Hampshire Safeguarding Adults Board

Annual Report 2015 - 2016

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

June 2016

Hampshire Safeguarding Adults Board Annual Report 2015/16

Foreword

I am very pleased to be able to introduce the Hampshire Safeguarding Adults Board's Annual Report for 2015/16. As the new independent chair of the Hampshire Safeguarding Adults Board, I have been meeting with partner organisations and I am impressed by the evident shared commitment to shared safeguarding principles and values as well as the comprehensive work that has already been undertaken. I am grateful to Pamela Charlwood as the outgoing chair of the Board, for getting the Hampshire safeguarding partnership onto a firm footing. Going forward, my goal is to provide leadership to take the Board forward into the next phase consolidating on the significant work already achieved and strengthening the partnership.

Our aim is to provide leadership and constructive challenge to all, in order that we can best safeguard adults in Hampshire at risk of harm or neglect. Prevention is critical and can be achieved by raising awareness of adult safeguarding risks, improving the quality of services and supporting carers can reduce risks of harm and abuse. We also need to learn from what happens when things don't quite work out, from experiences in Hampshire and elsewhere in England, and particularly where there is good practice. These are some of the themes that we will be developing through the strategy, and I welcome the engagement events that are currently taking place around Hampshire which are enabling us to have dialogue with local communities what the local priorities are and how best to take the strategic aims forward together.

Carol Bode
Independent Chair of the Hampshire Safeguarding Adults Board

1. Introduction

1.1 This report outlines the activities of the Hampshire Safeguarding Adults Board's (HSAB) has undertaken to enable it to fulfil its statutory responsibilities regarding the strategic development and oversight of adult safeguarding across Hampshire. This report covers a one year period (1st April 2015 to 31st March 2016) and highlights the Board's progress and achievements in delivering its strategic priorities and objectives. The report provides a review of the Board's business plan highlighting challenges and also key achievements. It also outlines the areas requiring focus for the coming year.

1.2 Given the current climate, HSAB and its member organisations have faced and will continue to face going forwards, significant challenges in its role of providing strategic leadership for adult safeguarding in Hampshire. These include:

- Significant organisational change within the NHS and local authority as well as the integration agenda.
- Austerity and the impact on public bodies and the voluntary sector making the 'business as usual' work and prevention more difficult.
- Changing demographics and the increase in the over 75 and 85 population and the impact of associated long term conditions.
- The reduction in the care agencies available to deliver the increased volume and complex level of care required by an older, frailer population and the current resilience of community support services.
- The challenge of social isolation and loneliness.
- Relationships with the voluntary sector and lack of resources to support training of its workforce.

1.3 These challenges have occurred within a broader context of increased expectations and responsibilities arising from the introduction of new duties on public bodies relating to modern slavery, Prevent and self neglect as well as the changes to Deprivation of Liberty Safeguards arrangements which have had a significant impact on volume of applications. Throughout this period however, HSAB and partner organisations have continued to deliver their responsibilities regarding the strategic development of adult safeguarding across Hampshire.

1.4 Going forward, the Board recognises the opportunities to mitigate the impact of the on-going challenges highlighted including better coordination with other strategic partnerships and work streams and using local, regional and national networks more effectively in order to minimise overlap and duplication of effort.

1.5 The Board leads the strategic the development of adult safeguarding in Hampshire and in holding local agencies to account and the core focus of the Board in fulfilling this role is on value driven practice to ensure service users are kept at the centre of what we do and that we learn from their experiences of safeguarding in order to shape and improve the 'safeguarding system' in the future.

2. About the Hampshire Safeguarding Adults Board

2.1 The Hampshire Safeguarding Adults Board (HSAB) is a statutory, multi-organisation partnership coordinated by the local authority, which gives strategic leadership for adult safeguarding, across the Hampshire County Council area. The main objective of the HSAB is to gain assurance that safeguarding arrangements locally and its SAB partners act to help and protect adults in its area who meet the criteria set out in Chapter 14 of the statutory guidance of the Care Act 2014.

2.2 The HSAB oversees and leads adult safeguarding across the locality and has an interest in a range of matters that contribute to the prevention of abuse and neglect. These will include the safety of patients in its local health services, quality of local care and support services, effectiveness of prisons and approved premises in safeguarding offenders and awareness and responsiveness of further education services.

2.3 The remit of the HSAB is to set priorities, agree objectives and to co-ordinate the strategic development of adult safeguarding across the area it serves. It is the key mechanism for agreeing how local agencies will work together effectively to safeguard and promote the safety and wellbeing of adults with care and support needs who are at and/or are in vulnerable situations. Under the Care 2014, HSAB is required to publish a strategic plan (developed in consultation with local communities) and an Annual Report. The HSAB also acts as an important source of advice and assistance, for example in helping others to improve their safeguarding mechanisms.

Our membership

2.4 The Board has an independent chair that is responsible for ensuring that all organisations contribute effectively to the work of the Board. The chair 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:

Table 1: Hampshire Safeguarding Adults Board Membership

Board management

- Independent Chair
- HSAB Board Manager
- Business Support

Core statutory members

- Adult Social Care
- Clinical Commissioning Groups
- Hampshire Constabulary

Associate members

- Advocacy provider
- Ambulance Service
- Children's Services
- Community Safety Partnerships
- District and Borough Councils
- Hampshire Fire and Rescue Service
- HM Prison Winchester
- Housing Services
- Independent care provider
- NHS England, Wessex Area Team
- NHS providers
- Probation Services
- Trading Standards

Advisory

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

2.5 The HSAB also maintains effective links with a range of other strategic forums and partnerships including the Hampshire Children's Safeguarding Board, Community Safety Partnerships, PREVENT Board, Crisis Care Concordat, Domestic Abuse Partnership, Learning Disability Partnership, Health and Wellbeing Board and Healthwatch in recognition of the strong synergies between the work of the HSAB and many of these forums and to minimise duplication and maximise efficiencies, particularly as objectives and membership are likely to overlap.

Our vision

2.6 The vision and principles of the HSAB are outlined in its published strategic plan. The HSAB believes that:

- Living a life that is free from harm and abuse is a fundamental right of every person.
- Safeguarding adults at risk and their carers, from abuse is everyone's business and responsibility.
- 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.
- 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 must 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 'Making Safeguarding Personal' approach is essential in order to ensure that any support offered or provided is person centred and tailored around the needs, wishes and the outcomes identified by the adult. The person at risk at the centre of any safeguarding process 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'.

- All organisations must have processes aimed at preventing abuse from occurring in the first instance and to enable support to be offered at an early stage. When abuse does take place, it must be identified early and dealt with swiftly and effectively, and in ways that are the least intrusive and proportionate to the issues presented.

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

- It is vital that there are clear processes in place to identify learning from cases with poor outcomes so that lessons can be used to improve partnership working in order to prevent a similar event in the future.

Six Principles from the Government Policy on Adult Safeguarding (Department of Health May 2013)

2.7 The Government has set out principles to be used 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 are used by the Hampshire Safeguarding Adult Board and its partner agencies with safeguarding responsibilities, to benchmark and assess the effectiveness of current adult safeguarding arrangements:

Table 2: Six Safeguarding 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 and*

Principle	Description	Outcome for Adult at Risk
		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 staff treat any personal and sensitive information in confidence, only share 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."*

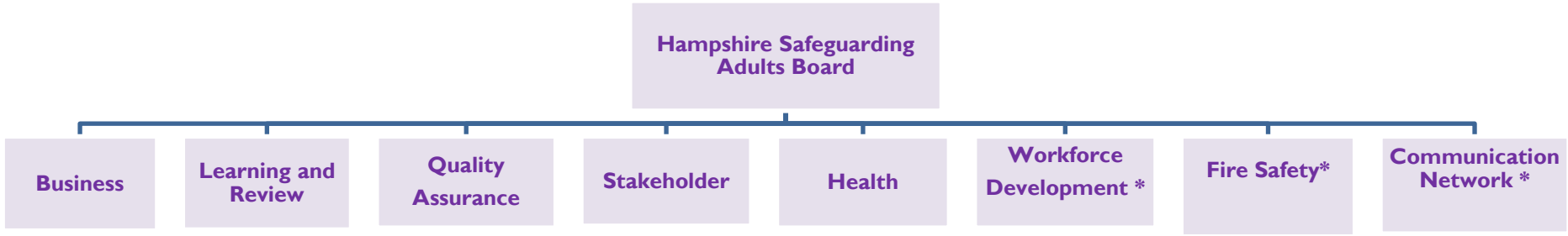
If you are interested in finding out more about the Government's policy on adult safeguarding, please click here:
Statement of government policy on adult safeguarding

2.8 In 2014, the Hampshire Safeguarding Adults Board (HSAB) published its Strategic Plan for the two year period 2014/16 setting out its vision for adult safeguarding 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 new statutory safeguarding arrangements introduced under the Care Act 2014 as well as the key themes that emerged from a series of engagement events undertaken by the Board in 2014 involving members of the public, service users and a wide range of voluntary and community organisations.

Our structure

2.9 The HSAB has a number of subgroups which are responsible for undertaking work to on key strategic priorities and objectives. Membership of the subgroups is made up of people from a broad range of organisations and groups which ensures Board developments take account of a wide range of perspectives and views. Subgroup chairs are responsible for providing regular progress reports back to the main board. The Subgroups are as follows:

Table 3: HSAB Structure



(* Denotes the Subgroup has been established as a joint working group with the other local SABs across Hampshire and the Isle of Wight)

2.10 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 and other stakeholders on the board and also ensure that the Board is informed by the voice of service users in general.

2.11 The HSAB is an active member of the 4LSAB Working Group which is forum made up of representatives from each of the 4 LSABs and their respective core statutory Board members. This has provided opportunities for joint work on common areas of policy and guidance so promoting a more consistent and joined up approach across the Hampshire and Isle of Wight area.

2.12 If you would like to find out more about the work of the Hampshire Safeguarding Adults Board please visit our website www.hampshiresab.org.uk . Click here to view the 2014/16 HSAB Strategic Plan and HSAB Business Plan.

3. Review of the activities of the HSAB 2015/16

3.1 Over the past year, the main focus of the HSAB has been on the implementation of the statutory safeguarding framework introduced under 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.

3.2 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 going 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

- 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.

3.3 The HSAB has provided an effective response to the implementation of the Care Act (2014) and we have worked with our partners to develop new safeguarding arrangements to ensure that the local 'safeguarding system' reflects the vision, principles and requirements of the Care Act (2014). 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 as consistent as possible across the area as a whole and provide a joined up approach. 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 section 42 safeguarding enquiry process as well as the development and publication of a wide range of 4 LSAB practice guidance covering Information Sharing, Prevention and Early Intervention, Self Neglect, Safeguarding in Commissioned Services and Allegations Management all of which were published in May 2015.

- A range of briefings and learning events were held throughout the period on the Care Act (2014) and the new statutory safeguarding framework across a wide range of sectors including Adult Services, Hampshire Constabulary, Independent Providers, voluntary and community organisations and district and borough councils.

- 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. Following the publication of the revised statutory guidance to the Care Act (2014) in March 2016 which removed the requirement for the DASM role, the local framework has been reviewed and a new framework relating to the management of allegations about people in a position of trust has been developed. In order to build on the good practice already achieved under previous arrangements, the Board has decided to maintain the Network which brings together the nominated lead professionals involved in this area of work from across Hampshire and the Isle of Wight.

3.4 A Board development day was held on 23rd March 2016 at which partner organisations reviewed the Board's overall activities over the past year and successes over the past year and considered the key priority areas the Board should be focusing on over the next 3 years. The following themes emerged from this review. These reflect the Board's strategic aims and priorities and examples of work undertaken by the Board and its partner agencies are summarised under each theme:

Safeguarding is everyone's responsibility

- Publication of a range of HSAB information leaflets as well as the continued development of the HSAB Website to promote awareness of abuse, keeping safe and how to report concerns. Joint work has also been undertaken with Hampshire County Council Adult Services on the 'Engaging Hampshire Communities' initiative aimed at promoting wide awareness of adult safeguarding concerns amongst people living and working in Hampshire . This project has resulted in the development and launch of an adult safeguarding alerters guide, safeguarding training video and phone App. for target audiences in including District and Borough Councils, churches and faith organisations, community and ambulance transport providers, housing providers, voluntary sector and community sector, leisure facilities and libraries and shops/commercial high street facilities/customer facing businesses.

- As part of its drive to make 'Safeguarding Everyone's Business, HSAB held a number of stakeholder engagement events in May 2016 to promote awareness of adult abuse and neglect and to engage local communities in this agenda. This year's events took place in Fareham, Andover, Aldershot and Lyndhurst and were held in partnership with a wide range of statutory, voluntary and community organisations including Advocacy providers, AFFECT (providing support to the families of prisoners), Alzheimer's Society, British Red Cross, Citizens Advice, Community Voluntary Services, Dementia Friendly Communities, Disability Advice Service, HealthWatch, MIND, Neighbourhood Watch, Princess Trust for Carers, You Trust (providing support on domestic abuse), local police neighbourhood teams, Hampshire Fire and Rescue Service, Trading Standards, Hampshire Adult Services. Through their involvement, partner organisations had an opportunity to highlight their services and what they offer to promote the wellbeing and safety of local people. Over 200 people attended our stakeholder events and this included members of the public, volunteers, grass root organisations and professionals.

- There has been on-going development of the HSAB website which forms a pivotal role in the Board's communication strategy. Usage data shows significant use of the website particularly of the publicity pages and professionals area. The website has received very positive feedback and it was commended as an example of best practice by the Peer Review Team which visited adult services in 2015.

Engagement and networking

- HSAB launched the 'Safeguarding Adult Lead' Network in In September 2015 which has enabled the Board to engage a wide range of community and voluntary organisations as part of its drive to ensure 'safeguarding is everyone's responsibility' and to support this sector to develop effective safeguarding responses both at an organisational and practice level. To date, there are over 120 different organisations who have joined the Network representing a wide range of community, voluntary, housing organisations and membership has more than doubled since the network was launched in September 2015. A Safeguarding Adult Lead network is in the process of being set up for independent care providers.

- HSAB has published a wide range of guidance material and tools and has made these widely available via Network events and the HSAB website – these include a Care Act implementation checklist, safeguarding self audit tool, guidelines on writing an internal adult safeguarding policy, etc.

- HSAB has also established effective links with the safeguarding and community safety leads in district and borough councils as well as at the strategic level, the Community Safety Alliance hosted by the Police and Crime Commissioner and comprised of all the chairs of the community safety partnerships across Hampshire.

- Hampshire Clinical Commissioning Groups have established a forum to support the independent health care sector in their safeguarding adult duties. The plan for the coming year is to invite hospices in the county to the forum.

- Hampshire Constabulary has engaged with a range of partner agencies and local communities to bring the Prevent plan to life designed to protect local communities against radicalisation. The police are currently engaging with minority communities and the voluntary and community sector around female genital mutilation (FGM) and have worked with partner organisations to develop a joint plan to manage this area of harm.

- In January 2016, HSAB commissioned 'Sounding Board', a consultation initiative based on the citizen panel model and hosted by an independent organisation, to undertake a survey of local people on their views about adult safeguarding generally and the key issues they feel the Board needs to focus on. Over 175 organisations (and individuals) took part in this survey. The responses highlighted further work is needed around promoting the Board and its role as well as doing more to raise awareness about adult abuse and neglect. Worryingly, two thirds of respondents said they had not seen leaflets or other publicity information on adult abuse and were unsure of the reporting process

(although reassuringly, the majority said they would either contact the police or social services). The barriers to reporting adult abuse were cited as people possibly not understanding that the behaviour they have experienced is in fact abusive, a fear of being seen as interfering or nosy, a fear of potential repercussions and making assumptions that someone else will report it. Other potential barriers highlighted were a fear of not being believed, of becoming isolated or the loss of relationships. It was felt that a lack of confidence, pride, shame and embarrassment may also deter people from speaking up about their experiences. Many respondents suggested establishing an abuse reporting line and what one called the 'human touch' or a more personalised approach which gives access to a trusted person with whom to discuss concerns rather than relying on technology such as on-line reporting or telephone. Greater support for informal carers and also victims of abuse was flagged. It was felt that access to advocacy, counselling services, information about support networks and the availability of safe places for people to go to would enhance the support available. It was encouraging to see that the majority of respondents felt that the public and local communities have a key role to play in tackling adult abuse with one respondent summing this up as follows: "we need to invest in rebuilding community spirit and caring for others. We will be using the survey findings to help shape the 2016/19 Safeguarding Plan and the HSAB Stakeholder Forum will be tasked with considering how best to respond to the issues highlighted by the survey in order to strengthen and improve awareness of and engagement in the adult safeguarding agenda.

Prevention and early intervention

- The introduction of the Care Act 2014 means that there is an increased focus on prevention and early intervention and in May 2015, the Board published its on Prevention and Early Intervention guidance to support this approach. Partner organisations have undertaken a wide range of developments to ensure their services are focused on prevention.

- Hampshire Fire and Rescue Service's (HFRS) targeted work with vulnerable groups has helped to improve their confidence, reduce the risk of falls and increase engagement in community activities – ultimately reducing health inequalities. HFRS launched 'Safe and Well' visits in April 2016 as a means of engaging with the most vulnerable groups. The updated home fire safety visit not only aims to reduce fire risk in the home by fitting and checking smoke alarms, but also takes into account the occupier(s) behaviours and the social and physical environment in which they live. The trusted relationships HFRS has with partnership agencies allows the referral of individuals for extra support where appropriate, to improve their health and wellbeing. These visits not only provide HFRS with access into homes, but also insight into the behaviours and environments different groups experience so allowing HFRS to be flexible with safety messages and to provide each household with a personalised home safety pack tailored to their needs.

- Trading Standards has a dedicated safeguarding team to support and put in place protective measures to safeguard adults at risk who have become, or are likely to become, the victim of financial abuse involving transactions for goods and services or as a result of a scam. Preventative / reassurance talks are given to Hampshire residents, partner agencies and financial institutions in in order to raise awareness about the latest scams and doorstep crime. The service also installs call blocking devices in the homes of people identified as persistent victims of phone scams. The safeguarding team monitor these devices and obtain specific data which assists in the ongoing safeguarding of these victims. Funding for this service came from monies recovered under the *Proceeds of Crime Act 2002*, from convicted criminals who had previously been subject to investigation and prosecution by Hampshire Trading Standards Service. During 2015, the safeguarding team held thirteen Fraud Awareness events at various banks across Hampshire and bank customers were given preventative advice regarding investment scams. Engagement has also been undertaken with all Hampshire NatWest and Lloyds Bank Branch Managers to highlight the work of this team.

- Adult services have established robust quality monitoring systems for the services it commissions to ensure that quality issues arising in residential and nursing homes and domiciliary agencies are known about and dealt with before they escalate into safeguarding. The approach to management of quality concerns has been strengthened by working closely with NHS partners to develop a shared Quality Strategy which includes close work with the social care regulator, the Care Quality Commission (CQC) and NHS colleagues to share information and agree consistent approaches to address poor quality care. Adult services have also introduced enforcement guidance to ensure a consistent response when CQC's inspection of services results in some form of enforcement action. The Care Act (2014) gave adult services an enhanced role in relation to market stability which aims to ensure an affordable supply of good quality care home provision to the people within Hampshire. Policies regarding market oversight and market failure have been developed to address this new area of responsibility.

- HSAB along with the other LSABs published a multi-agency Risk Management Framework in March 2016. Aligned with our Prevention and Early Intervention Strategy this approach is designed to guide staff on how to manage cases relating to adults where there is a high level of risk but the presenting circumstances may not engage the statutory safeguarding enquiry duty and for which a multi agency approach is needed to manage these risks in the most effective way in order to prevent an escalation to the point of crisis.

Making Safeguarding Personal

- 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.

- Making Safeguarding Personal standards and guidance were built into the local multi-agency Safeguarding Policy published in 2015. As a means of gaining assurance that safeguarding practice is moving more towards a person centred approach, the Board has developed a user feedback tool and process designed to gain feedback from service users who have been involved in the safeguarding process, via an independently facilitated discussion. This information will enable the Board to understand the extent to which 'Making Safeguarding Personal' is being embedded across the partnership and will provide evidence of the necessary change in culture to make this approach a reality. It is anticipated that this process will be piloted over the next 18 months.

Partnership Working

- The Multi Agency Safeguarding Hub or MASH is a joint service made up of police, adult services and NHS staff. Information from different agencies is collated and used to decide what action to take which 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. Following an independent review of the MASH, partner agencies have been working together to develop the service further in response to some of the findings from the review. The five Hampshire Clinical Commissioning Groups have funded two nurses from Southern Health NHS Foundation Trust to be located within the Multiagency Safeguarding Hub for Hampshire who work as part of a multi-professional group who provides triage and multi-agency assessment of safeguarding concerns in respect of vulnerable adults. Responses around mental health also continue to improve with numbers in custody reducing and quality care for those who need it improving. The MASH brings 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; and improved partnership working and less duplication of effort.

- The Modern Day Slavery partnership has made excellent progress resulting in a number of successful prosecutions and vital intelligence gathering and information sharing. The Clinical Commissioning Groups recognise how important it is that the health system has an understanding of modern slavery and the need to identify and provide support for victims. In order to support this agenda, the CCG Safeguarding Adults Team acts as the single point of contact for Hampshire Constabulary for the county. The need to provide support for victims has been included in this year's contract for major NHS community providers as core business. By acting as a single point of contact for the Police, the Safeguarding Adults Team can then liaise with the appropriate provider(s) to respond. The Safeguarding Adults Team established a mock Modern Slavery Operation for partner agencies and organisations to upskill staff and is also supporting local NHS providers to collaborate and to develop the service further.

- Prevent duties were introduced in July 2015 under the Counter Terrorism and Security Act 2015. All public bodies must now have due regard to the need to prevent people being drawn into terrorism. Whereas the lead for PREVENT previously lay with the police, local authorities now have the lead as support and interventions are now aligned with broader safeguarding role and responsibilities. Hampshire has a PREVENT Board which has been refreshed to establish a strategic forum in response to the new statutory duties. All key partner agencies are well engaged with the Board whose role is to provide a consistent and co-ordinated response across Hampshire and the Isle of Wight to the ideological challenge of terrorism and the threat posed by those who promote it through oversight of PREVENT activities across the area and ensuring PREVENT is addressed as appropriate in strategic plans and strategies. The HSAB has incorporated the PREVENT duty into the multi-agency safeguarding policies in order to link this activity into the wider safeguarding role..

Workforce Development

- In May 2015, the Board published a 4LSAB 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 implement this. This was informed by a training audit undertaken in 2014 with partner organisations across the 4 LSAB area covering over 30,000 staff. Partner agencies have reviewed their training plans in line with the Strategy.

- The Board's focus is now on developing a viable model to support the implementation of the Learning and Development Strategy. A number of models have been considered for with the preferred option being to develop a training area on the HSAB website and to employ a learning and develop coordinator to map current provision and resources and who will develop and implement a programme of topic days and 'learning into practice' events.

- Adult services have undertaken a comprehensive programme to ensure all social work staff in adult services have received updated guidance and enhanced training on their section 42 Care Act duties and responsibilities and key national developments and initiatives such as human trafficking and female genital mutilation. The section 42 training provided by adult services is open to partner agencies to attend which promotes multi-agency training. This programme is enriched by the contributions of a wide range of professionals from partner agencies in its delivery. The content of this course was recently reviewed to ensure it meets the needs of all partners going forward.

- Clinical commissioning groups (funded by NHS England Wessex) have undertaken a training programme across the residential sector, primary care sector, and independent hospital sector in order to support the understanding and application of on the Mental Capacity Act (2005). This has been a collaborative project with Hampshire County Council and to date over 1000 staff have received MCA training for which the evaluation has been outstanding.

- Online safeguarding refresher training for GPs across Wessex can now be accessed securely through the LMC (Local Medical Committee) website. NHS England Wessex has complimented this by developing a safeguarding webinar programme which is being rolled out in 2016/17 to GPs across Hampshire. Funding has been secured to employ a programme lead and it is anticipated that this programme will be further developed to include additional topics on adult safeguarding. An additional safeguarding development programme for 2016-17 will be delivered via evening workshops and e-learning for independent practitioners including Dentists, Pharmacists and Optometrists.

- The three Hampshire Clinical Commissioning Groups led by the Consultant Nurse for Safeguarding Adults has strengthened its work with University Hospitals Southampton NHS Foundation Trust and the University of Southampton to ensure that the Safeguarding Adults agenda is fully embedded into the training of nurses in the local area. This has been achieved by [providing placements in CCG Safeguarding Adults Team - this arrangement is considered to be the first of its kind in the country and feedback from the student nurses has been extremely positive. As the Clinical Commissioning Groups are only able to facilitate a limited student placements, an annual Safeguarding Adults Conference has been developed with the University of Southampton to ensure that all final year students of nursing have the opportunity to develop their knowledge base. In addition, the project was presented within the last year at a national conference by the University of Southampton to share best practice. The approach supports recent research which found that student nurses need to experience in practice, the process of safeguarding adults, in order to best learn for preparation as a Registrant. Links have been strengthened links with the University of Southampton which will enable the CCGs to ensure the safeguarding adults agenda and related duties are embedded in post-graduate programmes.

- Hampshire Constabulary continue to work at keeping vacancies to a minimum and that key high risk areas within safeguarding are filled by appropriately trained staff and so have made use of the safeguarding courses provided by partner agencies. The service now expect their commanders to take wider and greater safeguarding responsibility including working with the Multi-Agency Safeguarding Hub (MASH) and partners to solve safeguarding issues and take ownership of safeguarding incidents on their districts. Hampshire Constabulary are moving away from silo working towards taking joint responsibly with all of their staff rather than the bespoke few.

Gaining assurance and holding agencies to account

- The Board has introduced a range of processes designed to gain assurance about the quality, effectiveness and outcomes of the safeguarding work undertaken by local agencies and to hold them to account. The Learning and Review Framework provides a mechanism to identify learning from cases where there have been poor outcomes and then to use this learning to drive improvements across the wider safeguarding system. A learning summary is provided in section 4 of this report.

- As part of its continued drive to raise standards, the Board introduced in 2015, a Safeguarding Organisational Self Audit (akin to the children's sector Section 11 audit) to support the organisational development of adult safeguarding within partner agencies. The information gained from the audits has been used to inform Board priorities as well as the work programmes of subgroups. For example, the collated audits in 2015 highlighted a gap in the implementation of the Making Safeguarding Personal (MSP) approach across partner agencies and as a result, MSP will be a key priority in the upcoming 2016-19 Safeguarding Plan. The Board has also developed a feedback tool that it hopes to pilot across partner agencies over the coming 18 months.

- In 2015, the Board introduced a new performance framework. This consists of four domains: a) safeguarding activity data; b) data relating to Making Safeguarding Personal approach; c) feedback from local and national audits and d) analysis of themes and trends from all of the above.

- The Board has developed a 'Walk the Floor' process designed to ensure board members are knowledgeable about issues relating to adult abuse and to help HSAB develop a common understanding of how adult safeguarding arrangements operate across services in Hampshire. This process will provide the Board with useful information about issues impacting on front line services and any improvements needed to improve adult safeguarding services across the partnership. This will be implemented in over the coming year.

Joined up approach and links to other Boards and strategic partnerships

- The HSAB is an active member of the 4LSAB Inter-Authority Working Group (IAWG). This forum brings together the core statutory members of the four local safeguarding boards and acts as a mechanism for coordinating respective work programmes and sharing developing shared policies, guidance and supporting tools in order to gain as much consistency as possible. This approach is of particular benefit for organisations which work across all or a number of the local authority areas in Hampshire.

- The Board has continued to strengthen links with other strategic partnerships and work programmes including the Hampshire Domestic Abuse Partnership, Hampshire Childrens Safeguarding Board, PREVENT Board, Modern Slavery Partnership, Hate Crime Working Group and the Crisis Care Concordat to promote alignment between the work of the HSAB and the work of other partnerships. A programme of work has been agreed with the Hampshire Childrens Safeguarding Board for the coming year which will include joint work on sexual exploitation and transition; training and workforce development around training on neglect and sharing lessons learnt from serious cases; a joint workshop on 'Think Family' to develop a collective understanding and approach and engagement of Housing providers in safeguarding both operationally and strategically.

4 HSAB Learning Summary 2015/16

Learning and Review

4.1 The HSAB has implemented a multi-agency Learning and Review Framework designed to capture learning from serious cases where they have been poor outcomes and to use this learning to drive improvements across the wider safeguarding system as well as in the outcomes experienced by users of services. The approach builds on and complements the internal governance and learning processes within partner organisations 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.

4.2 The learning and review function is managed by a subgroup of the Board which screens all referrals for a multi-agency review forwarded to the Board and based on information provided, makes a decision about the most appropriate type of review to carry out, ranging from a statutory Safeguarding Adult Review, multi-agency partnership review, multi-agency reflective workshop or multi-agency themed audit.

4.3 The Board has developed a pool of facilitators made up of professionals from a wide range of organisations and areas of expertise who can be called upon to lead reflective workshops. Our Learning and Review Framework has been adopted by the other local safeguarding adult boards in Portsmouth, Southampton and the Isle of Wight thus providing a consistency of approach for partner agencies.

Safeguarding Adult Review Policy

4.4 In 2015, the HSAB introduced a new Safeguarding Adult Review Policy in order to bring our arrangements into line with section 44 of the Care Act (2014) which place a requirement on safeguarding adult boards to undertake 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 this 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 paragraph 4.10).

Learning from Experience Database

4.5 HSAB has maintained its Learning from Experience Database located on its website which contains links to a wide range of national and local safeguarding adult reviews, serious case reviews (pre 1st Aril 2015) and historic and current national reports and inquiries. The database aims to support the dissemination of the learning arising from these and in doing so promote evidence based practice. The database contains over 50 cases and for each, has a case summary and professional learning points. in 2016, Coroner 'Prevention of Future Death' reports were added as a new area to the database. In setting up the database five common themes emerged and these have helped to formulate the Board's area of focus 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

MS B Safeguarding Adult Review

4.6 During 2015/16 HSAB carried out one safeguarding adult review (SAR). The case concerned MS B, a 46 year old woman who had a mild learning disability, personality disorder and epilepsy. She was a Portsmouth City Council client who lived in a residential home in Hampshire. Ms B died in 2014 in Hospital with the cause of death recorded as heart failure. Ms B's care and support in the last weeks of her life had involved a complex mix of physical and mental health and care services. Her behaviour had changed significantly and different approaches to respond to this were attempted, but with limited success. Her physical health required her admission to hospital and was found to have deteriorated so substantially that little effective treatment was possible. This sequence of events made it appropriate to examine more closely how well the partner agencies and systems in place had worked in responding to Ms B's needs. The SAR carried out between June and November, was chaired by an independent person and supported by a multi-agency review panel. The key areas of focus in the review were the recognition of Ms B's complex needs and how they were handled, including how her views were taken into account and how well her health deterioration was managed; the overall co-ordination of the care and support provided to Ms B and communication and sharing of information between the agencies providing that care and support.

4.7 Whilst no single factor was identified which would have led to a different outcome, there were a number of missed opportunities to better manage Ms B's needs to influence the course of events. The review panel concluded that there had been missed opportunities to better manage Ms B's physical health and the response as this deteriorated. An annual health check may have detected the underlying heart condition at an earlier stage. Lessons were also learnt about how Ms B's care had been coordinated and that if she had been able to access to the type of case management appropriate to her needs, she then would have had the benefit of an allocated care coordinator, comprehensive needs assessment, annual review and more effective management of presenting risks around behaviour. It was also felt that a better managed hospital discharge may have facilitated better support and aftercare for Ms B and that the involvement of specialist learning disability liaison nurses may have improved communication during and post hospital admission. The final area of learning for the agencies involved in supporting Ms B prior to her death was the understanding and application of the Mental Capacity Act (2005) and ensuring that capacity assessment is carried put face to face rather than arms length in order to gain a more accurate picture of Ms B's ability to make decisions about her care and treatment providing factual information rather than relying on hearsay. The review panel concluded that the involvement of an advocate to support Ms B would have ensured her voice was heard and could have provided checks and balances throughout the process.

4.8 The final SAR report was presented to the HSAB on 16th December 2015 and the recommendations accepted in full. The full report and the action plan developed to respond to the recommendations, have been published on the HSAB website and shared with the agencies involved in supporting Ms B as well as more widely, with relevant strategic forums including the Health and Wellbeing Board.

4.9 The action plan takes a different approach and rather than prescriptive and detailing all the actions required, it instead focuses on key priority areas describing the outcomes all agencies should already be working to. The outcomes and standards are consistent with relevant statutory codes of practice, CQC fundamental standards and accepted good practice. The action plan also references actions arising from the Mr A serious case review carried out in 2011/13 as well as the findings from the national Confidential Inquiry into Premature Deaths of People with a Learning Disability carried out over a 2 year period in 2010-2012. The action plan also references a number of national and local frameworks which will support the delivery of the SAR recommendations including the NHS Standard Contract and Commissioning for Quality and Innovation (CQUINs) as well as the current Learning Disabilities Mortality Review (LeDeR) Programme.

Other multi-agency reviews carried out by the Board

4.10 Since the launch of the HSAB Learning and Review Framework in January 2014 to 31st March 2016, the Board has received a total of 29 referrals for a multi-agency review (9 of these referrals were received during 2015/16). Of the total number of referrals made to the Board, only one case has met the criteria for a statutory safeguarding adult review which was completed in November 2015 (the circumstances of this case and the learning gained are outlined in 4.5 above).

4.11 Of the other 28 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 multi agency reflective workshops which were involved bringing together practitioners involved in the case in order to reflect on practice and gain learning for future practice. There have been 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. A wide range of practice issues have been highlighted in the referrals received for a multi-agency review including:

- Respecting the dignity of individuals
- Poor clinical care and treatment which placed patients at risk
- Managing deteriorating physical health of people with learning disabilities in community settings
- Managing deteriorating mental health in community settings
- Discharge planning and delayed discharge from hospital
- Management of service users' refusal or disengagement from support
- Access to mental health beds and management of mental health in acute hospital settings
- Understanding and application of the Mental Capacity Act 2005 and other legal frameworks
- Access to places of safety and domestic abuse services for people with needs of care and support
- Fire deaths of vulnerable adults receiving care and support in their own homes

4.12 The Board is committed to using the learning gained both from the referrals and reviews undertaken to support improvements in local services and partnership working. For example, in response to the three referrals received relating to fire deaths, the Board has worked with the Hampshire Fire and Rescue Service (HFRS) to develop a process through which to review fire deaths involving vulnerable adults including dovetailing the HFRS internal fire investigation procedure with the HSAB Learning and Review Framework to ensure consistency. HFRS has undertaken this work within the wider context of its Fire Safety Framework designed to safeguard adults with care and support needs who are at significant risk from fire which provides general awareness raising and also training of care staff.

4,13 Another example of 'learning into practice' has been HSAB's publication of the multi-agency Risk Management Framework providing guidance on the management of cases relating to adults where there is a high level of risk, the circumstances of which sit outside the statutory adult safeguarding framework but for which a multi agency approach is needed to manage these risks in the most effective way and before a crisis point is reached. This guidance is likely to be useful to any professional who is working with adults experiencing an unmanageable level of risk as a result of circumstances which create the risk of harm but not relating to abuse or neglect by a third party such as vulnerability factors placing them at a higher risk of abuse or neglect including mate crime, network abuse, etc.; self neglect including hoarding and fire safety; refusal or disengagement from care and support services; complex or diverse needs which either fall between, or span a number of agencies' statutory responsibilities or eligibility criteria; on-going needs or behaviour leading to lifestyle choices placing the adult and/or others at significant risk; complex needs and behaviours leading the adult to cause harm to others; 'Toxic Trio' of domestic violence, mental health and substance misuse and risks previously addressed via a section 42 enquiry but for which the need for on-going risk management and monitoring has been identified.

4.14 NHS England Wessex is one of the pilot sites for the Learning Disability Mortality Review (LeDeR) Programme, working with Bristol University to assimilate and implement learning from deaths of people with a learning disability in the local area which will in turn inform key themes and recommendations at a national level. The study has been commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England and was launched in Wessex on 1st May 2016. HSAB and key partner organisations are actively engaged in this programme and it is anticipated that this will support the delivery of the Ms B SAR recommendations.

4.15 The understanding and application of the Mental Capacity Act 2005 (MCA) within NHS organisations has been highlighted in a number of multi-agency review referrals as well as in the learning arising from the Ms B SAR. This issue is being tackled through an extensive programme of MCA training across the residential sector, primary care sector, and independent hospital sector funded by NHS England Wessex and undertaken by the Clinical Commissioning Groups. Over 1000 staff to date have received training on MCA through this programme and the evaluation has been outstanding.

Mazars Review

4.16 In December 2015, the Mazars report into mental health and learning disabilities deaths in Southern Health NHS Foundation Trust was published. This review was commissioned by NHS England following the death of Connor Sparrowhawk in 2013 in order to look at the deaths of people with a learning disability or mental health problem at Southern Health NHS Foundation Trust. The review focused on people who had died in the period between April 2011 and March 2015 and who had been in receipt of the trust's mental health and/or learning disabilities services, either at the time of their death or within the twelve months preceding their death. The report is critical of the trust's internal governance and assurance processes which describes lack of leadership, focus and sufficient time spent in the trust on carefully reporting and investigating unexpected deaths of mental health and learning disability service users. The report also makes critical comment about the trust's 'lack of transparency' and the lack of involvement of families in investigations into the deaths of service users.

4.17 The Mazars report makes a number of recommendations to improve the systematic management and oversight of deaths and investigations, including best practice when working with families and carers, the processes by which lessons are learned, and that any resultant service change can be evidenced. HSAB recognises that the implications of the Mazars Report are far reaching across the system and therefore, set up a multi-agency workshop in January involving representatives from Hampshire, Southampton, Dorset, Oxfordshire and Buckinghamshire LSABs, NHS England Wessex, CCG and local authorities to draw out the multi-agency implications of the Mazars recommendations and to develop a shared approach to respond to these.

4.18 NHS England Wessex, clinical commissioning groups (CCGs) and HCC adult services have been working together to ensure a cohesive and consistent response to the Mazars Report. The CCGs that commission services from Southern Health Foundation Trust alongside Monitor, are involved in scrutinising the trust's improvement actions and delivery. HCC adult services have taken stock of its own organisational arrangements to maximise the learning opportunities in the event of the death of someone known to their services.

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), which came into force in April 2015, has also redefined how safeguarding is defined and recorded. One of the biggest of these changes being in terminology as safeguarding cases previously referred to as 'safeguarding referrals' are now know as a 'S42 Enquiries' under the Care Act. HSAB partner agencies have responded to these changes and a number (such as Adult Services, Police, NHS organisations, etc.) have continued to make organisational changes including how resources are allocated, to strengthen safeguarding work and partnership arrangements.

5.2 Over the last 5 years the number of safeguarding referrals made to Hampshire Adult Services and the and S42 Enquiries undertaken have increased year on year, although this increase has reduced over the last three years (see Figure1, Appendix A). Overall there were 3,324 S42 Enquiries in 2015/16, 101 (3%) more, compared to the 3,223 safeguarding referrals in 2014/15. As an individual can be the subject of more than one S42 Enquiry when the number of individual involved in safeguarding are compared it shows that these 3,324 S42 Enquiries involved 2,847 individuals, which is only a 1% increase on the 2,810 people that went through the safeguarding process in 2014/15. The increase in the number of incidents reported may be due in part to the ever increasing awareness of adult safeguarding and greater engagement amongst professionals leading to more reliable reporting of incidents.

5.3 When S42 Enquiries are broken down by client categories as in previous years, S42 Enquiries relating to older people still account for the highest proportion of safeguarding at 60% (58% in 2014/15). Clients aged 65 and under with a Physical Disability where the second most referred group accounting for 15%. In previous years, clients aged under 65 with a Learning Disability were the second biggest cohort. In 2015/16 the number of cases relating to people with a learning disability dropped for the second consecutive year from 570 to 463 representing 14% of safeguarding compared to 18% in 2014/15.

5.4 Concerns about neglect and physical abuse remain the most common reason for safeguarding (41% and 23% respectively). With the introduction of the Care Act new abuse categories where introduced;

- Domestic violence;
- Victim of hate crime;
- Sexual exploitation;
- Modern slavery; and
- Self Neglect.

5.5 Further details about safeguarding performance and activity and the figures outlined in this summary can be found in Appendix A.

6 Review of the Business Plan 2015/16

6.1 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 next strategic plan 2016/19:

HSAB Key Priorities and Objectives

Priority	What we said we'd do	What we've done	Focus for 2016/17
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) Publication of a 4LSAB multi agency safeguarding adults policy in May 2015 - available on the HSAB website and member organisations' staff intranet sites. b) Publication of human trafficking guidance – incorporated into the local multi agency safeguarding policy. c) Representation on the Modern Slavery Partnership hosted by the Police and Crime Commissioner which ensures the activities of each board are aligned. d) Events held to raise awareness and understanding of the new statutory safeguarding framework and local multi-agency safeguarding policy. e) Publication of DASM Guidance in May 2015 – revised following changes to statutory guidance and new requirements around allegations management. f) Network of safeguarding allegations management leads set up to facilitates information sharing and the development of best practice.	a) Develop financial abuse practice guidance. b) Develop local MSP guidance to support partner agencies to embed this approach.

Priority	What we said we'd do	What we've done	Focus for 2016/17
Provide a clear policy framework - robust policies and procedures are in place to enable staff in all agencies work to an appropriate policy context (continued)		g) Publication of a range of practice guidance for use by community, voluntary and independent care providers to support organisational development around adult safeguarding. h) Publication of guidance on new duties regarding PREVENT introduced under the Counter Terrorism and Security Act 2015. A Prevent Board, chaired by Adult services has been established and there is good engagement from partner agencies. 4LSAB Policy Implementation Group set up to coordinate and lead policy development across the SABs in Hampshire and IOW.	
Prevention and early intervention – acting before harm occurs and robust shared risk management approaches	a) Develop a Prevention and Early Intervention Strategy b) Develop a multi-agency risk management process c) On-going fire safety and fire death prevention work d) Include safeguarding in new processes being developed to reduce anti social behaviour and disability hate crime.	a) Publication of a Prevention and Early Intervention Strategy in May 2015 incorporated into the multi agency Safeguarding Adults Policy. This highlights the issue of social isolation and suggests a wide range of approaches. b) Publication of a multi-agency Risk Management Framework designed to guide staff on how to manage cases relating to adults where there is a high level of risk but the presenting circumstances may not engage the statutory safeguarding enquiry duty c) HFRS working group has formally been adopted as a subgroup of the Board. 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. In April 2016, HFRS launched its Safe and Well visits.	a) Joint work with partner agencies to embed the multi-agency risk management framework b) Adopt guidance on tackling loneliness and isolation published by the LGA and Age UK. Include this topic in the HSAB multi-agency training programme 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 2016/17
Prevention and early intervention – acting before harm occurs and robust shared risk management approaches (continued)		d) District and borough councils and community safety partners are now engaged on the Board and its subgroups to ensure that there are links and alignment between respective agendas. e) Domestic Abuse Strategy now sits within HSAB reporting structure. f) HSAB and HSCB have worked together to develop a reporting process relating to women who have experienced FGM. g) Prevent duties have been incorporated into the 4LSAB multi- agency safeguarding policy.	
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) HSAB co-sponsored work undertaken by HCC to develop publicity material and a phone APP to support the 'Engaging Hampshire Communities' initiative. These materials have bene launched and are also available on the HSAB website. b) Stakeholder Events were held designed to meet local people to find out what safeguarding means to them and the important issues we should be focusing on. This feedback will be used to develop our 2016/219 Safeguarding Plan. c) Launch of the 'Safeguarding Adult Lead' Network enabling engagement with a wide range of community and voluntary organisations. Over 120 different organisations have joined the Network to date. d) Publication of guidance and to support the voluntary and community sector to develop safeguarding – includes a Care Act implementation checklist, self audit tool, guidelines on writing a safeguarding policy.	a) Develop a Safeguarding Adult Lead network for independent care providers. b) Develop learning and development pages on the HSAB website. c) Links with the HCC Education Service to develop a Schools Awareness Programme. d) Use Sounding Board findings in developing the 2016/19 Safeguarding Plan.

Priority	What we said we'd do	What we've done	Focus for 2016/17
Wide awareness of abuse, its impact and engagement of the local community in the adult safeguarding agenda (continued)		e) 'Sounding Board' survey undertaken of local people on their views about adult safeguarding generally and the key issues they feel the Board needs to focus on. f) Links established with safeguarding and community safety leads in district and borough councils, Disability Hate Crime Group, Crown Prosecution Service, Modern Day Slavery Partnership and Prevent Board. HSAB website has been refreshed and now provides improved navigation. New sections added for DASMs, SALs, consultations, etc.	
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) Stakeholder Subgroup set up – consists 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. b) HSAB has developed a suite of leaflets about the Board and adult safeguarding. These are also available in an easier to read format and can be found on the HSAB website. c) 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.	a) Review the current suite of publicity leaflets. b) Review with the stakeholder group their role in raising awareness of abuse or neglect and how to report concerns. c) Reboot the Communication Network so that safeguarding messages are consistent. d) Develop a calendar of events relating to adult safeguarding so that activity to promote awareness is coordinated. e) Develop a user feedback process and tool to use with a sample of people who have received support through the safeguarding process.

Priority	What we said we'd do	What we've done	Focus for 2016/17
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) Introduction of new performance/quality review framework - consists of 4 key elements: safeguarding activity data, MSP data, feedback from local/national audits and analysis of themes and trends from all of the above. Reporting against this framework commenced Sept 2015. b) Completion of all HSAB members of the Self Audit Tool and action plans to address gaps highlighted. The self audit tool was revised to reflect Care Act (2014) requirements and changes to the multi-agency safeguarding policy. c) 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.	a) Implementation of the audit programme. b) Introduction of a Board 'walk the floor' process. c) Agree a data set relating to Making Safeguarding Personal activity and to collect data to evidence how practice is changing. d) Implement a user feedback process on a sample of people who have received support through the safeguarding process. e) Include benchmarking data in performance review arrangements. f) Revise the Integrated scorecard and implement. g) Improve coordination of processes across the 4LSABs to reduce duplication

Priority	What we said we'd do	What we've done	Focus for 2016/17
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) A SAR was completed in December 2015 which identified important lessons on how people with multiple, complex needs are supported. The SAR report and action plan has been published on the HSAB website. b) Learning from Experience Database has been refreshed and functionality improved. Searches can now be undertaken by local authority area, date and theme. A new area relating to Coroner prevention of future death reports has also been added. c) Hampshire is one of the pilot sites for the Learning Disability Mortality Review (LeDeR) Programme set to assimilate and implement learning from deaths of people with a learning disability in the local area. This was launched locally on 1st May 2016. HSAB and key partner organisations are actively engaged in this programme.	a) Monitor and evaluate the implementation of the MS B multi-agency action plan. b) Review the Safeguarding Adult Review Policy and templates in the light of the learning gained from conducting the Ms B SAR. c) Develop and implement mechanisms to disseminate learning arising from serious cases and to embed learning in practice. d) Update the Learning from Experience Database. e) HSAB representation on the LeDeR Steering Group - to ensure alignment between the review and the Board multi-agency review process.

Priority	What we said we'd do	What we've done	Focus for 2016/17
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) Publication of multi agency 4LSAB safeguarding learning and development strategy. b) Partner agencies have mapped staff roles against this strategy and have reviewed internal training plans. c) A plan to implement the Strategy has been developed. d) Professionals section on the HSAB website has been overhauled to improve navigation and a full range of guidance material is available. e) Publication of a regular Safeguarding Policy and Practice Bulletin available on the website and cascaded to the safeguarding leads in partner organisations.	a) Implementation of the Strategy. b) Engage with stakeholders and agencies to map current training provision, materials and resources and to identify key gaps and risks. c) Set up a system for HSAB training endorsement. d) Develop digital and paper publicity materials e) Consult and engage with key stakeholders to develop and deliver a programme of learning events on key priority topics to support the HSAB objectives in 2016/17. f) Develop proposals for the HSAB to consider for a sustainable funding / subscription based model to support ongoing training delivery from 2017 onwards. g) Establish effective links with workforce and training leads in partner agencies to support a partnership approach in the delivery and alignment of multiagency training.

7. Moving Forward

7.1As this annual report highlights, the HSAB and its partners have made significant progress in strengthening local safeguarding arrangements in response to the introduction of the statutory safeguarding framework which came into force in April 2015. As highlighted in the introduction to this 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. The Board has continued to benefit from excellent commitment and engagement of partner agencies and their valued contribution to 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.

7.2 HSAB's two year plan covering 2014/16 concluded in April 2016. HSAB is now working with partners and stakeholders to finalise the new three year Strategic Plan which will be supported by a business plan with a rolling set of priorities. Stakeholder events have been held to gain feedback from the public, local communities and grass roots organisations and partners about the key issues within adult safeguarding that they feel HSAB should be responding to. The Board has also commissioned an independent organisation to undertake a survey the results of which will inform the Board's priorities going forward.

7.3 The annual report will be shared with the chief executive and leader of the local authority, Police and Crime Commissioner, the Chief Constable and Hampshire HealthWatch. It is expected that those organisations will fully consider the contents of the report and how they can improve their contributions to both safeguarding throughout their own organisation and to the joint work of the Board. It will also be shared with the Hampshire Health and Wellbeing Board in order to ensure alignment of our activities with the broader 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 synergies and links between the agendas of the respective boards.

74 Partner organisations 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 they are sighted on the local strategic priorities for adult safeguarding so they can hold their own organisation to account around the delivery of these.

Appendix A

Hampshire Safeguarding Adults Board Annual Statement - Performance and Activity

Figure 1 – Safeguarding referrals

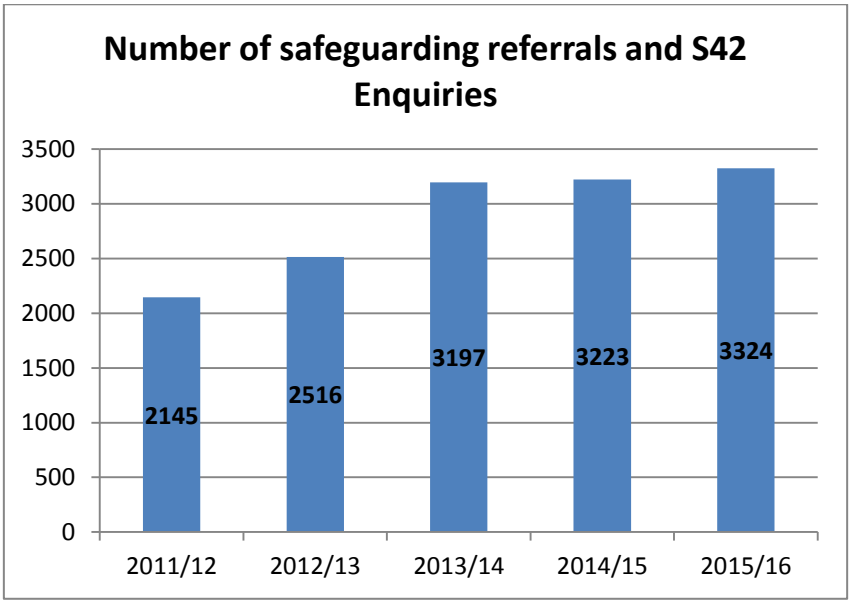


Table 1 shows the number of referrals by client group since 2011/12

Table 1 - Number of referral by client group	2011/12		2012/13		2013/14		2014/15		2015/16	
	No.	%	No.	%	No.	%	No.	%	No.	%
Older People 65+	1,150	54%	1,348	54%	1,828	57%	1,890	58%	1,999	60%
Learning Disability 18-64	697	32%	701	28%	724	23%	570	18%	463	14%
Mental Health 18-64	100	5%	248	10%	317	10%	459	14%	352	11%
Physical Disability 18-64	165	8%	200	8%	264	8%	290	9%	494	15%
Substance Misuse 18-64	4	<1%	6	<1%	37	1%	30	1%	16	<1%
Other/Not Known	29	1%	13	<1%	27	1%	0	0%	0	0
Total*	**2,145**	**100%**	**2,516**	**100%**	**3,197**	**100%**	**3,223**	**100%**	**3,324**	**100%**

A person can have more than one referral during the year

Table 2 – Type of abuse reported since 2011/12

Table 2 - Types of abuse reported	2011/12		2012/13		2013/14		2014/15		2015/16	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Physical	745	34%	783	30%	851	26%	941	28%	813	23%
Neglect	728	33%	908	35%	1,278	39%	1,223	37%	1,444	41%
Financial & Material	351	16%	440	17%	563	17%	541	16%	513	15%
Psychological	172	8%	235	9%	327	10%	319	10%	285	8%
Sexual	136	6%	138	5%	183	5%	230	7%	189	5%
Institutional	69	3%	81	3%	55	2%	42	1%	21	<1%
Discriminatory	11	<1 %	20	1%	26	1%	15	<1%	11	<1%
Domestic Violence	Categories introduced in 2015/16 under the Care Act								104	3%
Victim of Hate Crime									3	<1%
Sexual Exploitation									22	<1%
Modern Slavery									0	0%
Self Neglect									77	2%
Total*	**2,212**	**100%**	**2,605**	**100%**	**3,283**	**100%**	**3,311**	**100**	**3,482**	**100%**

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

Table 3 breakdowns the location of where the abuse is reported to have occurred over the last 5 years

Table 3 - Location of abuse	2011/12		2012/13		2013/14		2014/15		2015/16	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Own Home	715	33%	839	33%	1,340	42%	1,489	46%	1,429	43%
Residential Care	637	30%	856	34%	806	25%	677	21%	559	17%
Nursing Care	277	13%	308	12%	423	13%	509	16%	440	13%
Mental Health Inpatient Setting	76	4%	48	2%	63	2%	79	2%	56	2%
Alleged Perpetrators Home	72	3%	68	3%	75	2%	55	2%	56	2%
Acute Hospital	70	3%	66	3%	118	4%	121	4%	67	2%
Public Place	64	3%	57	2%	90	3%	83	3%	62	2%
Community Hospital	43	2%	38	2%	27	1%	15	0.5%	59	2%
Day Centre/Service	34	2%	48	2%	21	1%	48	1%	13	<1
Other Health Setting	17	1%	17	1%	16	<1%	14	0.4%	6	<1
Education/Training/ Workplace Establishment	14	1%	9	<1%	17	<1%	3	0.1%	5	<1
Supported Accommodation	51	2%	56	2%	38	1%	72	2%	75	2%
Other/Not Known	75	3%	106	4%	163	5%	58	2%	497	15%
Grand Total*	**2,145**	**100 %**	**2,516**	**100 %**	**3,197**	**100 %**	**3223**	100%	**3,324**	100%

Table 4 - Response to the safe and secure questions over the last 3 years, and compared to the average score for 16 local authorities within Hampshire's comparator group; 2014/15 is the most recent comparator information available.

ASCOF	Description	2015/16	2014/15	Comparator Group 2014/15	2013/14
ASCOF 1B	Proportion of people who use services who have control over their daily life	**80.0%**	79.5%	78.8%	80.9%
ASCOF 4A	Proportion of people who use services who feel safe	**76.0%**	74.3%	70.1%	69.0%
ASCOF 4B	Proportion of people who use services who say that those services have made them feel safe and secure	**91.0%**	89.8%	84.9%	82.1%

Nationally 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 people to rate how safe and secure they feel

The Hampshire survey was undertake in March and sent to over 1,500 clients in receipt of a service, across all client groups and service setting (residential and within a person own home) and over 500 responses were received.