to bring information to the HSAB from people in local communities who are working with, using or caring for someone who has experience of care services and/or safeguarding, so these views can inform the work of the Board. Members of the Subgroup also attend community events (they would normally attend) in order to gain peoples views and to raise awareness of adult safeguarding. b) HSAB held a number of Stakeholder Events designed to meet local people to find out what safeguarding means to them and the important issues we should be focusing on. We used this feedback to develop our 2014/16 Safeguarding Strategy. c) HSAB has developed a suite of leaflets about the Board and adult safeguarding generally. These are also available in an easier to read format. All leaflets can be found on the HSAB website. d) Service user involvement and the 'Making Safeguarding Personal' approach have been embedded in the new multi agency Safeguarding Adults Policy. Professionals are now required to ask and make a record of the adult's wishes and goals at the beginning of the safeguarding process and, prior to closing it, to check if the support provided has met their stated goals. e) A 'Safeguarding Adults Lead Network' has been set up.. The leads are a point of contact in their organisation and are a source of advice and guidance.	a) Stakeholder events in early 2016 and engagement in the 'Sounding Board' citizen-panel to get feedback from local people about what should be included in the HSAB Strategic Plan. b) Joint work with the Stakeholder subgroup to develop/launch publicity materials. c) Ensuring implementation of the Making Safeguarding Personal approach is consistent across all sectors and partner organisations. d) Agree a data set relating to Making Safeguarding Personal activity and to collect data to evidence how practice is changing. e) Implement an annual satisfaction survey of a sample of people who have received support through the safeguarding process. f) Develop the Safeguarding Adults Lead Network'.

Priority	What we said we'd do	What we've done	Focus for 2015/16
Quality assurance and governance	a) Implementation of the integrated quality assurance framework b) Implementation of the Integrated Scorecard and Self Audit Tool c) Publication and implementation of a 2014/16 audit programme d) Use of the 6 safeguarding government principles for benchmarking	a) HSAB has implemented its Quality Assurance Framework. This has been adopted by the other local safeguarding adult boards. b) All HSAB member organisations have now completed the Safeguarding Organisational Self Audit and have produced internal action plans to address any development needs highlighted. c) The Self Audit Tool has been revised to reflect requirements arising from the Care Act 2014 as well as the changes to the local Safeguarding Adults Policy and Guidance. An abridged version has also been developed for the voluntary and independent sector and also district and borough councils. d) HSAB has established an audit programme which is derived from five key factors: issues and themes from local monitoring information; patterns and trends in local cases referred for multi agency review; issues and themes highlighted in the Learning from Experience Database; HSAB priorities and response to national developments and events. Due to competing priorities, the audit programme has been slow to get off the ground but will be a key area of focus in 2015/16. e) A new performance/quality review framework has been developed consisting of four key elements: safeguarding activity data; feedback from "Making Safeguarding Personal" quality indicators; feedback from local and national audits and analysis of themes and trends from all of the above. Reporting against this framework will commence in September 2015.	a) Roll out of the Self Audit Tool across the voluntary and independent sector as well as district and borough councils. b) Implementation of the audit programme. c) Implementation of the new performance/quality review framework. d) Development of a cohesive approach to monitoring quality and safeguarding in Care Homes.

Priority	What we said we'd do	What we've done	Focus for 2015/16
Learning from experience	a) Learning from Experience Database is maintained b) Programme of activities to ensure lessons from serious cases are learned and applied in practice c) Hold learning and reflective practice workshops d) Pan Hampshire and IOW Annual Learning Conference	a) HSAB has produced a new Safeguarding Adult Review (SAR) Policy and a range of templates. b) Since the launch of its Learning and Review Framework in January 2014, HSAB has received a total of 23 referrals for a multi agency review. Of these, only one has met the criteria for a statutory safeguarding adult review. This review is in progress and is due to be completed by the end of October 2015. c) Three of the referrals resulted in a multi -agency reflective workshop and a further one is planned. The reflective workshop approach has proved to be a very helpful mechanism through which to gain learning about cases with a poor outcome but nonetheless do not meet the statutory criteria. d) HSAB has established a multi agency pool of facilitators which includes professionals from a wide range of organisations and areas of expertise. A training workshop for the facilitators was held earlier in March 2015 and standardised workshop materials have been introduced. e) The Learning from Experience Database's search functionality has been improved and visitors to the website are now able to search for reports by local authority area, date and theme.	a) Implement mechanisms to disseminate learning arising from serious cases and to embed learning in practice. b) Hold regular multi agency reflective/'learning workshops. c) Update the Learning from Experience Database. d) Hold a pan Hampshire and Isle of Wight Learning Conference.

Priority	What we said we'd do	What we've done	Focus for 2015/16
Skilled, competent workforce	a) Develop a Hampshire and Isle of Wight wide safeguarding learning and development strategy b) Develop a pan Hampshire and IOW learning and development programme c) Ensure practitioners are able to access up to date policy and practice guidance d) Development of a safeguarding practitioner network	a) HSAB has created a Workforce Development Group covering Hampshire, Portsmouth, Southampton and the Isle of Wight. b) The workforce development group undertook an audit of current safeguarding training (covering over 30,000 staff) in order to establish a baseline in current safeguarding provision and to identify any gaps. c) A multi agency safeguarding learning and development strategy has been developed which has been ratified by all four Safeguarding Adults Boards and their partner agencies. d) The Professionals Section on the HSAB website has been overhauled to improve navigation and a full range of guidance material is available on this. e) The Local Government Association Adult Safeguarding and Making Safeguarding Personal Knowledge Hubs are publicised on the HSAB website. f) HSAB publishes a regular Policy and Practice Bulletin which is cascaded to all member organisations. g) HSAB was a contribution to the development of the National Competency Framework for Adult Safeguarding led by Bournemouth University.	a) Development of internal actions plans by all organisations to implement the new strategy. b) Role mapping against the Strategy to inform planning for a joint professionals safeguarding course. c) Development of a multi agency safeguarding training programme and consideration of a range of funding models including a subscription based approach. d) Development of training materials, training packs, e:learning resources and tool kits. e) Agreement of a quality assurance framework for delivering safeguarding adults training. f) Development of a safeguarding practitioner network.

9. Moving Forward

9.1As this annual report highlights, the HSAB and its partners have made significant progress in strengthening local safeguarding arrangements in response to the implementation of the Care Act 2014. HSAB partner agencies have responded to these changes and a number have made fundamental changes to organisational structures and allocation of resources to support safeguarding work both within their own agencies as well as across the local safeguarding system as a whole. The Board has continued to benefit from the excellent commitment and engagement of partner agencies in the strategic development of adult safeguarding locally. Through its focus on the development of networks, the Board has successfully engaged with a wide range of stakeholders and organisations which may not previously have had an opportunity to influence the work of the Board.

9.2 HSAB's two year plan covering 2014/16 will conclude in April 2016. At this point, the HSAB will be working with partners and stakeholders to develop a new three year Strategic Plan which will be supported by a business plan with a rolling set of priorities. Stakeholder events will be held early in 2016 to gain feedback from the public, service users, grass roots organisations and partners about the key issues within adult safeguarding that they feel HSAB should be responding to.

Appendix A

Hampshire Safeguarding Adults Board Annual Statement - Performance and Activity

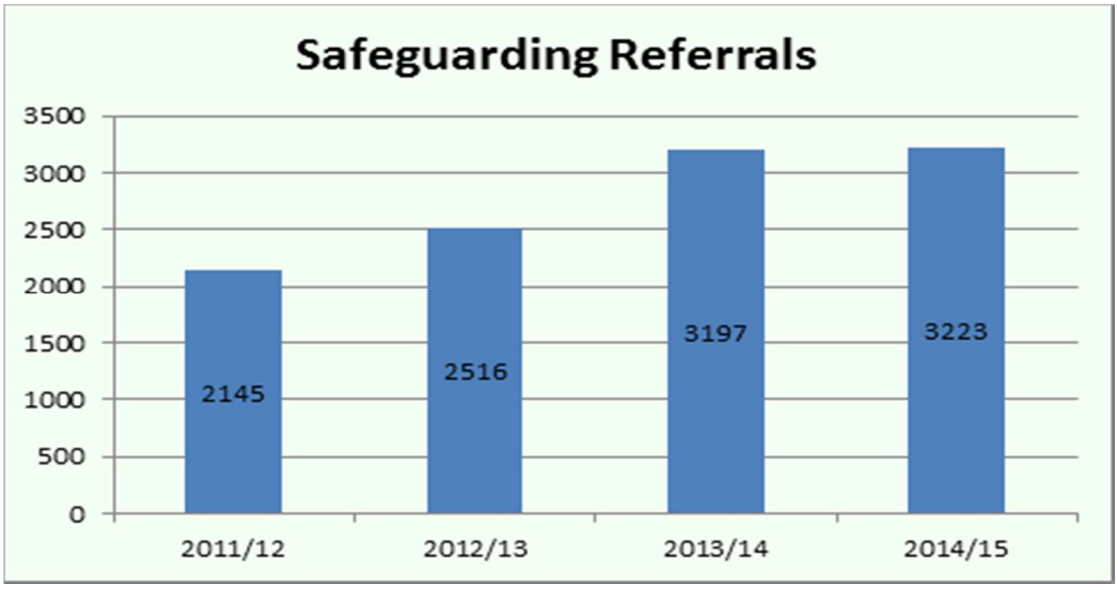
Safeguarding Activity

From 2011/12 the number of referrals made to Hampshire Adult Services have increased year on year, with the overall number of referrals increasing by 50% over the last 4 years (Figure 1).

This increase in referral rates is due in part to much stronger engagement and awareness amongst professionals and the public, less tolerance of poor quality care and more high profile reporting in the media of cases of abuse and neglect both nationally and locally.

There are now standard reporting forms across agencies such as Hampshire Fire and Rescue and much clearer referral processes, supported by the role of the Multi-Agency Safeguarding Hub (MASH) and much stronger interface with NHS governance processes.

Figure 1 – Total number of referrals by year.



However, overall referrals in 2014/15 were only very slightly higher than in the previous year with 26 more referrals. Monitoring undertaken throughout the year has also identified that the number of monthly referrals being made has been reducing since October 2014. There are several explanations for this change.

The majority of safeguarding referrals are now directed to the Multi-Agency Safeguarding Hub (MASH) where staff review them in relation to action required, multi-agency information sharing and appropriateness. This enables the service to ensure that referrals that require a different response, for example, a review of the care arrangements are dealt with by the social work teams and not through safeguarding. It is anticipated that this new model of service has reduced duplication and over recording of safeguarding referrals. It is believed the MASH team is having an impact on safeguarding rates, taking the role of screening referrals, signposting or taking appropriate action.

The Care Act 2014 encourages proportionate responses and the new framework has an information gathering stage built in which allows for professionals to consider the most appropriate course of action and more robust approaches to poor quality care.

Table 1 shows the number of referrals by client group since 2011/12

Table 1 - Number of referral by client group	**2011/12**		**2012/13**		**2013/14**		**2014/15**	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Older People 65+	1,150	54%	1,348	54%	1,828	57%	1,890	58%
Learning Disability 18-64	697	32%	701	28%	724	23%	570	18%
Mental Health 18-64	100	5%	248	10%	317	10%	459	14%
Physical Disability 18-64	165	8%	200	8%	264	8%	290	9%
Substance Misuse 18-64	4	<1%	6	<1%	37	1%	30	1%
Other/Not Known	29	1%	13	<1%	27	1%	0	0%
Total*	**2,145**	**100%**	**2,516**	**100%**	**3,197**	**100%**	**3,223**	**100%**

A person can have more than one referral during the year

Despite the overall number of referrals remaining largely consistent with the previous year there were variations between groups:

- Learning disability – Referrals reduced in 2014/15 accounting for 18% of activity compared to 23% in previous year, which can largely be attributed to a reduction in the number of safeguarding incidents within residential settings.

- Mental Health – The number and proportion of referrals increased in 2014/15 largely as a direct consequence of the continued work that has been undertaken with the Integrated Mental Health Teams to improve recording.

Types of abuse

For each safeguarding referral made, one or more abuse type can be recorded to reflect the nature of the incident that has occurred. **Table 2** breaks down the type of abuse reported over the last three years.

Neglect remains the most frequently reported type of abuse in 2014/15 linked to 37% of referrals followed by physical abuse (26%). The decline in organisational 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 Large Scale Enquiry.

Table 2 - Types of abuse reported	2011/12		2012/13		2013/14		2014/15	
	No.	%	No.	%	No.	%	No.	%
Physical	745	34%	783	30%	851	26%	941	28%
Neglect	728	33%	908	35%	1,278	39%	1,223	37%
Financial & Material	351	16%	440	17%	563	17%	541	16%
Psychological	172	8%	235	9%	327	10%	319	10%
Sexual	136	6%	138	5%	183	5%	230	7%
Organisational	69	3%	81	3%	55	2%	42	1%
Discriminatory	11	<1 %	20	1%	26	1%	15	<1%
Total*	**2,212**	**100%**	**2,605**	**100%**	**3,283**	**100%**	**3,311**	**100**

*A single referral can lead to multiple abuse type being identified, so total is greater than referrals

Whilst neglect was overall the most commonly reported type of abuse in 2014/15 there are variations between client groups:

- Learning disabilities - Physical abuse is identified in 41% of referrals, and is the most reported
- Mental Health – Physical abuse is the most frequently recorded abuse type at 33%, followed by 22% psychological abuse and 17% of referrals relating to financial or material abuse.
- Older person – Neglect is the main reason for referral in 47% of cases.

- Physical disability – Neglect and physical abuse both represent around 30% of incidents followed by financial abuse with 20% of referrals.

Location of abuse

Table 3 breakdowns the location of where the abuse is reported to have occurred over the last 4 years. 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. Since 2013/14 this trend has changed with a persons own home becoming the most frequently reported location for where the incident occurred; increasing further in 2014/15 to represent 46% of incidents.

Table 3 - Location of abuse	2011/12		2012/13		2013/14		2014/15	
	No.	%	No.	%	No.	%	No.	%
Own Home	715	33%	839	33%	1,340	42%	1,489	46%
Residential Care	637	30%	856	34%	806	25%	677	21%
Nursing Care	277	13%	308	12%	423	13%	509	16%
Mental Health Inpatient Setting	76	4%	48	2%	63	2%	79	2%
Alleged Perpetrators Home	72	3%	68	3%	75	2%	55	2%
Acute Hospital	70	3%	66	3%	118	4%	121	4%
Public Place	64	3%	57	2%	90	3%	83	3%
Community Hospital	43	2%	38	2%	27	1%	15	0.5%
Day Centre/Service	34	2%	48	2%	21	1%	48	1%
Other Health Setting	17	1%	17	1%	16	<1%	14	0.4%
Education/Training/Workplace Establishment	14	1%	9	<1%	17	<1%	3	0.1%
Supported Accommodation	51	2%	56	2%	38	1%	72	2%

Other/Not Known	75	3%	106	4%	163	5%	58	2%
Grand Total*	**2,145**	**100%**	**2,516**	**100%**	**3,197**	**100%**	**3223**	100%

User Survey Findings

National local authorities are required to undertake a user satisfaction survey every year which asks clients receiving social care support a range of questions on how the services they receive help to improve their quality of life. Including two questions asking how safe and secure people feel.

In March 2015 this survey was completed by 1,142 clients, out of a sample of 3,900. **Table 4** shows the response to the safe and secure questions over the last 3 years.

Table 4 - National User Survey Questions	2012/13	2013/14	2014/15	Comparator Average 2013/14
Proportion of people who use services who feel safe	67%	69%	74%	66%
Proportion of people who use services who say that those services have made them feel safe and secure	83%	82%	90%	79%

When this performance is benchmarked with the average responses for the 16 Local Authorities that make up the Hampshire County Council comparator group (those authorities that are deemed to be most similar to Hampshire), it shows that a higher proportion of Hampshire Adult Service clients responded that they feel safe and secure than the average.