Hampshire safeguarding Adults Board

Annual Report 2019/20

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Hampshire Safeguarding Adults Board Annual Report 2019/20

Foreword

I am pleased to be able to introduce the Hampshire Safeguarding Adults Board's Annual Report for 2019/20.

Our purpose as a Safeguarding Adults Board (SAB) is to provide strategic leadership to ensure that adults who are at risk of abuse or neglect are effectively safeguarded.

The role of the Chair and the Board is to support and challenge SAB partners and agencies in Hampshire to work collaboratively for the benefit of adults with care and support needs and to bring about continuous improvement in local safeguarding arrangements so that these deliver positive outcomes for people being supported.

The Board has agreed a different approach regarding chairing arrangements. I will continue to chair the Board going forward. However, we have invested in the appointment of an Independent Scrutineer to work alongside the Board and our member organisations to provide critical challenge and support.

The Covid-19 pandemic developed rapidly and has affected us all. I want to thank all our partners for the work they are doing to keep adults with care and support needs safe during this critical time.

Our goal has been to maintain 'business as usual' and ensure effective partnership working as far as possible but with a focus on working differently and flexibly in order to take account of the need to protect the wellbeing of staff and partners.

HSAB has continued to offer the same level of safeguarding oversight whilst recognising the increased operational pressures partner agencies have been responding to.

Going forward, our focus will be to continue our work to prevent and reduce the risk of harm to people with care and support needs. A key priority for the Board will be to gain assurance from partner agencies about how any impact of COVID on local safeguarding arrangements is being managed.

Despite the unprecedented challenge COVID has presented, I am pleased to see significant progress against the priorities set out in our Strategic Plan 2016-21. I would like to acknowledge the hard work and commitment shown by all our partner agencies in achieving these aims.

There has been a continued focus on joint working across the wider strategic partnership including with our neighbouring local SABs and the Hampshire Safeguarding Children Partnerships enabling us to align priorities and coordinate work programmes. This collaboration will continue as we move forward.

Graham Allen
Director of Adults Health and Care

Chair, Hampshire
Safeguarding Adults Board

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 work effectively individually and together, to support and safeguard adults with care and support needs 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.

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 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.

Our membership

The HSAB is made up of wide range of statutory, non-statutory, community and voluntary organisations which includes representatives from Hampshire County Council, Police, Clinical Commissioning Groups, NHS providers, Criminal Justice, Emergency Services, District and Borough Councils, Independent Care Providers, Housing, Advocacy, Service users and Carers, etc.

The Board has a chair who 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 Board also has an Independent Scrutineer whose remit is to provide objective scrutiny and critical challenge to the HSAB to ensure we fulfil our core statutory responsibilities and achieve our published strategic priorities.

Our Aims

Board aims

The HSAB aims to promote awareness and understanding of abuse and neglect among service users, carers, professionals, care providers and the wider community and works to generate community interest and engagement in safeguarding to ensure "Safeguarding is Everyone's Business".

Strategic aims

This Strategic Plan highlights the HSAB's strategic priorities and objectives over the next five years.

Annual business plan

This responds to the key priorities outlined in the Strategic Plan and explains the work the HSAB and its partner organisations will be undertaking to ensure these priorities are realised.

Annual report

The Safeguarding Strategy is reviewed and reported on every year via the publication of an Annual Report. This is the key mechanism by which the Safeguarding Adults Board is held to account for the work it carries out. The HSAB Annual Report is shared with the chief executive and leader of the local authority, Police and Crime Commissioner and the Health and Wellbeing Board for the area.

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

Personalised support is for everyone, but some people will need more support than others

All staff and volunteers have a key role in preventing abuse or neglect occurring and in taking prompt action when concerns arise

HSAB
Hampshire Safeguarding Adults Board

All organisations and local communities have a responsibility to ensure that they foster a culture which takes all concerns seriously

The person at risk is at the centre of any safeguarding process, and must stay as much in control of decision making as possible

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

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

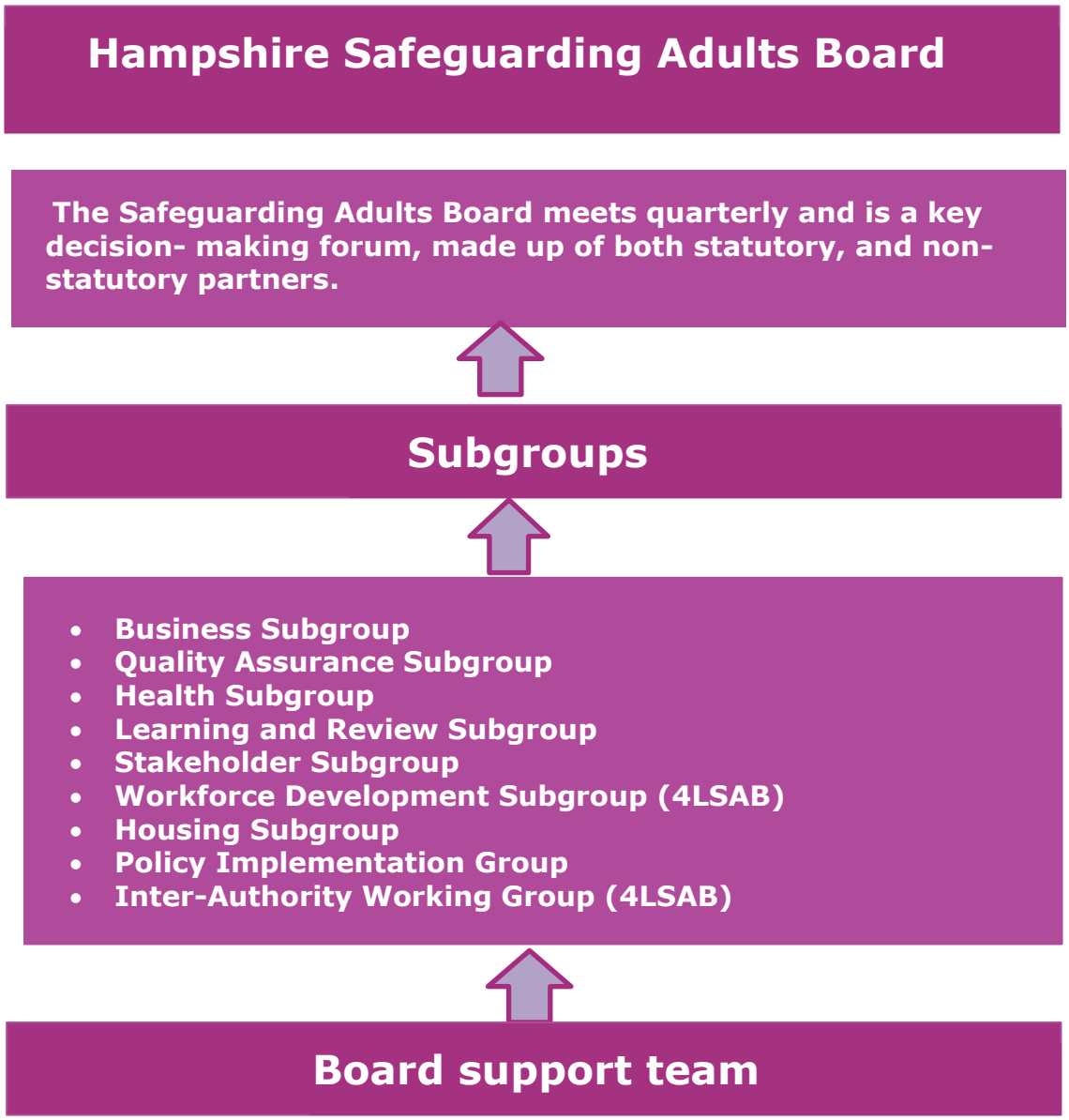
When abuse does take place, it must be identified early and dealt with swiftly and effectively, and in ways that are the least intrusive and most proportionate

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 in order to prevent a similar event in the future

Board Structure

The structure of the Hampshire Safeguarding Adults Board



Our HSAB Subgroups

HSAB is supported to achieve its goals and objectives through the work of our subgroups. These operate to agreed terms of and reference and work plan. Short term task and finish groups may also be set up with the purpose of developing and/or implementing projects linked to our strategic priorities.

HSAB Business Subgroup

The Business Subgroup sets the agenda of Board meetings and monitors the implementation of the Board's work programme ensuring this reflect HSAB business plan objectives and priorities.

HSAB Health Subgroup

The Health Subgroup brings together health representatives from local Health services (CCGs and all NHS Provider Health Trusts, Primary Care, Independent Hospitals and agencies), to develop a consistent response to HSAB strategic priorities across the Health sector.

HSAB Housing Subgroup

The overarching purpose of the Housing Subgroup is to safeguard and promote the welfare of vulnerable adults and to gain assurance that safeguarding arrangements are effective across the housing sector.

HSAB Learning and Review Subgroup

The Learning and Review Subgroup has the remit of commissioning safeguarding adult reviews and other multi-agency learning review activities in cases where there have been poor outcomes for service users to ensure that lessons are learned to improve partnership working.

HSAB Quality Assurance Subgroup

The Quality Assurance Subgroup has the remit of implementing the 4LSAB Quality Assurance Framework in order to provide a strategic overview of the quality of safeguarding work across the four-Board area using a range of tools.

HSAB Stakeholder Subgroup

To promote awareness of safeguarding adults and to involve all key stakeholders in developing a strategy to promote the awareness of and prevention of abuse or neglect of adults at risk.

Our Joint Groups

We run some of our subgroups jointly with the other neighbouring local Safeguarding Adults Boards in Hampshire, Isle of Wight, Portsmouth and Southampton enabling us to work collaboratively to address common priorities and objectives. These groups are termed '4LSAB' to denote the cross boundary working that occurs.

4LSAB Workforce Development Group

The role of the 4LSAB Workforce Development Group is to develop and implement guidance and standards to inform individual agency adult safeguarding training programmes. The Framework provides guidance about the level and nature of training required to ensure all staff groups have the right level of training to enable them to fulfil their safeguarding responsibilities. The Workforce Group also makes recommendations about how learning gained from reviews of serious cases should be addressed within local training plans.

4LSAB Policy Group

The 4LSAB Policy Group has the lead, coordinating role for developing multi-agency adult safeguarding policies and guidance across the 4 LSAB area. This group will also identify and develop any new policy and guidance required in response to changes in existing or new legislation, national guidance and learning arising from reviews of serious cases.

4LSAB – Fire Safety Development Group

The role of the 4LSAB Fire Safety Group is to coordinate work across the 4lSAB area aimed at ensuring fire safety and risk management is embedded into the day to day work of partner agencies. The Group also maintains oversight of fire incidents and deaths involving adults with care and/or support needs

Board Governance

The Hampshire Safeguarding Adults board reports to key decision-makers from the Local Authority, Hampshire Constabulary and the Local Clinical Commissioning Groups.

Given current demands and challenges facing all services, we continue to seek every opportunity to align priorities, objectives and coordination across Hampshire's wider strategic partnership.

Significant progress has been achieved in undertaking joint work with our neighbouring local safeguarding adult boards as well as the Hampshire Safeguarding Children Partnership.

The Board has established and maintains effective links with the following Strategic Boards and Partnerships:

- Hampshire Safeguarding Children Partnership
- Portsmouth, Southampton, IOW Local Safeguarding Adults Boards
- Hampshire Prevent Partnership Board
- Hampshire Modern Day Slavery Partnership
- Hampshire Domestic Abuse Partnership
- Hampshire County Strategy Group
- Hampshire Health and Wellbeing Board

The Board also maintains links with national and local adult safeguarding forums including:

- ADASS Safeguarding Network
- South East Regional Board Chair and Manager Network
- National Network of Chairs of Safeguarding Adults Boards

Board Membership

The Board consists of the following membership:

Chair
Chair
Independent Scrutineer

Support to the HSAB
Strategic Safeguarding Partnership Manager
Business Manager
Business Support Officer

Core Statutory Board Members
Hampshire County Council Adults Health and Care
Hampshire Constabulary
Clinical Commissioning Groups

Associate Members
Department of Work and Pensions
District and Borough Councils
Hampshire Care Association
Hampshire Fire and Rescue Service
Hampshire and Isle of Wight Community Rehabilitation Company
Hampshire County Council Children's Services Department
HMP Winchester
NHS England
NHS Acute Hospital Trusts
Solent NHS Community Trust
South Coast Ambulance NHS Foundation Trust
Southern Health NHS Foundation Trust
National Probation Service (South Central)
Trading Standards

Advisory
Advocacy
Care Quality Commission
Executive Member, Hampshire County Council
Hampshire Local Children's Safeguarding Partnership
Hampshire Prevent Partnership Board
Hampshire Domestic Abuse Partnership
HealthWatch Hampshire
Personalisation Expert Panel
Princess Royal Trust for Carers
Voluntary Sector (Community Action Hampshire)
Subgroup Chairs

Priority	What we said we'd do	What we've done	Focus for 2020/21
Wide awareness of adult abuse and neglect and its impact and engaging local communities	Develop material promoting wider awareness of adult abuse and neglect and the work of the HSAB across a number of platforms Undertake themed campaigns relating to specific social issues which directly or indirectly, increase a person's vulnerability to abuse or exploitation. Develop links with user forums including the Personalisation Expert Panel.	Social media strategy implemented with a Facebook page and YouTube channel set up which combined with the HSAB Twitter Account, aims to increase visibility of adult safeguarding and the work of the HSAB to a wider audience. Launch of the Animated Scribe resource. Very positive feedback received and used by LSABs in other areas of the country. To date, the resource has had approx. 2000 views on our website. Themed campaigns have been conducted relating to self-neglect, Loneliness and Social Isolation. Homelessness has identified as key campaign theme for 2020/21. National guidance on Homelessness and adult safeguarding has been adopted locally and included in the 4LSAB safeguarding policy. A member of PEP now attends the HSAB and formal links have been established between the Stakeholder Group and PEP.	Review and refresh/update of the See It Stop IT HSAB Safeguarding App. Conduct a campaign highlighting Homelessness and safeguarding. Include to loneliness and social isolation as a theme in the HSAB training programme for this year. Conduct a Stakeholder Survey and stakeholder events across the county to inform the refresh of the Strategic Plan in 2021.

Priority	What we said we'd do	What we've done	Focus for 2020/21
Prevention and early intervention – promoting well-being and safety and acting before harm occurs	Activities and resources promoting public awareness about prevention of abuse/ exploitation and keeping safe. A campaign on the use of the LPAs to safeguard against abuse and neglect. Raise awareness and embed the use of the Multi-Agency Risk Management Framework.	A multi-agency Fraud and Cybercrime working group has been set up to develop a joint approach and messages about how to protect oneself from fraud and cybercrime. Implementation of an on-line Let's Plan Ahead initiative on the HSAB website. This aims to raise public awareness of lasting powers of attorney and the benefit of these in order to increase the uptake. Managing risk and the Multi Agency Risk Management Framework forms part of the joint Family Protocol and Toolkit. A programme of workshops has been delivered both face to face and by webinar. Multi Agency Risk Management Framework was been updated in 2020. HSAB Guidance on Prevention and Early Intervention was updated in 2020.	Set up a multi-agency/cross sector homelessness and safeguarding working group to respond to learning arising from the national and local learning. Set up a multi-agency/cross sector Safeguarding in Transition working group to develop a joint protocol aimed at identifying and responding to the needs of young people who may be at risk when they reach adulthood but who may not meet care and support eligibility criteria. Promote awareness within mental health/substance misuse/ homelessness services of the toxic trio of capacity/unwise decision-making/ disengagement and develop a joint protocol to enable practitioners working with these groups to provide effective safeguarding responses. Develop/embed the use of MARM in key sectors e.g. transition, homelessness, substance misuse, mental health, high intensity users (ambulance, acute hospital care) and hospital discharge. Joint work with the FE/HE sectors to address student mental health.

Priority	What we said we'd do	What we've done	Focus for 2020/21
Competent, well-equipped workforce across all sectors	Review and update the 4LSAB Safeguarding Adults Policy, Guidance and Toolkit Produce and publish 4LSAB Guidance on Information Sharing Produce and publish 4LSAB Safeguarding Concerns Guidance Review and updating of the Professionals area of the HSAB website Joint Learning into Practice events to share learning from the Thematic Review of SARs re learning disability and physical health.	The new 4LSAB Multi-Agency Safeguarding Adults Policy, Guidance and Toolkit has been published as a web-based resource hosted on the HSAB website. Virtual briefing sessions will be held from Sept 2020 onwards. New 4LSAB guidance documents on Information Sharing has been published. 4LSAB Safeguarding Concerns reflecting the new national guidance has been produced and will be launched in Sept 2020. The Professionals section on the HSAB website has been comprehensively reviewed and updated. Learning from SARs is now included in the terms of reference and work programme of the 4LSAB Workforce Group.	Launch the 4LSAB Multi-Agency Safeguarding Adults Policy, Guidance and Toolkit in Sept 2020. Implement the ADASS/LGA Safeguarding Concerns Guidance once published. A virtual training programme linked to HSAB priorities – 4LSAB Multi-Agency Safeguarding Policy, Concerns Guidance, MARM (targeted at specific sectors), Family Approach, Homelessness, Hoarding. Update the 4LSAB Learning and Development Strategy Policy Group to develop new 4LSAB guidance on, Safeguarding in Transition, Homelessness, Large Scale Enquiries. Workforce Development Group to establish a mechanism for collating learning from local and national SARs ensuring this is shared with partner agency workforce development leads. HSAB to include thematic learning into practice events as part of its training offer to enable key learning to be cascaded across the 4 LSAB area.

Priority	What we said we'd do	What we've done	Focus for 2020/21
Safeguarding services improved and shaped by the views of service users, carers and stakeholders	Hold a Board development session on Mental Capacity in March 2020. Joint 4LSAB work on the Making Safeguarding Personal agenda. Include in the Board's core training programme. Seek the views of service users, carers and stakeholders and use the information gained to improve safeguarding arrangements.	The planned Mental Capacity development session had to postponed due to COVID 19 social distancing measures. This will be re-arranged for March 2021. Mental Capacity and Making Safeguarding Personal are included in the HSAB Safeguarding Self Audit Tool carried on a biennial basis. Making Safeguarding Personal forms part of the core HSAB training programme.	Mental Capacity Act Board Development day on MCA – early 2021. Continued joint 4LSAB work on the Making Safeguarding Personal agenda. Conduct a Stakeholder Survey and hold stakeholder events across different locations across Hampshire to gain feedback and views to inform the refresh of the Strategic Plan.

Priority	What we said we'd do	What we've done	Focus for 2020/21
Assurance that clear, effective governance processes are in place within and across organisations	Develop a 4LSAB Integrated Scorecard for adult safeguarding. Develop a multi-agency themed audit programme linked to learning from serious cases. Develop and implement a local peer review programme. Gain assurance from Board partners about the steps being taken within their respective organisations to develop and improve MCA practice.	A 4LSAB Integrated Scorecard has been produced. This will be further reviewed to ensure it captures the information highlighted in the HSAB COVID Assurance Framework. The 4LSAB Quality Assurance Group has been stood down so it will be necessary to re-establish the HSAB Quality Assurance Group. A key task will be to review our Quality Assurance Framework. The next Safeguarding Self Audit is due in 2021 and this will be programmed. However, given COVID it may be necessary to defer this. The development of a local peer review programme will involve collaboration with our neighbouring LSAB's and this can be progressed via the 4LSAB leadership forum over the coming year.	Implement the HSAB COVID Assurance Framework to understand the impact of COVID on service users and use information gained to increase future resilience and support the recovery phase. Re-establish the HSAB Quality Assurance Subgroup and review and update the HSAB Quality Assurance Framework. Implement the integrated Scorecard Partners to provide assurance to the Board of their progress against the MCA 6 step plan introduced in 2017/18 to address learning from our thematic review of 3 HSAB SARs. This highlighted a lack of understanding/application of MCA provisions which significantly contributed to the poor outcomes experienced by the service users involved. Introduce a 'lean' multi-agency audit programme linked to learning from serious cases.

Priority	What we said we'd do	What we've done	Focus for 2018/19
Learning from experience - mechanisms to gain learning from critical events and serious cases and promote service and practice improvement.	Partner organisational leads to review training to ensure learning from serious cases is addressed on staff training and development activities. Develop a memorandum of understanding to ensure effective communication and joint responses to critical events. Joint work with HFRS to address findings from the fire death analysis including publication of hoarding guidance. HSAB to gain assurance from partners about their response to the Gosport War Memorial Inquiry. Establish a 4LSAB Learning from Deaths Forum to enable the SAB's to gain assurance from partners about the response to critical events and inquiries. This will include Gosport WMH, Mazars, LeDeR and local SARs.	The COVID pandemic has had a significant impact in Hampshire as in all other areas of the country. . The Board has a vital role in gaining assurance that both service users and the wider public are safeguarded during this unprecedented period. The SAR Policy and Guidance has been updated. Our subgroups will incorporate key elements of the Framework within their respective work programmes. Fire Safety Group is up and running and it will review fire deaths and near misses involving people thought to have had care and support needs. A clear protocol exists for referring cases which may meet SAR criteria. Links have been established with the LeDeR programme - the learning and review subgroup receives regular updates on trends and themes which can be cross referenced with learning from SARs.	Implement the HSAB COVID Assurance Framework to ensure the Board is sighted on and able to respond to, the impact of COVID on local safeguarding arrangements. To include regular partner led discussion and input at Board meetings. Workforce Group to establish a mechanism for collating learning from local and national SARs ensuring this is shared with partner agency workforce development leads. HSAB to include 'learning into practice' events as part of its training offer to enable key learning to be cascaded across the 4 LSAB area. Trial the SCIE Rapid Time SAR Review process which enables reviews to be conducted within 15 days. Joint 4LSAB annual learning event covering lessons from local and national SARs, DHR's, LeDeR, SCRs, etc.

Learning and Development

A key focus of the HSAB is to promote multi-agency training and to respond to any specialist training that may be required. Where possible, we jointly commission training with other partnerships such as the Hampshire Safeguarding Children Partnership and our neighbouring Local Safeguarding Adults Boards.

HSAB Training Programme

This last year the HSAB has continued to run a multi-agency training programme of which the content is linked to our strategic priorities. These training events continue to be very popular with all multi-agency partners and has involved nearly 700 professionals representing a wide cross section of agencies and sectors. Over the past year, 16 half day training workshops have been held on the following topics:

Topic	Delegates
SAL Network Annual Event	88
Safeguarding Awareness x 2	36
Section 42 Enquiries x 2	42
Self-Neglect x 1	72
Making Safeguarding Personal x 2	41
Multi-Agency Risk Management Framework x 2	76
Family Approach Protocol x 3	213
Financial Abuse x 1	108
Total	**676**

A sample of the feedback received is provided on page 20.

Safeguarding Adult Lead Network (SAL)

The Board continues to maintain the Safeguarding Adult Leads Network (SAL) which was established in 2015 as part of its on-going drive to support the development of best practice in adult safeguarding work. This is a network of 'champions' who take the lead for adult safeguarding in their organisation. The Network has grown significantly during this period and we now have over 140 members who represent a wide range of organisations including district and borough councils, housing, independent care providers, community/voluntary sector and statutory agencies. The Network serves as a 'community of practice' enabling members to access regular updates

on local and national developments in adult safeguarding. This year, the HSAB held its annual SAL event which was well attended.

Training and development activity during COVID

Due to the restrictions arising from the COVID 19 pandemic, HSAB has been unable to implement a training programme in the first two quarters of 2020. However, a virtual training strategy will be developed to enable us to resume our training offer October 2020 onwards. This will focus on the roll out of the new 4LSAB Safeguarding Adults Policy (2020) and the 4LSAB Safeguarding Concerns Guidance (2020) as well as well other topics linked to HSAB priorities including, Family Approach, Making Safeguarding Personal, Multi-Agency Risk Management Framework and Financial Abuse, Fraud and Scams.

Joint HSAB and HSCP Conference

HSAB and the HSCP have established an annual joint conference with two conferences held so far. These have covered a range of topics of mutual interest including transition, mental capacity, domestic abuse and the Family Approach and are open to professionals from all partner agencies across the 4 LSAB/4LSCP area. Due restrictions arising from COVID 19, it was not possible to hold the joint conference in 2020. The conferences have proved very popular and are well received.

Animated Scribe

In October 2019, we launched our 'Animated Scribe' resource aimed at raising public awareness about adult safeguarding. To date, the Animated Scribe has had approx. 2000 views on our website. We have had very positive feedback about the resource and how key messages and information are presented in a very engaging and accessible way. We have been contacted by LSABs in other areas of the country requesting permission to use this. Click this link to view the video **https://youtu.be/whatisadultsafeguarding?**

HSAB Training Programme – Feedback

Our Learning

COVID 19 - What did we learn?

Safeguarding during COVID 19

During COVID 19, our goal has been to maintain 'business as usual' and to ensure effective partnership working as far as possible but with a focus on working differently and flexibly in order to take account of the need to protect the wellbeing of staff and partners. Our business continuity plan involved making a number of to our adjustments to our working arrangements to maintain progress including:

- Publication of the HSAB 2020/21 Training Calendar was deferred during which time we have bene developing a strategy to deliver training on a virtual basis. We anticipate that the training programme will resume in late September/early October.

- Planned learning and review events were deferred while we worked out appropriate alternative arrangements. SAR reports and learning summaries however, have continued to be shared.

- HSAB working groups have been convened as conference calls/dial-in with call details provided when the agenda and papers are circulated.

- HSAB main board meetings have been held on a virtual basis but these have been shorter and with a clear business focus.

Duties and responsibilities to safeguarding adults remains a statutory duty and Sections 42-45 of the Care Act 2014 that relate to safeguarding adults have not changed or been 'eased'. Consequently, safeguarding adults continues to be the responsibility of local authorities and partner agencies – to keep everybody safe from abuse or neglect, with a clear role in avoiding any breach of human rights.

The Care Act Easements guidance 2020 clarifies that it is vital that local authorities continue to offer the same oversight and application of Care Act2014 Section 42 duties as before, but that responses are proportionate, and are mindful of pressures on social care providers.

It is important that HSAB and our partner organisations closely monitor safeguarding activity and use this intelligence to support flexible partnership responses to meet needs. HSAB will be reviewing data to understand safeguarding trends locally and re-prioritise our strategic plan accordingly in order to support services to respond to any changes in the nature and pattern of local safeguarding activity.

HSAB has continued to offer the same level of safeguarding oversight whilst recognising the increased operational pressures partner agencies have been responding to. Going forward, our focus will be to continue our work to prevent and reduce the risk of harm to people with care and support needs.

A key priority for the Board will be to gain assurance from partner agencies about how any impact of COVID on local safeguarding arrangements is being managed HSAB has introduced a COVID 19 Assurance Framework which will enable us to closely monitor the extent to which and how, generally COVID 19 is impacting on people with needs of care and support and specifically, on the effectiveness of local safeguarding arrangements.

Impact of COVID 19

Safeguarding adults with care and support needs has therefore, remained an important part of everyday work of our partner organisations during the pandemic. The Board recognises the concern that during this time, people may be more vulnerable to abuse or neglect. This may be a result of increased social isolation, stress on carers and caring relationships, reduced face to face contact with service users, an increase in criminal behaviour (fraud and scams specifically) and an increase in domestic abuse.

HSAB Assurance - key areas of focus

As part of its assurance role, the Board will be actively monitoring the volume of safeguarding concerns raised in order to identify emerging patterns and trends in the nature of these. Board subgroups will be focusing their activities around key vulnerability factors and emerging national and local themes including:

- Isolation both for people living in care homes and in their own homes which can increase the risk of abuse happening and reduce the likelihood it will be reported and dealt with. Being detached from the outside world and from family and friends, as well as being away from the places we usually visit can be very unsettling. The HSAB Stakeholder Subgroup identified Loneliness and Social Isolation as a campaign theme in order to raise awareness of the issue and the support available.

- Some support services, such as day services or lunch clubs, will have closed to protect people from transmission of the virus and also to focus resources where they are most needed. These service disruptions may be unsettling and confusing due to changes in routine and to be more socially isolated with fewer daily contacts.

- Additional pressures on carers or family members as supports such as day services, respite services and lunch clubs are closed. Carers and family members may find themselves having to spend longer periods providing support without adequate breaks and assistance. This can cause stress and tensions that put additional strain on the caring relationship.

- In terms of domestic abuse, in quarter 1 of 2020 (Jan- Mar) we saw a 15% increase in domestic abuse incidents reported to the police compared to the same period in 2019. However, whilst the volume was higher the increase related to lower risk cases with higher risk cases slightly decreasing during this period.

- In terms of criminal activity, the pandemic has been seen as an opportunity by some criminals to exploit vulnerable people. Financial scams have increased and there has been a noted increase in scams relating to the pandemic. In response, HSAB has established a multi-agency working group bringing together professionals from a wide of agencies to develop joint guidance about protecting oneself from fraud, cybercrime and scams.

- Safeguarding activity during the COVID, the front door resolution rate has remained stable, so overall processing seems to be the same. There was a slight increase in PPN1's in April compared to April last year. There has been a substantial increase in missing persons over 18. Physical abuse continues to be the highest reported category by Police. The higher conversion rate suggests that referrals may be more relevant than previously. The reduction in referrals and formal "concerns" may reflect the reduction in home visits by a number of partner agencies. Despite an increased risk of domestic abuse referrals have remained static at approx. 3% of all safeguarding cases. Resource in AHC MASH has been kept under review and increased as demand picked up

- In residential care, approximately 40% of Hampshire care homes have been touched by COVID with a significant increase in fatalities observed in these settings during this period. Monitoring shows that at the peak of COVID (10–24 April) Covid19 cases accounting for up to 40% of the deaths. However, during May the reported number of deaths have reduced to levels usually expected. Overall, comparative analysis with other local authority areas shows 4.5 people per 1,000 care home beds have died with Covid-19 as the cause.

- Nationally, there has been a significant increase in deaths involving adults with a learning disability. From 10 April to 15 May, the Care Quality Commission received notifications of the deaths of 386 people Figures also show that people with learning disabilities were dying from Covid-19 at a much younger age than the wider population. While 89% of people to have died from suspected Covid-19 up to May 22 this year were aged 65 or over, deaths from the disease were highest among people with learning disabilities aged 55-64, who accounted for a third of COVID deaths in the CQC figures.

- Further work around COVID related deaths will be undertaken locally by partner organisations to understand the progression of COVID across all our care settings. Regarding learning disability specifically, HSAB has incorporated the LeDeR programme into the agenda of our Learning and Review Subgroup in order to maintain clear oversight of deaths relating to adults with a learning disability.

- Independent advocacy is still available for people who are using health and care services and want support in either making choices, speaking up or raising concerns about things that are (or are not) happening. None of the Care Act easements introduced within the Coronavirus Act reduced or removed the right to an advocate and everyone who was entitled to receive advocacy before Covid-19 is still entitled to access this same support. In fact, more people are likely to be eligible for independent advocacy as access to natural networks of allies and supporters are restricted during lockdown. Independent advocates are classed as key workers and, as such, advocacy services are still operating in all of the usual settings where people receive support from health and care services. Along with so many other frontline workers, advocates are thinking creatively about how to provide effective remote support as they observe social distancing. Use is increasingly being made of online platforms including Zoom, Microsoft Teams, Skype and WhatsApp to connect with people electronically.

Our Learning

Policy and Guidance - what did we learn?

The importance of an effective and coordinated approach across the 4LSAB area for developing adult safeguarding policies and strategies in order to achieve a high level of consistency across the area and to reduce unnecessary duplication. The four Safeguarding Adults Boards have jointly reviewed and updated the Multi-Agency Safeguarding Adults Policy, Guidance and Toolkit. This involved collaboration and consultation with all relevant agencies and was informed by the views of adults who have needs for care and support, their families, advocates and carer representatives.

Recognition that there was a gap in the 4LSAB Safeguarding Policy and Guidance relating to guidance on the types of circumstances giving grounds for concern and when they should be considered as a referral to the local authority. The 4LSABs have jointly produced in collaboration with partners a new Multi-Agency Safeguarding Concerns Guidance. This guidance reflects the soon to be published ADASS/LGA Safeguarding Concerns Guidance and will be launched in September 2020.

The 4LSAB Information Sharing Guidance was out of date and in urgent need of updating to reflect changes to data protection legislation including the introduction of the General Data Protection Regulations. The new guidance has now been published.

Partner agencies have been requested to review their internal adult safeguarding policies and guidance as well as training plans and content to ensure these are consistent with the new 4LSAB Multi-Agency Policy and Guidance.

The policy review highlighted other areas where multi-agency guidance would be beneficial and add value. The key areas highlighted include Safeguarding in Transition, Homelessness, Large Scale Enquiries. These topics have been added as work streams to the 4LSAB Policy Group's work programme and the work will be undertaken on a multi-agency basis involving all relevant partners and stakeholders as appropriate.

Whilst the 4LSAB Safeguarding Policy and Guidance is reviewed and updated regularly (every 3 years) this has been undertaken on the documentation as a whole. We have learned that this approach is time consuming and difficult to manage. Therefore, going forward it has been agreed that future updating will be managed as part of a rolling programme over a 2-year cycle so that the overall process is achieved in a more manageable and timely way.

Our Learning

Quality Assurance - what did we learn?

HSAB oversees and leads adult safeguarding across the locality and as such is interested in a range of matters that contribute to the prevention of abuse and neglect. These include the safety of patients in its local health services, quality of local care and support services, and awareness and responsiveness of further education services. HSAB needs intelligence on safeguarding in all providers of health and social care in its locality not just those with whom its members commission or contract.

The 4 Local Safeguarding Adults have developed a shared Quality Assurance Framework which is designed to enable respective Boards to fulfil their remit of ensuring local safeguarding arrangements are both effective and also deliver the outcomes that people want. The Quality Assurance Framework acts as the mechanism by which the LSABs will hold partner organisations to account for their safeguarding work, including activities linked to prevention and risk management.

In order for local agencies to be assured that they have foundations for effective safeguarding they need to demonstrate that they have the following things in place:

- Clear leadership and management of adult safeguarding
- Robust systems and processes in place to deliver the 4LSAB Multi-Agency Safeguarding Adults Policy and Guidance (December 2020)
- Adult safeguarding linked into all aspects of services
- Adult safeguarding placed at the centre of commissioning and contract monitoring arrangements
- Availability of appropriately trained, skilled and competent staff
- Clear internal care governance processes and awareness and understanding of the interface between these and local multi-agency safeguarding arrangements and Safeguarding Adult reviews.

To support partner organisations, the LSABs have developed an Organisational Safeguarding and MCA Self Audit Tool to be completed very other year. It is designed to help local organisations to evaluate the effectiveness of internal safeguarding arrangements and to identify and prioritise any areas in need of further development. The next audit cycle will commence in 2021 with the Quality Assurance Subgroup leading this process and ensuring coordination across the 4LSAB area.

The audit process is a facilitative activity designed to support continuous improvement so it is not intended to publish the results of individual organisations or to use the information provided to compare organisations. Instead, areas of generic learning and thematic findings will be identified and used to inform the strategic development of safeguarding for our area.

The Quality Assurance Group has agreed an Integrated Scorecard for use across the 4LSAB area to inform data collection and to better understand the and prevalence of and the patterns and trends in, abuse and neglect of adults with needs of care and support. To use this information to improve local safeguarding arrangements. In 2020/21, HSAB will reestablishing its own Quality Assurance Group to enable us to focus on meeting our local priorities, needs and objectives.

Our Learning

Safeguarding Adults Review what did we learn?

Under the Care Act 2014, the local safeguarding adults' board must arrange a Safeguarding Adults Review (SAR) when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult. SABs must also arrange a SAR if an adult in its area has not died, but the LSAB knows or suspects that the adult has experienced serious abuse or neglect. Duties and responsibilities to safeguarding adults remains a statutory duty and Section 44 of the Care Act 2014 relates to the need to conduct Safeguarding Adults Reviews have not changed or been 'eased'. Consequently, the Board has maintained activity regarding SARs, though new ways of conducting these have been adopted as a result of COVID-19.

The HSAB Learning and Review Subgroup will review all referrals and will determine whether the circumstances of the case engage SAR criteria and if yes, what type of 'review process will promote the most effective learning and improvement action to prevent future deaths or serious harm occurring again. This may be where a case can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults. SAR referrals are decided upon against agreed criteria which include:

- the concerns relate to a person with needs of care and support – whether or not in receipt of services at the time of death or injury
- there is information to indicate causal link between the death and abuse, neglect or acts of omission.
- There is concern about the way partners worked together to safeguard the adult.
- The concerns relate to systemic failings relating to multiple organisations and there is potential to identify learning to improve the local safeguarding system, multi-agency practice and partnership working.

The purpose of the SAR is to establish whether there are any lessons to be learnt from the circumstances of a particular case and 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 and provides a detailed overview of the interfaces involved in the case, in order to make recommendations for improving future practice, where this is necessary.

Over the past year, HSAB has received 15 referrals for a SAR representing a 50% increase in referrals, compared to the previous year and of these 3 cases

progressed to a review (2 of which have been completed and 1 is in progress). The issues raised in the referrals include concerns about self-neglect and hoarding, self-harm, substance misuse, homelessness, mental health in transition, financial, sexual and physical abuse, poor care and treatment including medication errors, misdiagnosis, unsafe hospital discharge. Since April 2020 to date, HSAB has received a total of 7 SAR referrals which means despite the significant challenges presented by COVID-19 and heightened operational pressures experienced by partners, the SAR referral rate remains stable and in line with expected volume. The majority of referrals do not progress to a review because they do not meet the criteria outlined in paragraph 31. However, in such cases other learning exercises, either at an individual organisational or multi-agency level are undertaken.

During the period covered by this report the HSAB has also competed and published 2 reviews commissioned the previous year (Ms D and Ms E). In January 2019, the HSAB commissioned a SAR to review the circumstances of Ms D's case and her support and during transition from Children's to Adults' Health and Care. A further SAR was undertaken during 2019/20 regarding Ms E who died in hospital following a poor end of life experience in the months prior to her death. Both SARs were undertaken with the full involvement of the families involved. The final report and learning summary for both reviews have been published on the HSAB website and a multi-agency action plan for each review addressing the learning highlighted have now been implemented.

Given the current challenges presented by COVID-19, the Board is exploring alternative approaches for conducting reviews to ensure it is able to fulfil its statutory responsibilities in this regard but that these are carried out in a proportionate yet effective way. In 2020/21, the Board will be piloting the SCIE 'Rapid Time SAR' approach which enables reviews to be completed in a very short timescale. It will also be adding virtual 'learning into practice' events to its training offer.

Safeguarding Adult Review Referrals received referral sources 2019/20

Over the past year, HSAB has received 15 referrals for a SAR representing a 50% increase in referrals received in the previous year. The issues raised in the referrals include concerns about:

- Self-neglect and hoarding
- Self-harm
- Substance misuse
- Homelessness
- Mental health in transition
- Financial, sexual and physical abuse, unexplained injuries
- Poor care and treatment:
- medication errors
- Misdiagnosis
- Hospital admission/discharge
- Was not bought for appointments

Referral sources:

Source	Number
Hampshire Police	3
Mental Health Trust	3
Clinical Commissioning Groups	2
Acute Hospital Trust	2
Hampshire Fire and Rescue	1
HCC Adults Health and Care	1
Hampshire Adult MASH	1
Local Safeguarding Adults Board	1
Family/ Friend	1
Total	**15**

Vulnerability Type:

Vulnerability type*	Number
Mental health	8
Substance misuse	5
Frail older person	5
Self-neglect	4
Supported living / home support	3
Homeless	1
Total	26

* In some referrals, more than one vulnerability type was identified

Referral by month:

Referrals by month	Number
2019	
April	1
May	0
June	0
July	0
August	3
Sept	1
October	2
November	0
December	0
2020	
January	2
February	4
March	2
Total	**15**

Since April 2020 to date, we have received a total of 7 SAR referrals which means despite challenges presented by COVID and heightened operational pressures experienced by partners, the SAR referral rate remains stable and in line with expected volume.

Fire Incidents

Fire fatalities and fire incidents resulting in significant injuries to individuals with care and support needs is incorporated into HSAB's Learning and Review Framework. This builds on learning gained from a thematic review of fire deaths involving adults with care and support needs carried out in partnership with the Hampshire Fire and Rescue Service (HFRS) in 2018. The learning from the review led to the creation of the Fire Safety Development Group formally adopted as a subgroup of HSAB and operating on a 4LSAB basis, as well as the introduction of a joint protocol for reviewing fire deaths and fire incidents resulting in significant injuries involving adults with care and support needs.

For the period of 1st April 2019 to 31st March 2020 within the Hampshire Local Authority area, a total of 6 incidents occurred that met the Fire Safety Development Subgroup criteria for review. These included 3 fire fatalities and 3 fire incidents resulting in significant injuries. For each of the 6 cases, a full review of the individual was undertaken by the 4LSAB Fire Safety Development Group, with all learning shared with partner agencies / group membership. However, none of these cases resulted in a formal SAR referral being made to the HSAB.

In terms of risk and vulnerability factors identified, the following themes emerged from the reviews:

- All (100%) of the incidents reviewed involved an individual who was living alone.
- Average age of the individuals was 66 and 2 thirds of cases involved men.
- 3 (50%) of the individuals were known to Hampshire Adult Services and in receipt of care and support services.
- High fire loading / hoarding conditions was identified in 2 (33%) cases.
- Poor mobility was present in 3 (50%) cases.
- Poor mental health was identified in 3 cases.
- Substance misuse was identified in 3 (50%) cases – however, only 1 individual was in receipt of substance misuse Services.
- 5 (83%) of individuals were smokers.
- 2 (33%) of individuals did not have working smoke detection in place at the time of the incident.

In terms of causes of the fire incident, the following themes emerged from the reviews:

- 3 (50%) of the incidents reviewed identified carelessness with smoking materials as the cause of the incident

- 1 (17%) of the incidents reviewed identified 'unattended cooking' as the cause of the incident

- 2 (33%) of the incidents reviewed identified 'other causes' (open fire, dangerous use of electrical equipment) as the cause of the incident.

The identified vulnerabilities of the individuals included in the case reviews are consistent with the previous fire death analysis. HFRS continues to work with partner agencies in providing fire risk management training, promoting Safe and Well (Home Fire Safety intervention) and targeting those organisations who regularly engage with individuals who, due to their individual, behavioural or environmental risk factors present a higher level of risk relating to accidental fire within the home.

Our Data

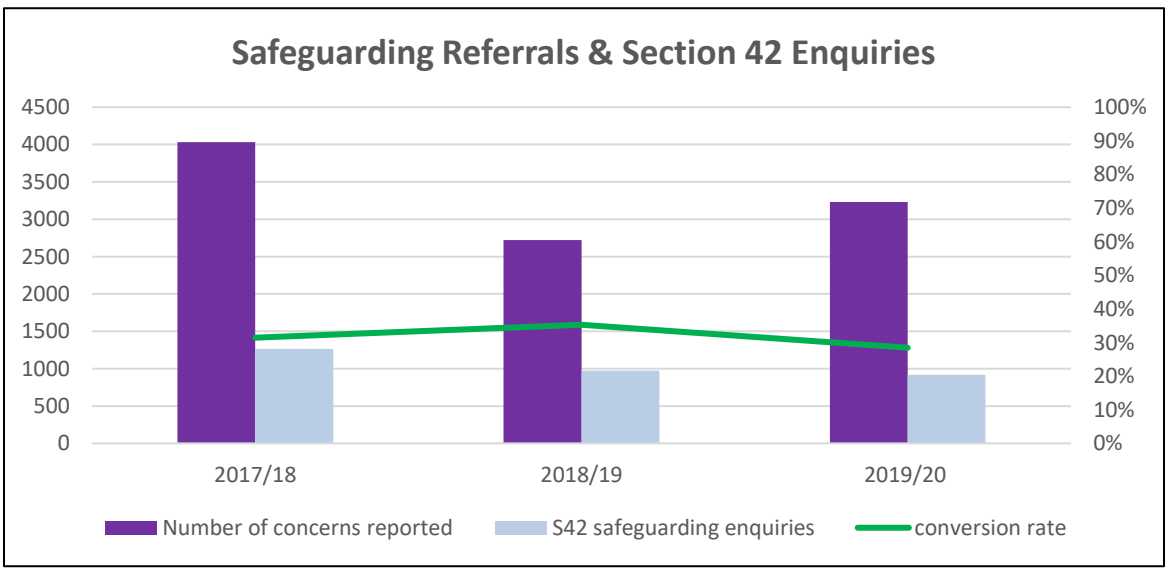
Safeguarding concerns 2019/20

Hampshire County Council Adults Health and Care 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 3,231 Safeguarding concerns in 2019/20 which is an increase on last year of 510 concerns (19%).

Number of concerns which led to a Section 42 enquiry

Of the 3,231 concerns reported, 919 resulted in a S42 safeguarding enquiry. This represents a conversion rate of **28%** of concerns that were reported progressing to an enquiry. This figure has decreased from 2018/19, when the percentage of concerns leading to enquiries was **35**%.

It is important to note that concerns that did not meet the criteria for a Section 42 enquiry may have been resolved through a more appropriate outcome. For example, an assessment of care and support needs or passing information onto another more appropriate service. Concerns may also have been closed where actions were taken to reduce the level of risk significantly.

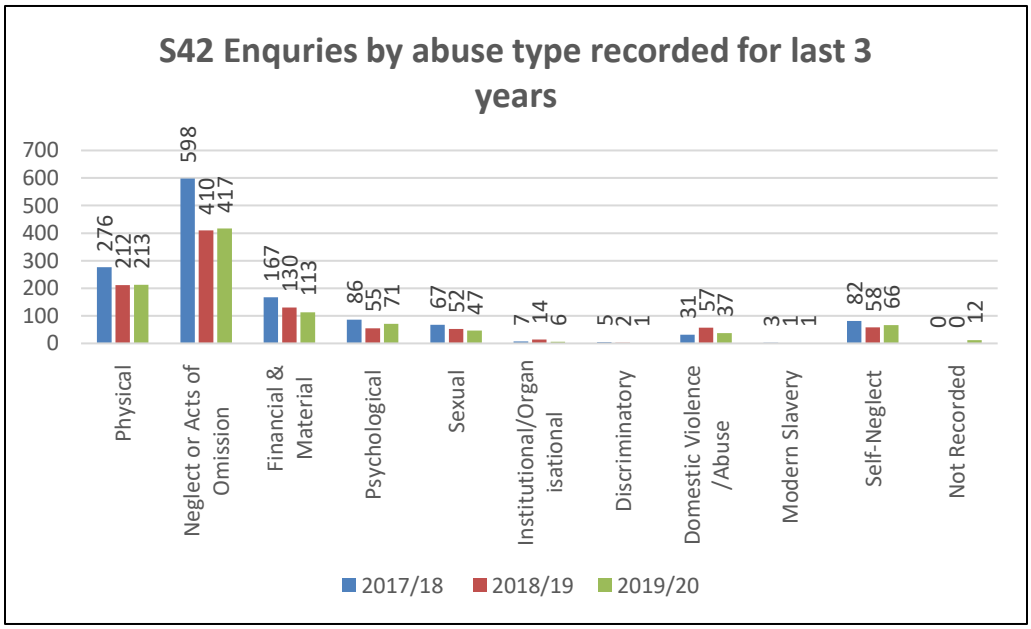


Types of abuse and needs

Of the Section 42 enquiries, there were **417** cases of neglect and acts of omission and **213** physical abuse enquiries. Together, these two categories represent **64%** of all concluded safeguarding enquiries and therefore, account for the majority of the concerns reported.

Neglect and acts of omission along with physical abuse have been the most common forms of abuse over the past four years. **The total figure of 984 is larger than the 919 recorded concerns, owing to the cases in which there are more than one type of abuse.*

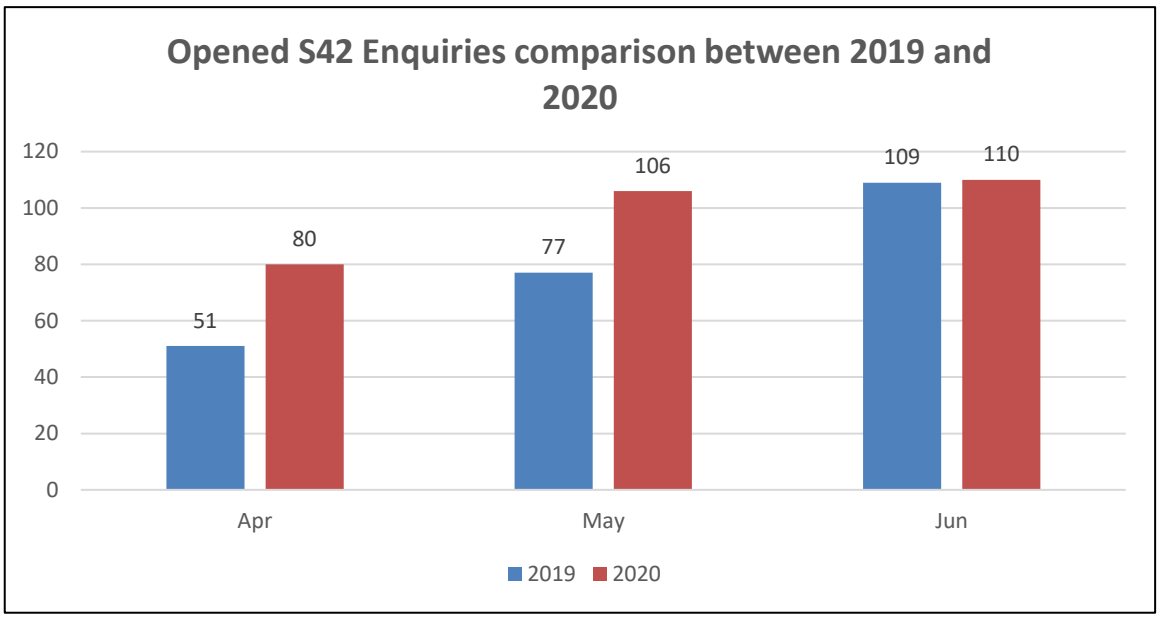
Types of abuse reported	2017/18	2018/19	2019/20
Physical	276	212	213
Neglect or Acts of Omission	598	410	417
Financial & Material	167	130	113
Psychological	86	55	71
Sexual	67	52	47
Organisational	7	14	6
Discriminatory	5	2	1
Domestic Violence /Abuse	31	57	37
Modern Slavery	3	1	1
Self-Neglect	82	58	66
Not Recorded	0	0	12
Total	**1,322**	**991**	**984**



Comparison between 2019 and 2020 S42 Enquiries

The graph below shows the number of S42 enquiries which were opened in the period April-June 2020 compared to the same period in 2019.

There has been an increase compared to last year for the months of April and May, but the June numbers are very similar.



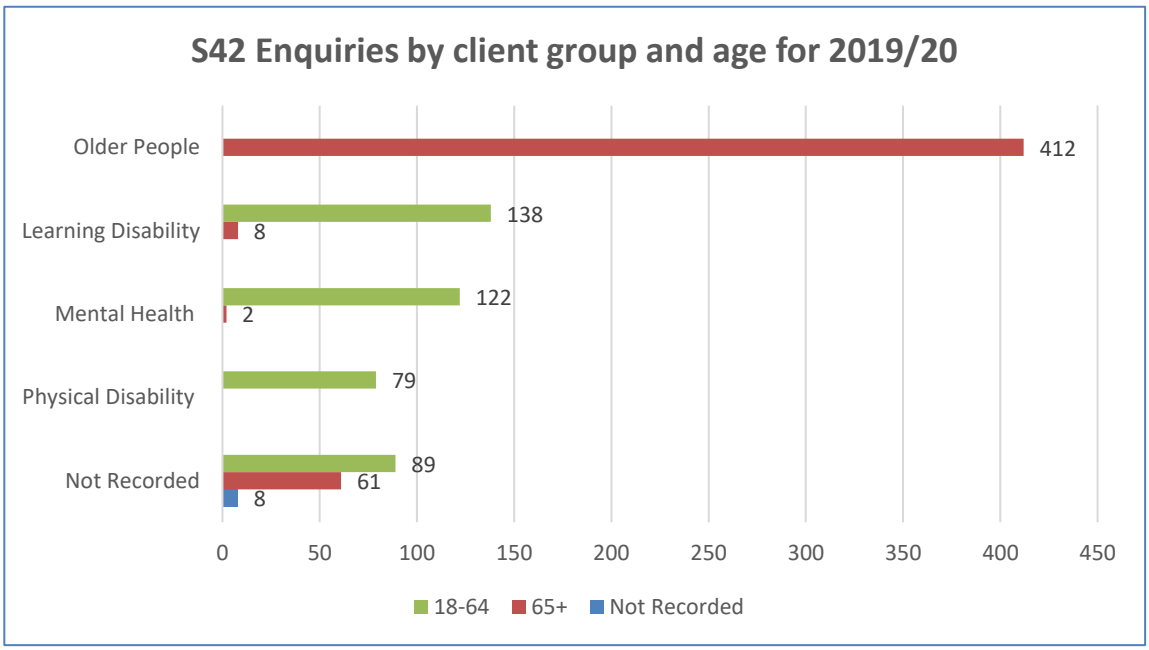
Due to a change of recording it is not suitable to compare the number of safeguarding concerns received over April- June 2019 and the same period for 2020.

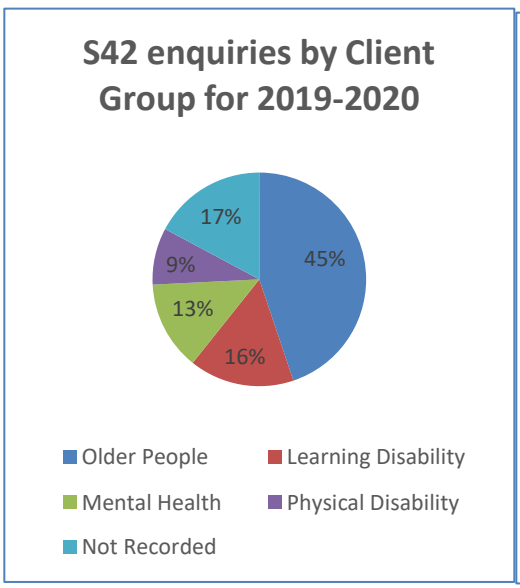
In 2019 CART Adult Concerns were used by CART to record contacts, during 2019 a case audit was completed by the Safeguarding officers and it was found that a significant number of these CART Adult concerns should have been recorded as Adult Safeguarding Concerns

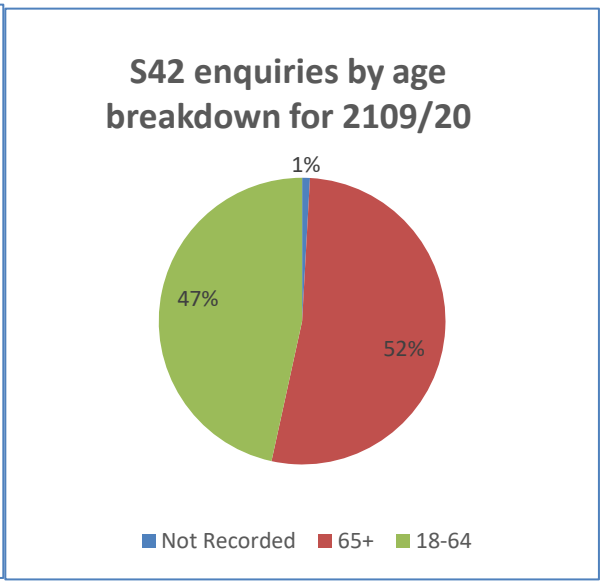
Demographics

Age

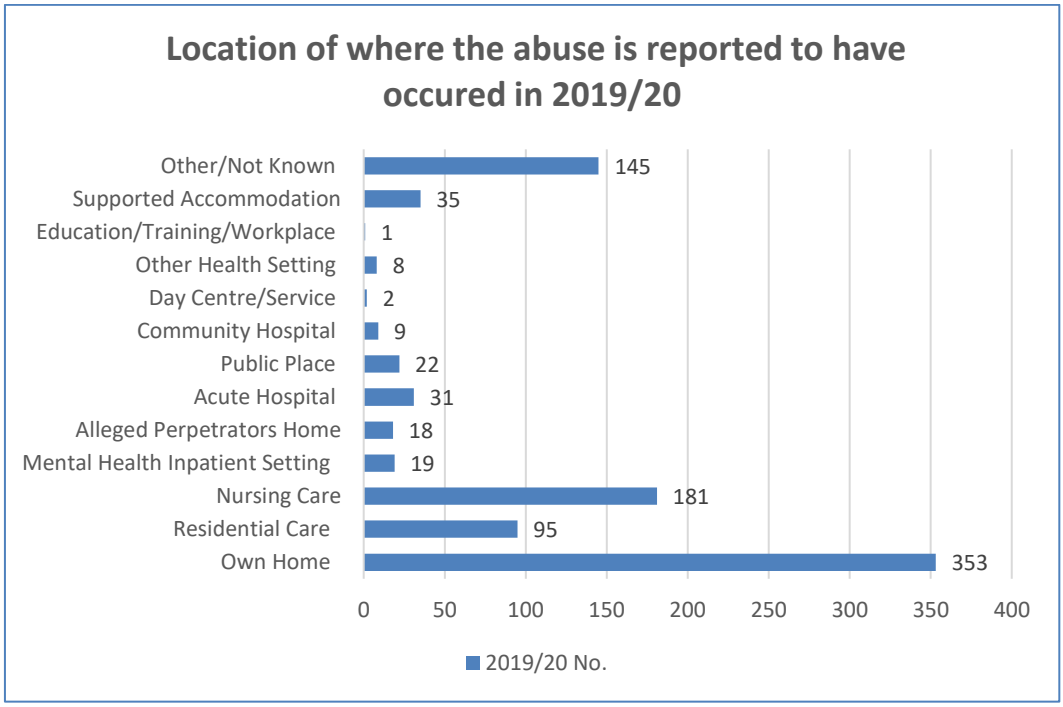
Continuing the pattern of previous years, the majority of adults having a Section 42 enquiry are older adults, that is, adults over 65 years old. This group accounts for a total of **52%** of all enquiries.







Location



Under half of adults, that is **38%**, for which Section 42 enquiries were completed, lived in their own home. The next most prevalent area of where adults lived when experiencing risk, lived in nursing and residential care homes, which accounted for 30% combined.

	2019/20	
	No.	%
Own Home	353	38%
Residential Care	95	10%
Nursing Care	181	20%
Mental Health Inpatient Setting	19	2%
Alleged Perpetrators Home	18	2%
Acute Hospital	31	3%
Public Place	22	2%
Community Hospital	9	1%
Day Centre/Service	2	0%
Other Health Setting	8	1%
Education/Training/Workplace	1	0%
Supported Accommodation	35	4%
Other/Not Known	145	16%
Total	**919**	**100%**

Looking forward - Our focus in 2020/21

We have a published Strategic Plan, outlining our vision for the Board and the outcomes we want for the people of Hampshire. Our key priorities are highlighted in the table below. Our Strategic Plan is due to be refreshed in 2021 and to aid this process we will be conducting a number of 'Stakeholder Events ' across the area to find out from local people their views to help inform and shape our future priorities.

No.	Our Priorities
1.	Wide awareness of adult abuse and neglect and its impact and engaging local communities
2.	Prevention and early intervention – promoting wellbeing and safety and acting before harm occurs
3.	Well-equipped workforce across all sectors
4.	Safeguarding services improved and shaped by the views of service users, carers and other stakeholders
5.	Clear, effective governance processes are in place within and across organisations
6.	Learning from experience mechanisms to gain learning from serious cases and promote service and practice improvement

Our focus in 2020/21:

- **Gaining assurance that people are safeguarded well during COVID.**
- **Ensuring that national and local learning is embedded in and improve our local safeguarding arrangements.**
- **Embedding our new Adult Safeguarding Policy, Guidance and Tools and introducing new guidance.**
- **Pilot new ways of gaining learning from serious cases.**
- **Implementing a virtual Training Programme linked to HSAB priorities.**
- **Improving Safeguarding during Transition.**
- **A focus on key social issues and vulnerabilities which may increase the risk of abuse - mental health, loneliness and social isolation, homelessness.**
- **Improving safeguarding responses for people experiencing homelessness, mental health and substance misuse.**
- **Refresh our Strategic Plan ensuring the views of local people and service users and carers inform this.**
- **Review Board resources to ensure we have the capacity to continue to deliver our comprehensive programme.**
- **Ensuring our work and activities are aligned with and coordinated across, the wider strategic partnership.**

Contact us

Find out more about adult safeguarding

https://youtu.be/whatisadultsafeguarding?

Report concerns about harm, abuse or neglect

Help is available if you are concerned that you, or someone you know is being harmed, neglected or exploited

If you think the danger is immediate, phone the emergency services on 999

- **Contact number for Adult Services Referrals and Enquiries: 0300 555 1386**
- **Contact number for Hampshire's Out of Hours Service: 0300 555 1373**
- **Phone Hampshire Police on 101**

Find out more about the HSAB

For more information about the work of the Hampshire Safeguarding Adults Board or our training programme, policies, guidance and resources please visit:

www.hampshiresab.org.uk