HSAB
HAMPSHIRE SAFEGUARDING ADULTS BOARD

Hampshire Safeguarding Adults Board

Annual Report

April 2016 – December 2017

Long term support provided to 20,000 adult residents

3027 safeguarding enquiries

Neglect most common form of abuse

Over 6 million hours of homecare are provided

Over half of incidents take place in the adult's own home

2,800 customers are being supported with drug and alcohol issues

Hampshire Safeguarding Adults Board Annual Report 2016/17

Forward from the Independent Chair

I am pleased to be able to introduce the Hampshire Safeguarding Adults Board's Annual Report for 2016/17. During this period we have published a new Strategic Plan which outlines our strategic priorities and objectives going forward over the next five years. As a Board, our aim is to provide leadership and constructive challenge in order to ensure adults with care and support needs who are at risk of abuse or neglect are effectively safeguarded. Prevention and early intervention is critical to this vision as is the need to identify and apply learning when people experience poor outcomes.

Given the context of increased pressures on capacity and funding across all sectors, the Board has over the past year, been working to review and identify opportunities for increased joint working, alignment and improved coordination across the wider strategic partnership in Hampshire. To this end, we have been undertaking joint initiatives with neighbouring local safeguarding adult boards as well as the Hampshire Children's Safeguarding Board.

This approach has led to the successful revision of the Hampshire and Isle of Wight Multi-Agency Safeguarding Adults Policy and Guidance as well as the development and roll out of new 4LSAB multi-agency guidance such as the Risk Management Framework and guidance on Managing Allegations against People in a Position of Trust. I am also pleased to say that in September 2017, we held our first ever joint conference with the Hampshire Safeguarding Children's Board on Adopting a Family Approach to Domestic Abuse.

There has been a strong focus on engagement and networking enabling the Board to broaden Hampshire's adult safeguarding 'community'. We have established new networks within key sectors such as Housing and we have continued to develop our Safeguarding Adult Lead Network involving a wide range of cross sector events. I would invite you to visit our excellent website where you will find a wide range of publicity and information raising awareness of adult abuse and neglect as well as the updated Hampshire and Isle of Wight Multi-Agency Adult Safeguarding Policy and Guidance and related resources.

Carol Bode

Independent Chair, Hampshire Safeguarding Adults Board

1. About us

The Hampshire Safeguarding Adults Board (HSAB) is a statutory, multi-organisation partnership coordinated by the local authority, which oversees and leads adult safeguarding across the Hampshire County Council (HCC) area. HSAB's main objective is to gain assurance that safeguarding arrangements locally and its partner organisations act work effectively individually and together, to support and safeguard adults in its area who are at risk of abuse and neglect.

The HSAB also has an interest in a range of matters that contribute to the prevention of abuse and neglect including 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. Our purpose

HSAB's remit is to set priorities, agree objectives and to co-ordinate the strategic development of adult safeguarding across the HCC area. 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 Act 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 arrangements.

3. Our membership

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 statutory, community and voluntary organisations which includes representatives from Hampshire County Council, police, clinical commissioning groups, NHS providers, emergency services, district and borough councils, independent care providers, housing, advocacy, service users and carers, etc. The HSAB is made up of wide range of organisations as follows:

Figure 1: HSAB Membership

HSAB also has links with a wide range of other strategic forums and partnerships including the Hampshire Children's Safeguarding Board, Community Safety Partnerships, PREVENT Board, Domestic Abuse Partnership, Modern Slavery 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.

The HSAB aims to promote the involvement and contribution of service users on the Board and will continue to explore a range of approaches to achieve meaningful involvement of service users and other stakeholders and also ensure that the Board is informed by the voice of stakeholders in general.

4. Our vision

The HSAB works to promote a zero tolerance culture of abuse and neglect of adults who are vulnerable and its work is underpinned by the following ethos and principles:

- Living a life free from harm and abuse is a fundamental human right of every person;

- Safeguarding adults at risk and their carers 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.

- 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 most proportionate.

- People supporting adults with care and support needs and/or their carers must have the appropriate level of skills, knowledge and training to safeguard adults from abuse.

- It is vital that clear processes are in place to identify learning from serious cases so that lessons can be used to improve partnership working.

5. Our Structure

The HSAB has a number of Subgroups which are responsible for undertaking work on key strategic priorities and objectives.

Membership of the Subgroups is made up of people from a broad range of organisations and groups. This 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:

Figure 2: HSAB Structure

6. Priorities for 2016 – 2021

The vision and principles of the HSAB have been set over the five years and are outlined in its published strategic plan. A number of factors have helped to shape and influence these priorities including:

- The Board's review and evaluation in March 2016 of its progress in achieving its stated objectives in the HSAB Business Plan. This review highlighted a number of 'wrap around' themes and areas requiring further development;

- Response to national and local events which provide a focus on governance including the Mazars Review, national mortality reviews relating to adults with a learning disability, the Transforming Care Programme, etc.;

- Requirements in the Care Act 2014 relating to Making Safeguarding Personal and the need to embed this approach within and across organisations;

- Findings of a survey (undertaken by HSAB in January 2016) 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 and their responses highlighted further work is needed around improving awareness of adult abuse and neglect and how to report concerns. Feedback from the survey also highlighted a wide range of barriers to disclosing or reporting adult abuse. Greater support for informal carers and also the victims of abuse was flagged as an area the Board should be focusing on including the availability of advocacy and access to counselling services, information about support networks as a means of supporting victims in their recovery from abuse. The majority of respondents felt that the public and local communities have a key role to play in tackling adult abuse.

Our Priorities are:

- Wide awareness of adult abuse and neglect and neglect and its impact and engaging local communities.
- Prevention and early intervention – promoting well being and safety and acting before harm occurs.
- Well equipped workforce across all sectors.
- Safeguarding services improved and shaped by the views of service users, carers and other stakeholders.
- Clear, effective governance processes are in place within and across organisations.
- Learning from experience - mechanisms to gain learning from serious cases and promote service and practice improvement.

The following Table outlines HSAB's key priorities and work streams:

Priority	Key actions			Owner
Board governance	Alignment/coordination with other partnerships	Review of Board membership	Stakeholder events, survey & annual report	**Business subgroup**
Awareness and engagement	Refresh of publicity material & social media	Joint themed campaigns with LSABs/HSCB	Joint annual calendar of events	**Stakeholder Subgroup**
Prevention, early intervention	Launch of the risk management framework	Mapping transition	Tackling loneliness and social isolation guidance	**Policy Implementation Group**
Well equipped workforce	Training website	A system of training endorsement	Training programme linked to priorities (Risk, MSP, LIP, SAL, SAMA)	**Workforce Subgroup**
User voice	Service user representation on HSAB	Links with difficult to reach groups	Tools for participation and co-production	**Stakeholder Subgroup**
Effective governance	Develop an integrated scorecard	Annual MSP themed audit and MSP feedback pilot	Process for effective monitoring/evaluation of SARs – outcome focus	**Quality Assurance Subgroup**
Learning from experience	Mr C SAR and thematic review and post SAR audit in 2018	Integrated SIRI process and themed review of safeguarding SIRIs (Health Subgroup)	Thematic learning review, activities to share/embed learning + LFE database refresh	**Learning and Review Subgroup**

7. What we have accomplished

Over the past year, this is what we have done:

Priority	What we said we'd do	What we've done	Focus for 2018/19
Wide awareness of adult abuse and neglect and its impact and engaging local communities	a) Review HSAB's communication plan and publicity material to reflect the issues highlighted in the 2016 Survey. b) Undertake theme based awareness campaigns to develop community awareness and engagement of adult abuse and neglect and its impact. c) Establish a calendar of events and reboot the 4LSAB communication network. d) Build networks and engage with community level organisations – Neighbourhood Watch, Citizens Advice. e) Focus on breaking down barriers to reporting, personal responsibilities to speak out, 'building confidence' to report concerns and that the 'system' will respond. f) Development of the 'Safeguarding Adult Lead' Network and targeted work in the independent care provider, housing.	• New Communication plan written and published on HSAB website. • A financial abuse themed campaign was undertaken in 2017 launching newly developed publicity materials – this information is available on the HSAB Website. • Calendar of events produced, and Stakeholder events mapped and material distributed. • Stakeholder subgroup membership widened to include Citizens Advice, victim support and sensory services. • HSAB publicity material on adult abuse and neglect has been reviewed and is being updated and will include innovative and fresh approaches. • Events held twice per year and programmed to continue in 2018. A housing subgroup has been established. • In 2016, HSAB held 4 stakeholder events across Hampshire - information gained informed the development of our strategic plan.	• Development of a social media strategy and plan to increase visibility to a wider audience. • Tackling social isolation themed campaign in 2018. • Development of community engagement forum • Roll out of new publicity materials and animated information. • Engagement work with the further and higher education sectors.

Priority	What we said we'd do	What we've done	Focus for 2018/19
Prevention and early intervention – promoting well being and safety and acting before harm occurs	a) Board activity aligned with wider initiatives aimed at promoting well being, prevention and early intervention b) Promote initiatives aimed at addressing social isolation and loneliness. c) Joint work with partner agencies to embed the 4LSAB multi-agency risk management framework. d) Alignment of Board activities with the broader health and well-being agenda and to deliver accountability to the wider local strategic partnership - Health & Wellbeing Board. Healthwatch. e) Partners to audit against the HSAB Prevention Strategy in order to explore further opportunities to promote wellbeing, prevention and safety within business as usual activity.	• Links are been established between HSAB and the Health and Wellbeing Board, ensuring initiatives are shared. • Multi-agency risk management workshops delivered throughout the year. The guidance is published on the HSAB website. • Links established with other strategic partnerships.	• Adopt LGA/Age UK guidance on tackling loneliness and isolation and include this topic in the HSAB multi-agency training programme. • Joint work with HSCB to develop use of the risk framework within children's services. • Joint work with health trusts to develop use of the risk framework in acute hospital settings and ambulance service. • More joined up working with neighbouring LSABs and also the HSCB. • 4LSAB organisational self audit to be completed in 2018 – prevention and early is included in the benchmark.

Priority	What we said we'd do	What we've done	Focus for 2018/19
Well equipped workforce across all sectors	a) Implement the HSAB Learning and Development Strategy. b) Build networks and partnerships with the safeguarding and workforce leads in partner organisations. c) Joint work with partners to develop a multi-agency safeguarding training programme d) Develop training web pages on HSAB website to support single agency training. e) Source/develop training materials, resources and innovative delivery methods f) Develop a system of HSAB training endorsement. g) Establish a sustainable model for multi-agency training 2017/18 onwards. h) Policy Group to formulate new policy and guidance in response new legislation and national/local developments. i) Learning gained from serious cases is shared within and across organisations and this is used to inform and improve practice.	• SAL Network membership has been increased to 145 organisations. Four Network events held over the period involving 250+ members. • HSAB learning and development coordinator recruited. • HSAB training programme linked to strategic priorities has been developed and launched. • Training offer includes multi-agency risk management, Making Safeguarding Personal, Undertaking S42 Enquiries, Allegations Management. Good engagement and attendance from partners on this programme. • Training website developed with access to HSAB training, resource zone and partner agencies training websites. • Funding received from NHSE to design and deliver a safeguarding adults training programme for primary care professionals. • 4LSAB Multi-agency Safeguarding Adults Policy and Guidance updated.	• Roll out of the safeguarding adults training programme for primary care professionals. • Multi-agency guidance on Financial Abuse, Thresholds for raising a concern, Legal Powers and Remedies. • Development of a 4LSAB risk assessment tool. • Further development of the HSAB Training Website. • HSAB Training programme to be developed to include 'Responding to Financial Abuse' and 'Modern Slavery'. • Learning into Practice events to share learning arising from HSAB's Thematic Review from SARs related to Learning disability and Physical Health Care.

Priority	What we said we'd do	What we've done	Focus for 2018/19
		• Publication of the 4LSAB multi-agency Risk Management Framework and guidance on Managing Allegations against People in a Position of Trust. • Two multi agency workshops held for named professionals in statutory agencies with responsibility for managing allegations against people in a position of trust. • HSAB ran a two day safeguarding adults master class for Hampshire Constabulary's District Commanders. • A joint HSAB/HSCB conference on a 'Family Approach to Domestic Abuse' held in 2017. • Domestic Abuse and Toxic Trio training jointly commissioned with HSCB.	
Safeguarding services improved and shaped by the views of service users, carers and other stakeholders	a) Introduce the Making Safeguarding Personal (MSP) approach across all agencies. b) Design and implement a pilot of an independently facilitated user feedback process on a sample of people who have received support through the safeguarding process.	• MSP workshops included in the HSAB training programme. • A MSP feedback tool has been developed.	• Pilot of an independently facilitated service user feedback process. • Development of a Community Engagement Forum. • Co-production of a Communication ad Engagement Plan.

Priority	What we said we'd do	What we've done	Focus for 2018/19
	c) Develop a sustainable model for the MSP reviews going forward including the sourcing of funding to support this. d) Explore a range of approaches to achieve meaningful involvement of service users and other stakeholders on the Board and work groups to ensure Board activities are informed by the voice of stakeholders.		
Clear, effective governance processes are in place within and across organisations	a) Formally adopt the HSAB Assurance and Accountability Framework (AAF). b) Review the Quality Assurance Framework against the HSAB AAF. c) Undertake an annual themed audit. d) Reboot the Integrated Scorecard approach to gain a holistic overview of safeguarding risks across the 'system'. e) Benchmark local data against the HSAB AAF, government 6 safeguarding principles and national comparator information.	• HSAB Assurance and Accountability Framework (AAF) endorsed by member organisations and embedded in the Strategic Plan. • A 4LSAB Organisational Self Audit Tool has been published. • A MSP feedback tool has been developed.	• Undertake the Organisational Self Audit in 2018. • Develop a 4LSAB Integrated Scorecard for adult safeguarding. • Multi-Agency case file audit in September 2018 to check improvements in practice and partnership working regarding the HSAB Thematic Review of learning from SARs related to learning disability and physical health care. • Development of a multi-agency themed audit programme linked to information gained from the Integrated Scorecard.

Priority	What we said we'd do	What we've done	Focus for 2018/19
Learning from experience - mechanisms to gain learning from serious cases and promote service and practice improvement.	a) Formally adopt the HSAB Assurance and Accountability Framework (AAF). b) Align single agency governance processes as far as possible to avoid duplication and provide an holistic and multi agency perspective to learning. c) Undertake activities to ensure lessons from serious cases are shared and applied d) Establish mechanisms to evidence that services have improved as a result of lessons gained from investigations reviews and these have led to better outcomes for service users.	• Learning from Experience database has been developed further – local multi-agency partnership reviews have been added. • A new approach has been developed for undertaking multi-agency partnership reviews for cases not meeting SAR criteria.	• Implementation of the Mr C SAR and Thematic Review Action Plan. • Joint work with partner agency organisational leads to review training to ensure learning form serious cases is addressed on staff training and development activities. • Joint annual learning event covering lessons from local and national SARs, DHR's, LeDeR, SCRs, etc. • Update the Learning from Experience Database • Develop a framework to enable effective communication and joint working across health and adult social care commissioning organisations in response to critical events.

8. Learning and Development

HSAB Training Programme

In January 2017, a Learning and Development Coordinator was recruited on a fixed basis to develop and implement a multi-agency training programme including setting up a training Website. The training programme has included workshops on the Multi-Agency Risk Framework, Making Safeguarding Personal and Section 42 Enquiries. A sustainable model will be developed going forward.

During the period, four Safeguarding Lead Network (SAL) events have also been delivered which together involved representation from approx. 200 organisations across Hampshire. These have been well attended and received by participants.

The Board has also facilitated two multi-agency workshops for the named professionals in statutory agencies with responsibility for managing allegations against people in a position of trust.

In January 2017, the HSAB ran a two day safeguarding adults training course for Hampshire Constabulary's District Commanders.

Joint HSAB and HSCB Conference

In September 2017, HSAB and HSCB held their first ever joint conference on a common theme affecting both children and adults at risk. This year's theme was Domestic Abuse – A Family Approach. The conference was co-chaired by the safeguarding board chairs. The event was very well attended and received by professionals from a wide range of sectors. It is intended to run the joint conference on an on-going basis.

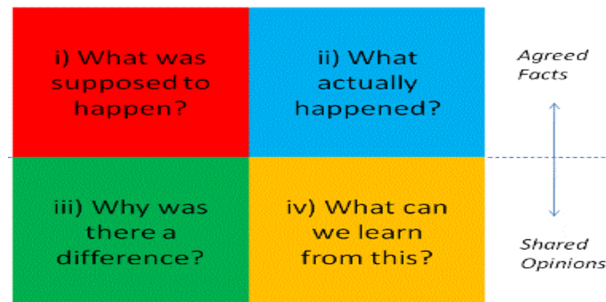
HSCB and HSAB are currently in the process of commissioning joint domestic abuse training addressing the 'Toxic Trio' of mental health, substance misuse and domestic abuse. This initiative is designed to support awareness and implementation of the Joint Working Protocol published earlier in the year.

NHS England Primary Care Training Programme

HSAB has been given £10,000 by NHSE to develop and deliver an adult safeguarding training programme for primary care practitioners in Hampshire. The programme has been designed and it is planned to be delivered between January and the end of March 2018.

9. Safeguarding Adult Reviews (SAR)

Under the Care Act 2014, local safeguarding adults boards (LSAB) have a statutory duty to carry out a Safeguarding Adults Review (SAR) when an adult with care and support in its area dies and the Board knows or suspects the death was as a result of abuse or neglect and there is concern about how the SAB, its members or organisations worked together to safeguard the adult.



The SAR process is designed to establish whether there are any lessons to be learnt from the circumstances of a particular case, about the way in which local professionals and agencies worked together to safeguard the adult at risk. The SAR brings together and analyses findings from investigations carried out by individual agencies involved in the case, in order to make recommendations for improving future practice where this is necessary.

Mr C SAR

During 2016/17, HSAB has carried out one SAR. This related to Mr C who had a diagnosis of mild learning disability. As an adult, Mr. C had lived independently in supported housing in the same area for many years and was well known to both the community he lived in and the care team that supported him. Following a series of moves of placement, Mr. C's behaviour deteriorated. He stopped eating and drinking and experienced a deterioration in his physical health. Mr C's care team expressed concerns that there may be an underlying physical cause for him not eating and drinking and losing weight. He was admitted to hospital for observations and diagnostic tests and was discharged two months later as it was felt by the hospital that his condition was due to behavioural and not physical causes. After leaving hospital, Mr C went to a nursing home where he received end of life care where he died several days later.

In December 2016, HSAB commissioned a SAR to review the circumstances of Mr C's case to draw out specific learning relating to his support, care and treatment. This included compiling a chronology and completion of a case audit by the individual agencies involved. As part of the SAR process, a multi-agency reflective workshop was held with the practitioners and operational managers involved in Mr C's care and support. This event focussed on Mr C's journey through the system and enabled reflection and shared learning in order to identify opportunities for improved working within and between agencies in the future.

Thematic Review of Learning

Mr C was the third case since 2012 which involved the death of an adult with a learning disability highlighting concerns about the way deteriorating physical health needs of people with complex needs and behaviours are managed (Mr A 2012 and Ms B 2015). HSAB therefore, undertook a thematic review and analysis of common issues and root causes across the three cases. This included a full day multi-agency event to explore with partner agencies the blockages and barriers that have hindered implementation of the learning and recommendations from the previous cases.

The Thematic Review identified that there has been considerable improvement since the first of the three SARs and therefore there should be recognition of this. There is, however, still more that can be done to improve the experiences of those people with a learning disability who require admission to an acute hospital for diagnosis, care and/or treatment. People with learning disability often have a range of family, carers and health and social care professionals involved in their care. This makes coordination of that care when there is a change, especially complex for people for whom change can be particularly difficult.

Many of the issues identified in all three reviews were associated with an increase of challenging behaviours brought on by issues related to transition planning. In at least one case, that then had an impact on physical health and so the links are important considerations. There was no one agency that the Thematic Review identified requires significant improvement. Many of the elements that the Thematic Review focused on can be brought under four main areas for improvement:

- Understanding and application of the Mental Capacity Act
- Use of the Hospital passport
- Availability of the Learning Disability Liaison Nursing Service
- Continuity of the Care Programme Approach (or similar)

11. 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.

As part of its continued drive to raise standards, the Board has developed a Safeguarding Organisational Self to support organisational development and self improvement relating to adult safeguarding. The information gained from these audits is used to inform Board priorities as well as the subgroups work programmes.

In 2016/2017, the HSAB led work with the other neighbouring safeguarding adult boards to develop one combined audit tool and process. This has been rolled out this year and the first joint audit process is planned to take place in 2018.

12. Performance Summary

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. Overall there were 3,027 Safeguarding referrals in 2016/17 which is 116 (4%) more, compared to the safeguarding referrals in 2015/16 (2,911).

The increase in the number of concerns raised may be due in part to the ever increasing awareness of adult safeguarding and greater engagement amongst professionals leading to more reliable reporting of concerns.

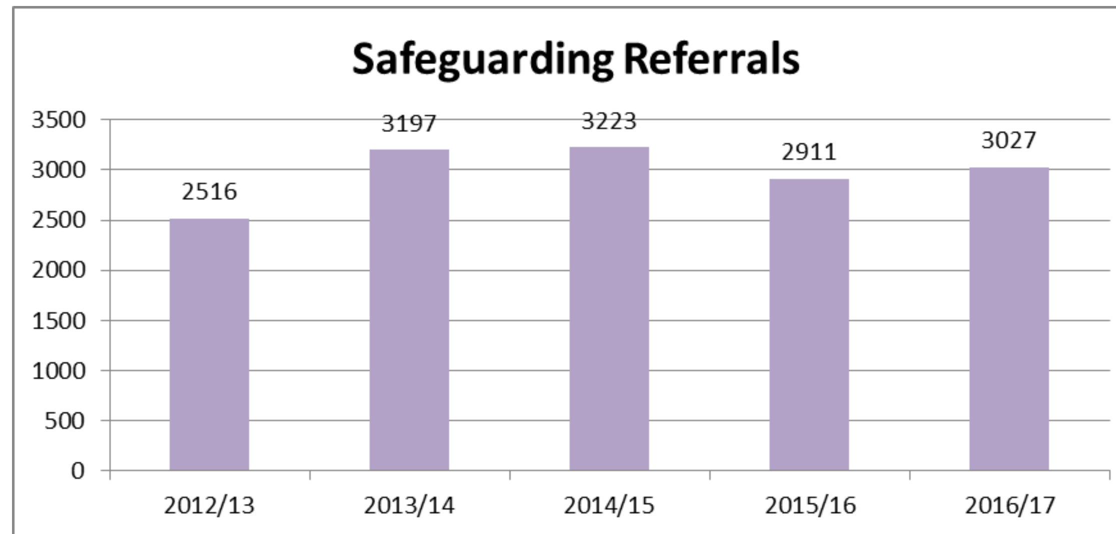
When S42 Enquiries are broken down by client categories as in previous years, S42 Enquiries relating to older people still account for the highest proportion of safeguarding at 63% (61% in 2015/16). Clients aged 65 and under with a Physical Disability where the second most referred group accounting for 7%. As in previous years, clients aged under 65 with a Learning Disability remain the second biggest cohort. In 2016/17 the number of cases relating to people with a learning disability increased from 463 to 594 representing 20% of safeguarding compared to 19% in 2015/16 (see Table 1, Appendix A).

Concerns about neglect or acts of omission as well as physical abuse remain the most common reason for safeguarding (51% and 20% respectively). Financial and material abuse has continued to reduce over the last three years and now represents 11%, compared to 14% last year.

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

Appendix A - Hampshire Safeguarding Adults Board Annual Statement - Performance and Activity

Figure 1 – Safeguarding referrals (2016/17 refers to S42 enquires)



Additional facts and figures

- Hampshire has over 1.34 million residents and 545,000 households
- Between 2014 - 2021 the population is forecast to grow by 6%

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

Table 1 - Number of referrals by client group	2012/13		2013/14		2014/15		2015/16		2016/17	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Older People 65+	1,348	54%	1,828	57%	1,890	58%	1,762	61%	1,915	63%
Learning Disability 18-64	701	28%	724	23%	570	18%	541	19%	594	20%
Mental Health 18-64	248	10%	317	10%	459	14%	290	10%	195	6%
Physical Disability 18-64	200	8%	264	8%	290	9%	239	8%	204	7%
Substance Misuse 18-64	6	<1%	37	1%	30	1%	10	<1%	4	<1%
Other/Not Known	13	<1%	27	1%	0	0%	69	2%	115	4%
Total*	**2,516**	**100%**	**3,197**	**100%**	**3,223**	**100%**	**2,911**	**100%**	**3,027**	**100%**

**A person can have more than one referral during the year*

Additional facts and figures

- The over 75s make up 10% of the population forecast to increase by 25% from 2014 – 2021
- The whole population is comparatively healthy but there are marked and increasing health inequalities
- Long term support is provided to over 20,000 adult residents. Over 6 million hours of homecare are provided
- 2,800 customers are being supported with drug and alcohol issues and over 5,500 people have been supported by the domestic abuse victim services

Table 2 – Type of abuse reported since 2011/12

Table 2 - Types of abuse reported	2012/13		2013/14		2014/15		2015/16		2016/17	
	No.	%	No.	%	No.	%	No.	%	No.	%
Physical	783	30%	851	26%	941	28%	660	22%	629	20%
Neglect or Acts of Omission	908	35%	1,278	39%	1,223	37%	1,292	43%	1,583	51%
Financial & Material	440	17%	563	17%	541	16%	433	14%	328	11%
Psychological	235	9%	327	10%	319	10%	240	8%	219	7%
Sexual	138	5%	183	5%	230	7%	160	5%	104	3%
Institutional /Organisational	81	3%	55	2%	42	1%	25	1%	7	0%
Discriminatory	20	1%	26	1%	15	<1%	10	<1%	2	0%
Domestic Violence /Abuse	Not recorded in these years						116	4%	60	2%
Victim of Hate Crime							3	<1%		
Sexual Exploitation							3	<1%		
Modern Slavery							0	<1%	2	0%
Self Neglect							96	3%	141	5%
Total*	**2,605**	**100%**	**3,283**	**100%**	**3,311**	**100%**	**3,038**	**100%**	**3,075**	100%

*more than one abuse type per referral can be recorded

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

Table 3 - Location of abuse	2012/13		2013/14		2014/15		2015/16		2016/17	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Own Home	839	33%	1340	42%	1489	46%	1267	44%	1492	49%
Residential Care	856	34%	806	25%	677	21%	481	17%	417	14%
Nursing Care	308	12%	423	13%	509	16%	398	14%	568	19%
Mental Health Inpatient Setting	48	2%	63	2%	79	2%	37	1%	32	1%
Alleged Perpetrators Home	68	3%	75	2%	55	2%	40	1%	22	1%
Acute Hospital	66	3%	118	4%	121	4%	61	2%	40	1%
Public Place	57	2%	90	3%	83	3%	53	2%	56	2%
Community Hospital	38	2%	27	1%	15	1%	59	2%	77	3%
Day Centre/Service	48	2%	21	1%	48	1%	11	<1%	25	1%
Other Health Setting	17	1%	16	<1%	14	0%	5	<1%	16	1%
Education/Training/Workplace Establishment	9	<1%	17	<1%	3	0%	5	<1%	3	<1%
Supported Accommodation	56	2%	38	1%	72	2%	63	2%	29	1%
Other/Not Known	106	4%	163	5%	58	2%	431	15%	250	8%
Grand Total*	**2516**	**100%**	**3197**	**100%**	**3223**	**100%**	**2911**	**100%**	**3,027**	**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.

Description	2014/15	2015/16	2016/17	England 2015/16
Proportion of people who use services who have control over their daily life	80%	80%	79%	77%
Proportion of people who use services who feel safe	74%	76%	70%	69%
Proportion of people who use services who say that those services have made them feel safe and secure	90%	91%	90%	85%

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.

Appendix B Glossary of Terms

This section explains the meaning of terms commonly used in the context of adult safeguarding:

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

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

Advocacy: support to help people say what they want, secure their rights, represent their interests and obtain services they need. Under the Care Act, the Local Authority must arrange for an independent advocate to represent and support a person who is the subject of a safeguarding enquiry or a safeguarding adult review if they need help to understand and take part in the enquiry or review and to express their views, wishes, or feelings.

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

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

Assessment: a process to identify the needs of the person and how these impact on the wellbeing and outcomes that they wish to achieve in their day to day life.

Best interests decision: a decision made in the best interests of an individual defined by the Act) when they have been assessed as lacking the mental capacity to make a particular decision. The best interest decision must take into consideration anything relevant such the past or present wishes of the person, a lasting power of attorney or advance directive. There is also a duty to consult with relevant people who know the person such as a family member, friend, GP or advocate.

Care Act 2014: came into force in April 2015 and significantly reforms the law relating to care and support for adults and carers. This legislation also introduces a number of provisions about safeguarding adults at risk from abuse or neglect. Clauses 42-45 of the Care Act provide the statutory framework for protecting adults from abuse and neglect.

Care and support needs: the support a person needs to achieve key outcomes in their daily life as relating to well being, quality of life and safety. The Care Act introduces a national eligibility threshold for adults with care and support needs which consists of three criteria, all of which must be met for a person’s needs to be eligible.

Carer: unpaid carers such as relatives or friends of the adult. Paid workers, including personal assistants, whose job title may be ‘carer’, are called ‘staff’.

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

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

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

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

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

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

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

Duty of Candour: a requirement on all health and adult social care providers registered with the Care Quality Commission (CQC) to be open with people when things go wrong. The duty of candour means that providers have to act in an open and transparent way in relation to service user care and treatment.

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

Harm: involves Ill treatment (including sexual abuse and forms of ill treatment which are not physical), the impairment of, or an avoidable deterioration in, physical or mental health and/or the impairment of physical, intellectual, emotional, social or behavioural development.

Hate Crime: any crime that is perceived by the victim, or any other person, to be racist, homophobic, transphobic or due to a person's religion, belief, gender identity or disability.

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

Human Trafficking: the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation".

Independent Mental Capacity Advocate (IMCA): established by the Mental Capacity Act 2005, IMCAs are a legal safeguard for people who lack the capacity to make specific important decisions, including decisions about where they live and serious medical treatment options. IMCAs are mainly instructed to represent people where there is no one independent of services (such as a family member or friend) who is able to represent the person. However, in the case of safeguarding concerns, IMCAs can be appointed anyway (i.e. irrespective of whether there are friends or family around and irrespective of whether accommodation or serious medical treatment is an issue).

Local Safeguarding Adults Board (LSAB): a statutory, multi-organisation partnership committee, coordinated by the Local Authority, which gives strategic leadership for adult safeguarding, across the Local Authority. A SAB has the remit of agreeing objectives, setting priorities and coordinating the strategic development of adult safeguarding across its area.

Making Safeguarding Personal (MSP): an approach to safeguarding work which 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.

Mental Capacity refers to whether someone has the mental capacity to make a decision or not on a specific issue.

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

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

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

Mate Crime: a form of exploitation which occurs when a person is harmed or taken advantage of by someone they thought was their friend.

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

No Delay: the principle that safeguarding responses are made in a timely fashion commensurate with the level of presenting risk. In practice, this means that timescales act as a guide in recognition that these may need to be shorter or longer depending on a range of factors such as risk level or to work in a way that is consistent with the needs and wishes of the adult.

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

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

Office of the Public Guardian (OPG): the administrative arm of the Court of Protection and supports the Public Guardian in registering enduring powers of attorney, lasting powers of attorney and supervising Court of Protection appointed deputies.

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

Prevention: describes how the care and support system (and the organisations forming part of this system) work to actively promote the well being and independence of people rather than waiting to respond when people reach a crisis point. The purpose of this approach is to prevent, reduce or delay needs escalating.

Protection of property: the duty on the Local Authority to protect the moveable property of a person with care and support needs who is being cared for away from home in a hospital or in accommodation such as a care home, and who cannot arrange to protect their property themselves. This could include their pets as well as their personal property (e.g. private possessions and furniture).

Radicalisation: involves the exploitation of susceptible people who are drawn into violent extremism by radicalisers often using a persuasive rationale and charismatic individuals to attract people to their cause. The aim is to attract people to their reasoning, inspire new recruits and embed their extreme views and persuade vulnerable individuals of the legitimacy of their cause. The PREVENT Strategy, launched in 2007, seeks to stop people becoming terrorists or supporting terrorism.

Referral: an alert becomes a referral once it has been assessed and it has been determined that the concerns raised fall within the remit of adult safeguarding arrangements.

Safeguarding: activity to protect a person's right to live in safety, free from abuse and neglect. It involves people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that their well being and safety is promoted.

Safeguarding activity: actions undertaken upon receipt of a safeguarding referral. This may include information gathering, holding a safeguarding planning meeting, activities to resolve the risks highlighted, safeguarding review meetings and developing a safeguarding plan with the adult at risk.

Safeguarding support plan: one outcome of the enquiry may be the formulation of agreed actions for the adult which should be recorded on their care plan. This will be the responsibility of the relevant agencies to implement.

Safeguarding planning meeting: a multi-agency meeting (or discussion) involving professionals and the adult if they choose, to agree how best to deal with the situation as determined by the views and wishes of the individual.

Safeguarding work: describes all the work multi-agency partners undertake either on a single agency basis (as part of their core business) or on a multi agency basis within the context of local adult safeguarding arrangements.

Safeguarding Adult Review (SAR): a statutory review commissioned by the Safeguarding Adults Board in response to the death or serious injury of an adult with needs of care and support (regardless of whether or not the person was in receipt of services) and it is believed abuse or neglect was a factor. The process aims to identify learning in order to improve future practice and partnership working.

Safeguarding enquiry: the action taken or instigated by the Local Authority in response to a concern that abuse or neglect may be taking place. An enquiry could range from a conversation with the adult, or if they lack capacity, or have substantial difficulty in understanding the enquiry their representative or advocate, prior to initiating a formal enquiry under section 42 of the Care Act 2014, right through to a much more formal multi-agency plan or course of action. This is sometimes referred to as a section 42 enquiry'.

Self neglect: the inability (intentional or non-intentional) to maintain a socially and culturally accepted standard of self-care with the potential for serious consequences to the health and well being of the self-neglecters and perhaps even to their community.

Serious Incident Requiring Investigation (SIRI): a process used in the NHS to investigate serious incidents resulting in serious harm or unexpected or avoidable death of one or more patients, staff, visitors or members of the public.

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

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

Wilful neglect or ill treatment: an intentional, deliberate or reckless omission or failure to carry out an act of care by someone who has care. Abuse includes physical, sexual, emotional, psychological, financial, material, neglect, acts of omission, discriminatory and institutional abuse.