Hampshire Safeguarding Adults Board

Annual Report 2020-21

HSAB
Hampshire Safeguarding Adults Board

Published July 2021

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Message from our Chair

I am pleased to introduce the Hampshire Safeguarding Adults Board's Annual Report for 2020/21.

As the Covid-19 pandemic unfolded, the past year has brought unprecedented challenges – for our residents, communities and the organisations that work to keep us safe. We have yet to see the full scale of the impact of Covid-19 on adult safeguarding - but we know it is there, exacerbated by prolonged periods of social isolation for many.

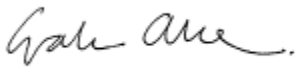
In this context, the multi-agency work of the HSAB, with Hampshire's communities, remains vital. 2020-21 has seen agencies working ever more closely to ensure effective safeguarding arrangements during Covid-19, whilst making significant progress to deliver on the five-year Strategic Plan. This is testament to the strength of partnership arrangements in Hampshire.

Both our key achievements and areas for future focus are outlined in this report, which marks the end of this five-year plan. I would like to acknowledge the hard work and commitment shown by all partner agencies in achieving our shared aims and delivering better outcomes for Hampshire's residents.

Looking ahead, HSAB partners remain committed to delivering an equally ambitious plan to improve safeguarding outcomes across Hampshire. This will need to remain flexible and responsive to emerging demands and developments, including the ongoing response to, and recovery from, Covid-19.

The development and implementation of the new Plan remains a shared endeavour and as Chair of the Board, I will continue to work to deepen an open culture of support and challenge to ensure its success. This will be greatly aided by HSAB's Independent Scrutineer working to provide objective support and challenge – as well as partners holding one another to account.

Alongside this – and particularly in the context of wider health and care reforms – the HSAB will continue to seek to forge links with the four local authority areas of Portsmouth, Southampton and the Isle of Wight, recognising there are many opportunities for closer working to deliver better outcomes for the people we serve.



Graham Allen
Director of Adults Health and Care, Hampshire County Council

Chair, Hampshire Safeguarding Adults Board

Section one: Introduction

Purpose

This report details the progress made by the Hampshire Safeguarding Adults Board to deliver its priorities during 2020-21, driving continuous improvement and supporting better outcomes for Hampshire's residents.

About HSAB

The HSAB is a **statutory, multi-organisation partnership** coordinated by Hampshire County Council (the County Council), which **oversees, leads, and coordinates the strategic development of adult safeguarding** across the Hampshire local authority area.

HSAB's main objective is to **gain assurance that local partners work effectively to safeguard adults** who are at risk of abuse and neglect, including those with care and support needs.

The HSAB also has an interest in a range of matters that contribute to the **prevention of abuse and neglect,** including:

- safety of patients in 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.

The HSAB also acts as an important **source of advice and assistance**, for example in helping others to improve their safeguarding arrangements.

HSAB Membership

The HSAB is made up of wide range of statutory, non-statutory, community and voluntary organisations which includes representatives from Hampshire County Council, Hampshire Constabulary, Hampshire Fire and Rescue, Clinical Commissioning Groups, NHS providers, Criminal Justice, Emergency Services, District and Borough Councils, Independent Care Providers, Housing, Advocacy, service users and carers. The Board's membership is detailed at **Appendix A.**

The Board's Chair is responsible for ensuring that all organisations contribute effectively to the work of the Board. The Board also has an Independent Scrutineer whose remit is to provide objective scrutiny and critical challenge to the HSAB to ensure it fulfils its core statutory responsibilities and achieves its strategic priorities

HSAB Structure

The HSAB meets quarterly and is supported by a Board Manager and a small business support team. Its work is delivered through several sub-groups, several of which are run jointly with neighbouring local Safeguarding Adults Boards where there are common priorities.

More widely, the HSAB works to align its priorities with a range of local partners, and to maintain links with national local adult safeguarding forums. **Appendix B** details the main strategic boards and partnerships that the HSAB works with. Further information on the HSAB subgroups can be found on the HSAB website hampshiresab.org.uk.

Vision and priorities

The current HSAB Strategic Plan covers the period 2016-2021 and is intended to the partnership's vision to '**promote a zero-tolerance culture of abuse and neglect for adults who are vulnerable**'.

Over the past five years, the HSAB has sought to deliver its vision by working to achieve five key priorities:

- Wide awareness of adult abuse and neglect and its impact and engaging local communities.
- Prevention and early intervention – promoting wellbeing 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.

Each year, the HSAB is required by law to publish an annual report detailing how it has delivered on its priorities over the past 12 months. This is the main vehicle by which the partnership is held to account. It is shared with the Chief Executive and Leader of Hampshire County Council, the Police Chief Constable, Police and Crime Commissioner and the Health and Wellbeing Board for the area. For more information about the HSAB please visit hampshiresab.org.uk.

HSAB key achievements

Highlights

This section provides a **snapshot of HSAB's key achievements** during 2020-21. Detailed progress against the HSAB's 2019-20 Business Plan is set out in **Appendix C**. Progress reports from HSAB partners are also included at **Appendix D**.

- **Improved quality assurance** through a new Integrated Scorecard and Safeguarding and Mental Capacity Act self-audit tool.
- Established a cross-sector, multi-agency transitional safeguarding working group to develop a **new process incorporating Multi-Agency Risk Management** and contributed to **new national transitional safeguarding guidance**.
- Contributed to the develop of a 4LSAB multi-agency **Fire Safety Framework** providing frontline staff with guidance for the effective management of fire risks.
- Introduced a Covid**-19 Assurance Framework**, enabling close monitoring of safeguarding activity.
- **Participated in the national Insights Project** comparing **COVID impacts** on safeguarding activity across authorities.
- Worked collaboratively with the four LSABs across Hampshire and the Isle of Wight to **deliver daily digital campaigns during National Safeguarding Week**, with a **reach of 84,033** via social media. Daily Adult Safeguarding Awareness clips were aired on Greatest Hits Radio, with a potential reach of 168,000 listeners.
- Refreshed the four LSAB **Adults Multiagency Safeguarding Policy and Guidance**, embedded this into training and delivered multi-agency briefings.
- **Created a training programme** consisting of Workshops and Multi-Agency Safeguarding Briefings, including: Safeguarding Concerns, Financial abuse, MARM and Family Approach.
- Since Jan 21, the HSAB has had **258 participants attend its Multi Agency training events.**
- **Incorporated the national Learning Disability Deaths Review Programme** into HSAB's work.
- **Engaged 359 stakeholders and residents** through an open survey, helping to shape key priorities for the future.

Training

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, the HSAB jointly commissions training with other partnerships, such as the Hampshire Safeguarding Children Partnership, and our neighbouring Local Safeguarding Adults Boards. The HSAB's Learning and Development Strategy (2020-23) can be viewed on the HSAB website hampshireasb.org.uk.

During the course of the Covid-19 pandemic, the HSAB has innovated to develop a virtual training offer, enabling its training programme to resume from January 2021. 21 sessions are currently planned, with a focus on the roll out of the new 4LSAB Safeguarding Adults Policy (2020) and the 4LSAB Safeguarding Concerns Guidance (2020) - as well as other topics linked to HSAB priorities, including safeguarding awareness, prevention, and early intervention, keeping safe, etc. So far this year the HSAB has ran 9 multiagency training events, with the **total number attended - 258.**

Session	**No. of sessions**
Multi Agency Safeguarding Adults Policy and Guidance	3
Safeguarding Concerns Guidance	4
Multi Agency Risk Management Framework	2
Homelessness and Adult Safeguarding	2
Domestic Abuse and Adult Safeguarding	1
Transitional Safeguarding	2
Family Approach (supporting the HSCP)	3
Financial Abuse	2
Self-Neglect	2

I will be clearer with staff through my support and internal guidance about various referral pathways.

The training gave me a clear understanding of the MARM process.

The scenarios were very interesting and mostly situations that we come across in our daily jobs.

Safeguarding data

Hampshire County Council Adults Health and Care are the lead agency who records all safeguarding information on behalf of the HSAB. Data shows a slight increase in safeguarding concerns raised, and those which went on to require a Section 42 enquiry. [1]

Neglect and acts of omission formed the main type of abuse followed by physical abuse. Section 42 enquiries were mostly **focused on adults over 65** and most commonly those who **live in their own home**.

12,875 concerns in 2020-21 (12,437 in 2019-20)
1,595 S.42 enquiries (919 in 2019-20)

64% related to **neglect and acts of omission** (739) and **physical abuse** (365)

57% related to adults over 65 years old

37% lived in own homes; 26% in residential settings and 11% in nursing homes

Hampshire Constabulary responded to **423 Public Protection Notice** (PPN1) **referrals**. A new **National Referral Mechanism referral process** was introduced advocating the use of PPN1 to flag drug associated safeguarding concerns.

Hampshire Fire and Rescue Service reviewed five fire incidents (1 involving a fatality), with key learning identified. In addition, the service referred 253 **safeguarding concerns** to AHC.

Detailed information on safeguarding concerns data is included at **Appendix E**.

Safeguarding review and learning

HSAB continued to fulfil its statutory duty to undertake Safeguarding Adult Reviews (SARs). During 2020-21 there were:

- **15 SAR referrals**, covering 13 issues, from 7 sources. The main vulnerability types were mental health (10); self-neglect and hoarding (7) and complex health issues (3).
- **7 SARs commissioned**, of which 6 are being considered thematically under 'self-neglect.'

[1] In view of the national framework, future reporting will focus on other sources of performance information, recognising the difference in definitions between a safeguarding concern and a safeguarding enquiry. This will be alongside an ongoing interest in understanding the outcome of concerns raised that do not progress to an enquiry.

More detailed information on SAR referrals is included at **Appendix D**.

Reports on emerging learning from the HSAB's review work - as well as wider workstrands, including learning from COVID-19 and policy and guidance is detailed at **Appendix G.**

Report from HSAB Scrutineer

As Independent Scrutineer, I work alongside the Hampshire Safeguarding Adults Board (HSAB) and its member organisations, providing objective challenge and supporting development. As I write this contribution for the Annual Report, I have been operating in the role for six months. Reform in the 2017 Children and Social Work Act and requirements in the Working Together guidance in 2018[1] introduced the concept of independent scrutiny to children's safeguarding partnerships. This concept is very new in its application in Safeguarding Adults Boards, with just a very few adopting this model.

The scrutiny role is not solely the domain of the Independent Scrutineer. The Care and Support Statutory Guidance (DHSC 2020) refers to evidencing of challenge and 'mutual holding to account' as a core aspect of how SAB partners and partner organisations must operate. This is an important ingredient in partnership endeavour in safeguarding adults from abuse and neglect.

SAB partnerships' duties and responsibilities are set out in the 2014 Care Act and in the Care and Support Statutory Guidance (DHSC, 2020). These underline the wide-ranging roles and responsibilities of SABs, including a role in prevention and early intervention, as well as intervention when there is abuse or neglect. There is emphasis too on connecting with communities and people, raising awareness, and enhancing resilience (including the ability to identify and manage risks). Maintaining a focus on the SAB's role and purpose (as set out in the Statutory Guidance[2]) and repeatedly checking that statutory duties and responsibilities are met are invaluable reference points for achieving effective safeguarding arrangements. They provide a baseline for mutual challenge and holding to account across the partnership.

Early work in the Independent Scrutineer role has developed an initial understanding of the HSAB. The focus has been on considering how the SAB works as a partnership (including what its priorities are and how it works to fulfil its assurance role), what works well and where there are challenges. Insight has been gained through conversations with a range of individuals and groups (both members of SAB and those with an interest in its work) as well as through attendance at key meetings and through considering the work of groups associated with the SAB and SAB subgroups.

At this early stage, a detailed picture of agreed priorities across all areas of the HSAB's work is yet to be decided upon. But, as this report is being written, the partnership has an emerging plan for the coming year. There is awareness that alongside areas of strength there are also challenges and that addressing these will

support strengthening the SABs response to its responsibilities and duties. This in turn will enhance safeguarding outcomes.

The high level of engagement with, and openness to, independent scrutiny is indicative of a strong desire across HSAB to further develop. Conversations have reflected a high level of commitment and hard work and a breadth of insight and experience across the range of partners. Harnessing this potential across all partners and including hearing the voice of those who may be in need of safeguarding support will add value.

The scrutiny role will continue to build on areas identified during this initial stage. For example, collaborative effort on co-owned and evidence-based priorities and being clear about outcomes and impact was widely reflected as a priority in conversations that were part of this early scrutiny work. A focus on prevention and early intervention will be maintained. A robust quality assurance culture and methodology is seen as significant going forward and alongside this, assurance that learning from audit and Safeguarding Adult Reviews (and other local review processes) impacts on practice and outcomes.

There is commitment in the HSAB to developing how the partnership operates as well as its specific areas of work focus. Identifying and developing the hallmarks of an effective SAB culture will be an important aspect of the scrutiny role. Many of the challenges are those being addressed by SABs elsewhere. Making connections outside the local area will support development.

Services, partner organisations and communities in Hampshire are working well together in unprecedented and deeply challenging circumstances in dealing with the public health crisis presented by the many effects of the Coronavirus pandemic. Lessons are being learned to inform present and future priorities, including understanding the likely risks that will emerge with the easing of lockdown. The effects of the pandemic will continue to be significant for the SAB, for its member organisations and for the range of partnerships in Hampshire. Joint working to establish resilience for the future is part of this.

Jane Lawson
Independent Scrutineer

[1] *Working Together to Safeguard Children A guide to inter-agency working to safeguard and promote the welfare of children* DfE, July 2018
[2] Including the role of the safeguarding adults board as set out chiefly in 14.133-14.161, Care and Support Statutory Guidance (DHSC 2020)

Looking ahead

The HSAB will seek to build on its achievements and learning gained during 2020-21 to shape a flexible work programme for the future – one that is responsive to change and that remains focused on delivering better outcomes for Hampshire's residents.

Drawing on feedback from the stakeholder survey conducted in April 2021, the HSAB has developed a new Business Plan comprising two parts:

- longer-term strategic priorities covering the period 2021-2024 (shown below); and
- shorter-term objectives which support the main priorities to be delivered during 2021-22.

This Plan will be supported by a detailed implementation plan with progress reported regularly. Some workstreams have already started and will be developed further and continue in the next year. Key areas of focus include improving awareness of safeguarding, support to carers, and improving Board effectiveness.

The 2021-2024 Business Plan is available on the HSAB website – hampshireasb.org.uk.

HSAB Strategic Priorities 2021

Prevention	Learning	Protection
We will **prevent abuse and neglect and improve awareness** of adults at risk within and across Hampshire's communities and partner agencies.	We will draw on evidence to improve how we work and **learn from people's experience, supporting better outcomes** for others.	We will **protect adults from abuse and neglect**, ensuring that the **rights of people with care and support needs are also protected**.

Contact and further information

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

Report concerns about harm, abuse or neglect.

- **If you or someone else is in imminent danger, phone the police on 999 or call them on 101 if it is less urgent.**

- **If your request is urgent and you need support in the next 24 hours contact Adult Services on 0300 555 1386 opening times and 'out of hours' numbers are below.**

- **If your concern is not urgent then you can use one of the online forms below.**
  - Form if the referral is for you
  - Form if the referral is for someone else
  - Form if you are a professional making a referral (e.g., care provider, GP, clinician)

Telephone Services Opening Hampshire Adult Services

Please be aware, at busy times, there may be a wait for your call to be answered.

0300 555 1386	**Out of hours 0300 5551373**
Monday to Thursday 8.30am to 5pm	Monday to Thursday 5pm to 8.30am
Friday 8.30am to 4.30pm	Friday 4.30pm to Monday 8.30am
	All day on Bank Holidays

To find out more about adult safeguarding visit:
https://youtu.be/whatisadultsafeguarding?

Further information about the HSAB, including its training programme, policies, guidance and resources, is available via www.hampshireasb.org.uk.

Appendix A: HSAB Membership

The Board consists of the following membership:

Chair

Chair
Independent Scrutineer

Support to the HSAB

Board Manager
Business Support Officer

Core Statutory Board Members

Hampshire County Council Adults Health and Care
Hampshire Constabulary
Hampshire and Isle of Wight Clinical Commissioning Group

Associate Members

Department of Work and Pensions
District and Borough Councils
Hampshire Care Association
Hampshire Fire and Rescue Service
Hampshire County Council Children's Services Department
Hampshire County Council Mental Health Department
Hampshire County Council Public Health
HMP Winchester
NHS England
NHS Acute Hospital Trusts
Probation Service
Solent NHS Community Trust
South Central Ambulance NHS Foundation Trust
Southern Health NHS Foundation Trust
Surrey and Borders Partnership NHS Foundation Trust
National Probation Service (South Central)
Trading Standards

Advisory

Voiceability - Advocacy
Speakeasy - Advocacy
All Inclusive CIC
Care Quality Commission
Crown Home Care
Executive Member, Hampshire County Council
Hampshire Local Children's Safeguarding Partnership
Hampshire Prevent Partnership Board
Hampshire Domestic Abuse Partnership
HealthWatch Hampshire
Princess Royal Trust for Carers
Voluntary Sector (Community Safety North Hampshire)

Appendix B: HSAB key partners

The Board has established and maintains effective links with the following strategic boards and partnerships:

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

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 Board Managers Network
- National Network of Chairs of Safeguarding Adults Boards

Appendix C: HSAB progress on priorities

Priority	Commitments	Progress	Next steps
Wide awareness of adult abuse and neglect and its impact and engaging local communities.	Review and refresh the See It Stop IT HSAB Safeguarding App.	Work commissioned to carry out the review of the HSAB See It Stop IT Safeguarding App. A first draft has been created and is scheduled to be completed in the Autumn of 2021.	Complete the review of the App and launch the updated version with partners and the wider public across Hampshire.
	Conduct a campaign highlighting Homelessness and safeguarding.	Included as a theme in National Safeguarding Week. Wider campaign planned, to align with the launch of new Homeless Guidance.	Develop and coordinate an evidence-based thematic safeguarding campaign. Deliver a programme of engagement to promote safeguarding across diverse community groups and citizen cohorts.
	Include to loneliness and social isolation as a theme in the HSAB training programme for 2020-21.	Multi-agency workshops on homelessness and self-neglect are included in the annual L&D programme for next year.	Create accessible information to raise awareness of abuse and neglect and how to report concerns, targeted at key audiences and promoted across a range of channels.

Priority	Commitments	Progress	Next steps
	Conduct a Stakeholder Survey and stakeholder events across the county to inform the refresh of the Strategic Plan in 2021.	Stakeholder Survey undertaken in April 21. Due to continued COVID restrictions other planned events have not taken place. Information gained has been used to inform the refresh of the HSAB Strategic Plan for 2021/22.	
Prevention and early intervention – promoting well-being and safety and acting before harm occurs.	Set up a multi-agency, cross-sector homelessness and safeguarding working group to respond to learning arising from 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.	The 4LSAB Housing subgroup have established a task and finish group and are developing local 4LSAB guidance to support the implementation of national guidance. Cross sector multi-agency working group established. The local guidance has been commissioned. New process to be published in the Autumn of 2021. Promotes use of Multi Agency Risk Management (MARM). HSAB had the opportunity to contribute to the new national transitional safeguarding guidance, which included a section on MARM.	Once completed, publish and launch the 4LSAB local guidance. Disseminate national guidance once published. Publish 4LSAB local transitional safeguarding process. Drive up use of MARM in transitional safeguarding, homelessness, and self-neglect. Monitor use of the local framework.

Priority	Commitments	Progress	Next steps
	Promote awareness within mental health/substance misuse/ homelessness services of the toxic trio of capacity/unwise decision-making/ disengagement. Develop a joint protocol to enable practitioners working with these groups to provide effective safeguarding responses.	4LSAB Multi-Agency Safeguarding Briefings have included: Safeguarding Concerns, MARM and Family Approach workshops that promote prevention, early intervention and trauma informed practice with an emphasis on understanding the barriers hindering an adult's engagement and working to break these down.	Ensure learning from the HSAB's thematic SAR review on self-neglect is shared and drives improvement in practice. Deliver a good practice workshop on self-neglect.
	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.	MARM Framework reviewed and updated in June 2020. MARM workshops form part of the core HSAB training offer. MARM is being used to address high intensity service use, complex hospital discharge.	MARM workshops to continue as part of the HSAB Learning and Development programme. Review and consider the need to include targeted sessions due to the Transitional and Homelessness guidance.
	Joint work with the FE/HE sectors to address student mental health.	Unfortunately, due to COVID19 and associated pressures, this work has not been completed.	Undertake research to better understand the nature of safeguarding referrals arising from mental health setting to inform future practice guidance.

Priority	Commitments	Progress	Next steps
Competent, well-equipped workforce across all sectors.	Launch the 4LSAB Multi-Agency Safeguarding Adults Policy, Guidance and Toolkit in Sept 2020.	Published in June 2020. Series of multi-agency policy briefings delivered. Rolling programme of review introduced.	Undertake a system-wide review of safeguarding matters during the Covid-19 pandemic, ensuring that lessons are captured and drive improvement in safeguarding practice.
	Implement the ADASS/LGA Safeguarding Concerns Guidance once published.	Local 4LSAB Safeguarding Concerns Guidance developed and published. Concerns workshops included in HSAB training programme. National guidance published on HSAB website and national workshop programme published.	Contribute to wider regional and national reviews as appropriate.
	A virtual training programme linked to HSAB priorities – 4LSAB Multi-Agency Safeguarding Policy, Concerns Guidance, MARM (targeted at specific sectors), Family Approach, Homelessness, Hoarding.	Virtual training programme published, linked to HSAB priorities – 4LSAB Multi-Agency Safeguarding Policy, Concerns Guidance, MARM, Self-Neglect, Homelessness, Financial Abuse, Transitional Safeguarding, Family Approach.	Complete an organisational self-assessment of Board Members to support the further development of safe services. Keep abreast of, and seek to influence, legislative and policy developments relating to safeguarding.

Priority	Commitments	Progress	Next steps
	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.	4LSAB Learning and Development Strategy updated and published. Self-neglect workshops will be delivered during 2021 – addressing self-neglect as this topic has been a key feature of SAR referrals in the second half of 2020. Thematic learning events to be completed as part of the dissemination of learning from current and ongoing HSAB Thematic Self Neglect SAR.	Explore opportunities to gather people's experiences to understand what Making Safeguarding Personal means to them. Capture good practice to showcase how citizen and service user feedback is used to inform learning and development and drive improvement.
Safeguarding services improved and shaped by the views of service users, carers and stakeholders	Mental Capacity Act Board development day on the Mental Capacity Act in early 2021.	Personalisation Expert Panel (PEP) representation on Board and stakeholder subgroup.	Multi-agency MCA self - audit Sep/Oct 2021 – assurance re implementation of 6 step plan.

Priority	Commitments	Progress	Next steps
	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.	Lasting Power of Attorney (LPA) project with conjunction with CCG and AHC to drive up uptake of LPA's. Added to the *Keeping Safe* area on the website. Publication of Mental Capacity Act and Court of Protection Guidance in response to the Sasha SAR. Stakeholder survey carried put April 21. Results have informed the update of our Strategic Plan.	Undertake a strategic Board review, including a focus on further developing a culture of positive learning, appropriate challenge, and mutual accountability. Update the Strategic Plan. Further Stakeholder engagement planned as previously reported.
Assurance that clear, effective governance processes are in place within and across organisations.	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.	HSAB COVID Assurance Framework introduced. Discussed at each Board meeting. Opportunity for HSAB to be sighted on current and emerging challenges and risks to safeguarding responses due to COVID. Has helped HSAB understand the impact of COVID and the information gained is being used to increase future resilience and support the recovery phase.	Deliver HSAB multi-agency COVID review. Organisational and Mental Capacity Act Self Audits to be competed in Sept/Oct 2021. Implementation of the Integrated Scorecard. On-going participation in the National Safeguarding Data Insight Project.

Priority	Commitments	Progress	Next steps
	Re-establish the HSAB Quality Assurance Subgroup and review and update associated tools. Partners to provide assurance to the Board of their progress against the Mental Capacity Act six-step plan, introduced in 2017/18 to address learning from the HSAB's thematic review of three 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.	HSAB has participated in the National Safeguarding Data Insight Project. National work in the collection of data to help the sector promptly understand the nature of the impact of COVID-19 and the lockdown on safeguarding activity, and how it compares to the previous year. All subgroups have built key actions from the C-19 Assurance Framework into respective work programmes with regular feedback to the HSAB. Multi-agency COVID review planned but deferred due to reduced capacity in partner agencies. HSAB Quality Assurance Subgroup re-established. Quality Assurance Framework and tools are being updated and refreshed.	Implement a lean audit programme to gain assurance that learning from SAR's is embedded within practice.

Priority	Commitments	Progress	Next steps
Learning from experience - mechanisms to gain learning from critical events and serious cases and promote service and practice improvement.	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 Social Care Institute for Excellence Rapid Time SAR Review process which enables reviews to be conducted within 15 days. Joint 4LSAB annual learning event covering local and national learning.	In 2021, SAB has undertaken five SARs across 10 cases. Two reviews were undertaken in 2020 in the form of multi-agency partnership reviews. three SARs have been commissioned covering eight cases. These involved two individual SARs ad one thematic review covering six cases related to self-neglect which have commenced but not yet concluded. A smarter, streamlined virtual SAR process has been introduced. HSAB learning and development programme for 2021/22 reflects several themes highlighted at the local and national level. Given the prevalence of deaths involving adults with a learning disability during COVID, HSAB has incorporated LeDeR learning into the Learning and Review Subgroup.	Implement action plan to respond to the learning for SABs and frontline practice from the National Analysis of SARs, which reviews all Safeguarding Adults. Action plan to form the basis of the Learning and Review Subgroup's work programme in 2021/22. Actions for the Learning and Review Subgroup: - Refine SAR decision making process. - Create a proforma capturing demographic and key information relating to the individual involved. - Update the Board's SAR policy and guidance to ensure it addresses all the recommendations in the report.

Priority	Commitments	Progress	Next steps
			Regularly update the HSAB learning and development programme and its content in line with the recommendations Board learning event to understand the changes and any actions required in response to the national analysis. Introduce the 7 Minute Briefing approach which has shown itself to be highly effective as a tool to support learning into practice.

Appendix D: Partner update reports

Hampshire County Council Adults Health and Care (AHC) Report

This section details how Hampshire County Council's Adults' Health and Care Department has contributed to delivery of key priorities, aligned to the HSAB Strategic Plan and vision.

1. Gaining assurance that people are safeguarded well during COVID.

The HCC Care Covid Learning Review was completed in Nov 2020. This focused on understanding the Covid challenges experienced by HCC Care and supporting performance to ensure the safety and wellbeing of residents.

In response to the pandemic, a Care Act responsibilities sub-group of the AHC Practice Network met between May 2020 and April 2021 to monitor demand and distress in the community, and AHC's capacity and service response. This included services that were paused or reduced due to national restrictions and putting in place plans to mitigate associated risks.

AHC took part in the National Insights project to compare the impacts of COVID on safeguarding activity across local authorities. More information about this project can be found here:
COVID-19 Safeguarding Adults Insight Project | Local Government Association

Throughout the pandemic, the Department continued to conduct interim quality reviews with providers.

2. Ensuring that national and local learning is embedded in and improve our local safeguarding arrangements.

Relevant national research, for example ADASS briefings and national SARS analysis, was published on relevant intranet pages and highlighted in internal communications.

Recommendations and learning points from SARS, for example fire death, were an important part of AHC's annual safeguarding updates which all practitioners were expected to attend. Other learning from individual Safeguarding Adults Reviews was disseminated through the Practice Network (for example Sasha SAR) and the *Learning from the Frontline Practice* internal website.

The Hampshire SAB Learning and Review subgroup will be using the "Analysis of SARs 2017-19'2 (Braye and Preston-shoot) to improve our commissioning and management of the SAR process.

3. Embedding our new Adult Safeguarding Policy, Guidance and Tools and introducing new guidance

AHC has introduced the refreshed 4LSAB Safeguarding Adults Multiagency Safeguarding Policy and Guidance, published in June 2020, through communication and virtual learning events - such as safeguarding updates, public websites and social media. New guidance has been integrated into revised training packages for staff.

4. Pilot new ways of gaining learning from serious cases.

During the pandemic, AHC has continued reflective workshops adapting the process to MS Teams to draw learning from multi-agency cases – with a particular focus on understanding how the pandemic is impacting practice.

The three main pieces of learning so far are:

a. Exploring the challenges associated with working across agencies and responding to home closures during the pandemic.

b. Virtual workshop for the Prevent partnership.

c. Multiagency workshop following the death of a woman in the New Forest.

Summaries of the learning will shortly be added to the *Learning from the Frontline* internal webpages and action plans are complete or under development.

5. Implementing a virtual Training Programme linked to HSAB priorities

There is a full virtual training programme now provided on the Hampshire Safeguarding Adults Website.

6. Improving Safeguarding during Transition

Learning from transition related SAR (Sasha) was disseminated but further work will be continued. The 4LSAB Policy Implementation subgroup is developing a Transitional Safeguarding policy which is scheduled to be rolled out in the Autumn of 2021.

7. Improving safeguarding responses for people experiencing homelessness, mental health and substance misuse.

Learning from a homelessness related SAR for Vicky will shortly be disseminated. Key learning relates to mental capacity, challenges for communication across mental health and epilepsy services, and working with adults who are on the fringes of services and remain ambivalent to engage.

8. Refresh our Strategic Plan ensuring the views of local people and service users and carers inform this.

Hampshire Safeguarding Adults Board have completed a Stakeholder Survey and findings are incorporated into a new Business Plan.

9. Review Board resources to ensure we have the capacity to continue to deliver our comprehensive programme

The review of board resources has been delayed due to our COVID response. A review will take place in 2021/22.

10. Ensuring our work and activities are aligned with and coordinated across, the wider strategic partnership

Work has continued to be closely aligned with all partners including the HIOW 4 Local Authority HSABs, working collaboratively with the Hampshire and Isle of Wight Integrated Care System to ensure the best safeguarding outcomes for people across the system.

Aims and Objectives for Adults Health and care in 21/22:

- Learning from Gosport War Memorial Hospital
- Further embedding of Making Safeguarding Personal
- Making use of safeguarding data to improve and assure services
- Domestic Abuse
- Hoarding and self-neglect
- Safeguarding recovery following COVID
- Consolidating work on fire death and safeguarding during transition
- Review of board resources

Jess Hutchinson
Principal Social Worker
Assistant Director- Young Adults
Hampshire Adults Health and Care

Clinical Comissioning Groups (CCGs) Report

This report has been raised against the strategic priorities for HSAB 2016-2021 on behalf of West, North Hampshire and North East Hampshire & Farnham CCGs , Fareham & Gosport and South Eastern Hampshire CCGS now known as Hampshire, Southampton, Isle of Wight CCG. This includes contributions from Kathryne Abbott, Michele Ennis, Dr.Jaki Metcalfe, Laura-Jane Osbaldeston – Designate Nurses/Professionals Safeguarding Adults.

1. **Widen awareness of adult abuse, neglect, its impact and engaging local communities**:

   Health partnerships have engaged and supported raising awareness specifically within the areas of financial abuse, self-neglect, loneliness and isolation and other emerging themes from Serious Incidents, Safeguarding Adult Reviews and Domestic Homicide Reviews. Health currently engage in working alongside homelessness collaborations supporting a review of current health service and system provisions from a health/homeless perspective.

   Health partners have worked together to develop safeguarding adult and children level three training, focusing on the themes identified during the Covid-19 response period. In addition, peer supervision and a monthly newsletter has been offered for primary care staff to refer to. These supported opportunities include learning identified for dissemination by the board.

2. **Prevention and early intervention – promoting wellbeing and safety and acting before harm occurs:**

   The CCG has collaborated with the Local Authority and other partners to develop two short films to raise awareness of the importance of having a Lasting Power of Attorney for Health and Welfare for professionals and the public. The films and associated supporting materials are available on the HSAB website. National dissemination has also taken place. HSAB partners to continue to promote the use of the materials to raise awareness in the local population.

   Health partners continue to align their training needs analysis and internal audits, reporting with reference to the embedding of the 4LSAB policy and procedures whilst reviewing risk for their organisations across the health economy.

   There is currently a proposed focus under discussion to review health themes from pandemic MASH activity, all HSAB sub-groups and risk registers to support a SMART response to hidden harm themes that are currently emerging. This might be developed into a work plan for the health sub group against the next HSAB strategic priorities.

3. **Well-equipped workforce across all sectors**:

Health partnerships have continued to embed and deliver local training against HSAB priorities. Health subgroup are working with Learning & Review sub group to identify that learning from SARs has been shared.

Currently there is an electronic questionnaire in circulation supporting an analysis and assurance of health recommendation from recent SARs.

It is anticipated that a wider survey might be completed against new HSAB strategic priorities as part of the pandemic recovery work force development.

There is need for further training needs analysis and feedback survey to be carried out across the health economy to seek assurance of training provision and identify any gaps for further training support and development.

4. **Safeguarding services improved and shaped by the views of service users, caers and other stakeholders:**

Health partners continue to work across safeguarding services to improve and develop Making Safeguarding Personal outcomes for patients, carers and all other stakeholders. This has been evidenced widely in the pandemic responses to national, regional and HSAB assurance requirements.

From April the CCGs will merge into an Integrated Care System (ICS), as part of the NHS Long Term Plan, and will be building on the work of the Sustainability and Transformation Partnership (STP), which is made up of NHS and local authority organisations across Hampshire and the Isle of Wight.

One of the strengths of the system is that arrangements can be adapted to reflect what makes sense locally.

It is anticipated that there will be enhanced working within the ICS to ensure statutory safeguarding responses and services are enhanced and shaped by the view of patients, carers and other stakeholders.

The Health Subgroup aims to collaborate collegiately on learning and supporting a work plan alongside HSAB and 4LSAB work that engages this as a core development need against HSAB strategic priorities facing forwards.

5. **Clear, effective governance processes are in place within and across organisations:**

Health partners have contributed fully and comprehensively to improving governance processes within and across the health economy for HSAB and 4LSAB.

6. Learning from experience - mechanisms to gain learning from serious cases and promote service and practice improvement:

National pandemic working and learning themes that are emerging suggest there is room for more health economy focused audit and review. The development of the new Integrated Care System (ICS) enables opportunity for strategic review of safeguarding systems and governance and risks with increased development of partnership work with MASH and HSAB statutory/strategic priorities. This is recommended as a priority action for next steps.

The current recommendation to HSAB is consideration for the Private, Voluntary and Independent (PVI)/care home sector to be part of this review from a safeguarding lens and need for HSAB support. This would support compliance with the NICE Guidance for Safeguarding Adults in Care Homes (2021). Additionally, triangulation with LeDeR/Learning Disability learning alongside mental health themes might be given a more specific focus within thematic reviews alongside the physical health of the Hampshire Health economy

RECOMMENDATIONS

For 2021/2022 progression with development of a work plan by the subgroup at the next meeting against HSAB new strategic priorities:

- Review and develop collegiate and collaborative working partnerships across crossing boundaries/multi agencies to ensure an enhanced health focus reference prevention, protection and management of risk around statutory compliance and new changes.

- Continued strategic partnership approach in supporting and developing the response to COVID challenges.

Louise Spencer
Interim Director of Quality and Nursing and Caldicott Guardian
Working in North and Mid Hampshire, South East Hampshire and the Isle of Wight as part of the Hampshire and Isle of Wight Integrated Care System

Hampshire Constabulary Report

Introduction

The safeguarding challenges presented by the ongoing Covid-19 global pandemic is without precedence in UK Policing. This makes any current year to year data comparisons more or less near impossible to assess and draw accurate inferences from, as the fact is there are too many independent variables affecting one person's risk of harm to another.

It cannot be understated that the demands and pressures placed upon the Constabulary throughout the pandemic were significant, as staff stepped forward to support Public Health partners with the monitoring and where necessary enforcement of the Co-19 regulations, alongside managing other daily policing and safeguarding demands.

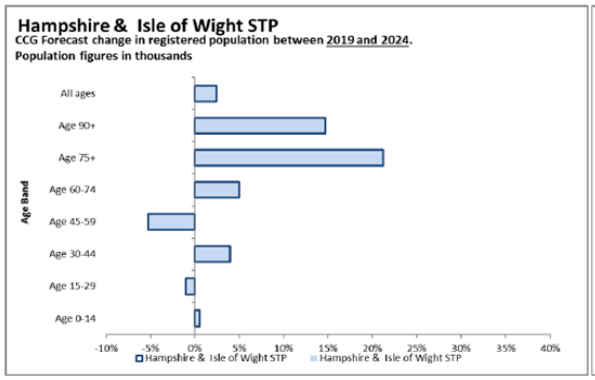
It will not be until we return to some form of normality, that we will be able too fully assess the longer-term impact the pandemic has had on our communities in terms of both mental and physical harm across all social demographics.

Providing context (Social & demographic forecasts for Hampshire & IOW).

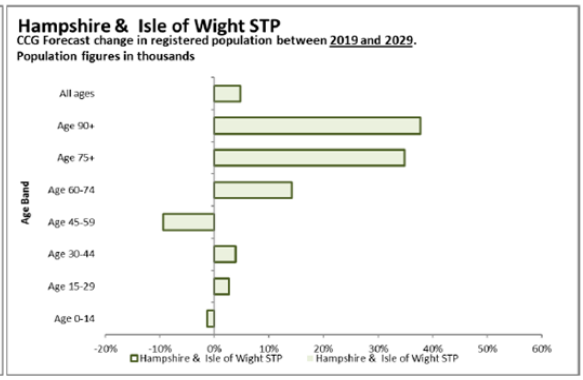
Between 2020 and 2026 Hampshire's population is predicted to increase by 6% (+109,914) to 1,994,044, based on a similar 6% increase in residential dwellings. Later this year the ONS 2021 National Census will help confirm actual population numbers within the county, removing the inaccuracies created by over-reliance on historic 2011 data.

This year's Hampshire Joint Strategic Needs Assessment continues to predict a significant rise in the older population of Hampshire and the Isle of Wight over the next ten years. In particular, the over 85-year-old population is expected to increase by +24% by 2025.

Population change over the next five years



Population change over the next decade



Source: ONS 2016-based subnational population projections for NHS regions and clinical commissioning groups in England

Similarly, current growth projections for 12–17-year-olds is disproportionately high compared to other age categories (increasing by +16% by 2026).

The combination of all these factors will create further demand on the Constabulary, with significant challenges faced by Public Protection Teams in meeting the associated harm issues linked to a growing children and elderly adult population.

The financial challenges faced by local authorities in maintaining their health and social care services are significant. This may require agencies in the future to reassess and raise their current risk thresholds in order to meet demand. If this happens this will increase the number of persons that still require some form of support, but are considered not serious enough to have access to a full care plan. Therefore, in order to prevent any person from then falling through these widening social care gaps, Local Authorities will need to maximize the support offered from third sector, private and charity organisations.

Over the past two years, the Violence Reduction Units (VRUs) have helped shaped thinking by pushing an early intervention agenda across the county, identifying, and promoting national best practice and evaluating all commissioned work to examine value for money, so there is hope that if adopted more widely, the Constabulary may be able to maximise the effectiveness of the limited funds available.

Public Protection Notices (PPN1s)

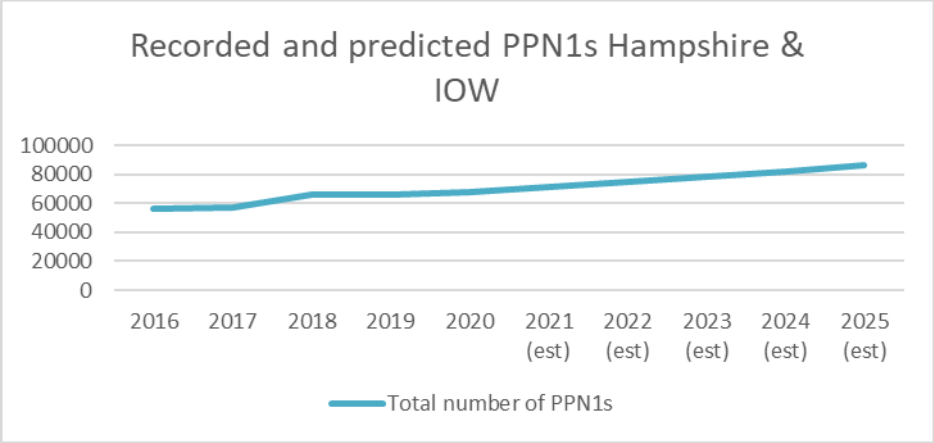
PPN forms are submitted to the MASH under four different headings: Domestic Violence, Child Concern, Vulnerable Adult and Honour Based Violence.

Some initial points to consider around the provenance and value of PPN1 data.

- The impact of the COVID-19 Pandemic on the safeguarding of vulnerable children and adults will take to review and assess. This will be the subject of local and national studies over the coming months, with an intention that those findings will help shape future safeguarding strategies.

- The total number of PPN1 safeguarding forms submitted by operational staff within Hampshire Constabulary are considered to be a good indicator on the total level of safeguarding demand faced by each of the Local Authority areas across Hampshire and the IOW. Much of the work managed by the Children and Adult Social Services teams arise from these referrals.

  From researching PNN1 data recorded on RMS between 2016 and 2020, the total number of PPN1s increased by approx. +20% (+11,010 reports).



Using this increase as a baseline, year on year increases averaged +5% during this time, which if projected forward predicts a total figure of **86,424 PPN1s by 2025**.

However, it is important to note that there are many influencing factors that could lead to a change in the total numbers of PPN1 referrals from one year to the next. The COVID pandemic, subsequent likely loss of employment for many, cuts in public services and general austerity measures from 2022 will all have a likely impact on the number of vulnerable people in our society.

Vulnerable adults

Multi Agency Risk Management (MARM) & S42 cases

Due to MARM meetings only being introduced since 2018 it is difficult to predict future demand, however it would be expected to remain similar or slightly above 2019 figures.

In relation to s42 cases, there has been an upsurge in total numbers since 2019, however each authority area appears to be adopting a different approach to which cases require an s42 meeting and which do not.

Homelessness

Research by the MASH Inspectors with each of the LA adult social care and housing leads revealed that there currently appears to be inaccurate information contained within those organizations on the current number of homeless persons living in Hampshire and IOW. This included those that have been temporarily rehoused due to the Covid-19 national requirements in 2020.

The only figures provided were by PCC who stated they had only 18 x rough sleepers, all of which are currently engaging with adult social care and are on a pathway to independent living. There was no discussion on what would happen to the larger cohort of temporality housed persons once funding is withdrawn.

The total numbers within Hampshire & IOW are believed to be significant, when considering approx. 1,700 persons were recorded in May 2020, often with underlying mental and physical health conditions.

HIOWFRS (fire prevention & neglect)

HFRS continue to play a key role in fire prevention and the identification of neglect and other social care harm issues. From March 2020 to February 2021, they responded to 423 PPN1 referrals.

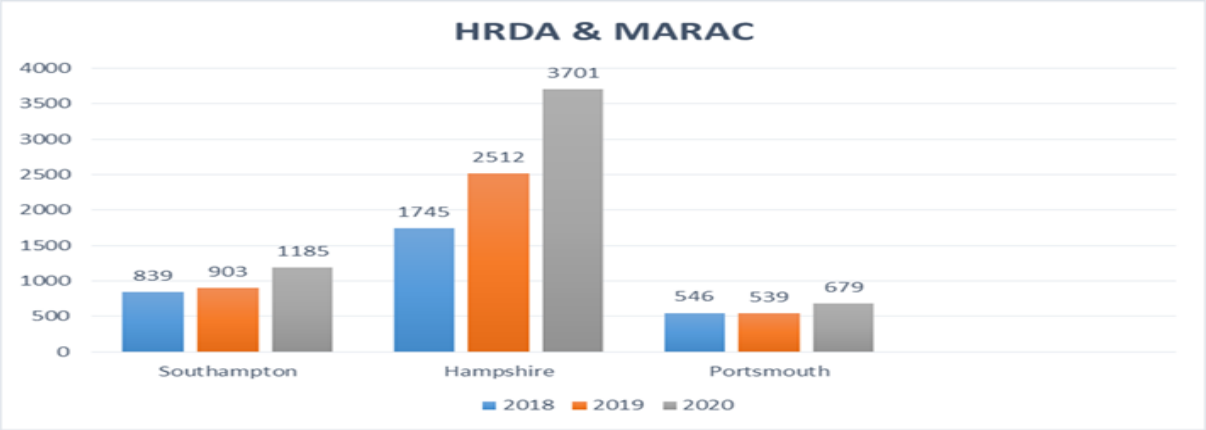
Domestic Abuse

Throughout the course of the pandemic, domestic abuse has continued to be a key priority for the Constabulary, with reported crime figures one of the few thematic crime types that increased during this period.

Working with partners, a number of review meetings are scheduled each month to manage those at risk of harm. The High Risk Domestic Abuse meetings (HRDA) oversee the majority of these cases, with the highest risk cases then escalated on to Hampshire's Multi-Agency Risk Assessment Conference meetings (MARAC), which Police attend routinely.

Although the total number of DA reports has increased since 2020, we have seen a slight reduction in the number of most serious violence cases, which evidences the positive work taking place to divert and reduce the risk of harm to those subject to often daily physical and mental domestic abuse.

Total number of HRDA and MARAC case conferences over the past three years:



Drug Related Harm

The issue of drug related harm is a significant cause for concern now and in the future. In addition to the associated criminality it causes, often involving vulnerable adults and children, the increased usage of drugs by known habitual users and the larger unknown group of recreational users across the county, has created further physical harm issues, occasionally leading to death of serious harm. It appears that many of those affected often fall between the health and social care services gaps, which is potentially why Hampshire continues to remain a national outlier for a disproportionately high number of drug associated deaths and serious injuries across all age groups.

The National Referral Mechanism

Following a review of the National Referral Mechanism by Dame Sara Thornton (The national Anti-slavery commissioner), Hampshire Constabulary responded by introducing a new NRM referral process at the start of 2021. This advocated the use of PPN1s to flag a drug associated safeguarding concern immediately to relevant professionals, so that a review could then take place which as part of the safeguarding plans would also consider whether a NRM referral was required or not. By adopting a more informed approach to assessing risk, this will ultimately improve the safeguarding options offered to children and vulnerable adults.

In addition to these procedural changes, Hampshire Constabulary have invested in a dedicated investigation team looking specifically at tackling County Lines.

Over the past year, that team have dismantled a number of organized crime gangs and whilst they continue to prosecute those at the top running these drug lines, they have also looked at maximizing all opportunities to better safeguard the children and vulnerable adults they routinely encounter in their work. This has included early diversion to drug support services and escalation to the relevant social care teams, considered best placed to provide that longer-term support.

Detective Chief Inspector 27585 Mark Lynch
Hamps & IOW MASH & Adult Safeguarding Lead
Public Protection Department
Hampshire Constabulary

Hampshire Fire and Rescue

Throughout 2020-2021, the 4LSAB Fire Safety Development sub-group, a partnership led by Hampshire and IOW Fire and Rescue Service (HIWFRS), has maintained and built upon a multi-agency membership of key HSAB partner agencies and practitioners. The Group continues to regularly review and share learning obtained from serious fire incidents that have occurred across the Hampshire Local Authority area. The aim of this learning is to ensure effective inter-agency processes, procedures and preventative practices are in place, identifying any presenting trends for causes of incidents and to support partner agencies in the management of fire risks for individuals who either require or are receiving care and support Services.

A key area of work progressed throughout 2020.2021 has been the development of the 4LSAB Multi Agency Fire Safety Framework. The framework is a tool to provide all frontline staff with practical support and guidance for the effective management of fire risks within the home and other settings. It aims to provide an awareness to the key risk factors of individuals who have an increased vulnerability towards fire and the early interventions and control measures available to ensure such risks can be managed in the most effective way. The framework also provides a Person Centred fire risk assessment that can be maintained and monitored within an individual's care plan and details of the referral pathway in order for partners to refer an individual to HIWFRS for Safe and Well early intervention activities (home fire safety visits etc).

For the period of 1st April 2020 to 31st March 2021 a total of 5 incidents occurred that met the Fire Safety Development Sub Group criteria for review from within the Hampshire Local Authority area. These included 1 incident resulting in a fire fatality and 4 incidents resulting in either life threatening injuries or the incident being classified as a 'near miss'.

For each of the cases, a full review of the individuals risk factors, their supporting agencies and the cause of incident was conducted by the group. In terms of the identified risk and vulnerability factors, the following themes emerged from the reviews:

- All of the incidents reviewed in 2020.2021 involved an individual who was living alone. This is consistent with data from 2019.2020.

- The average age of the individuals involved in the incidents reviewed for 2020.2021 was 54. The average age from incidents reviewed 2019.2020 was 66

- For 80% of the cases reviewed within 2020.2021 the casualty was male. This is an increase from the cases reviewed for 2019.2020 where 66% of cases were male.

- 20% of the cases reviewed for 2020.2021 were known to Hampshire Adult Health and Care and in receipt of care and support services. This is a reduction from data obtained from cases reviewed for 2019.2020

- In 20% of cases reviewed for 2020.2021 high fire loading / hoarding conditions

were identified. This is a reduction from data obtained from cases reviewed for 2019.2020 where this was identified for 33% of cases

- In 20% of cases reviewed for 2020.2021 poor mobility was identified as a vulnerability factor. This is a reduction with cases reviewed for 2019.2020

- In 60% of cases reviewed for 2020.2021 poor mental health was identified as a vulnerability factor. This is an increase on data obtained from 2019.2020 where 50% of cases identified this as a vulnerability factor.

- In 40% of cases reviewed for 2020.2021 substance misuse was identified as a vulnerability factor. This is a reduction on data obtained from cases reviewed in 2019.2020.

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

- 40% of the incidents reviewed identified carelessness with smoking materials as the most likely cause of the incident. This is a reduction on data obtained from cases reviewed for 2019.2020

- 20 % of the incidents reviewed identified ‘unattended cooking’ as the cause of the incident. This is consistent with the data obtained from cases reviewed for 2019.2020

- 20% of the incidents reviewed identified ‘other causes - accidental’ as the cause of the incident. This is a reduction from the data obtained from 2019.2020 where this was identified for 33% of the cases reviewed

- 20% of the incidents reviewed identified ‘a deliberate act’ as being the most likely cause of the incident.

Hampshire and the IOW Fire and Rescue Service 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.
For the reporting period of 1st April 2020 to 31st March 2021, Hampshire and IOW Fire and Rescue Service reported a total of 253 safeguarding concerns to Hampshire Adults Health and Care.

Paul Francis
Community Development and Safeguarding Manager
Community Safety

Appendix E: Safeguarding data

Safeguarding concerns

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 **12,875** Safeguarding concerns in 2021, which compared to **12,437** in 2020 a small increase of **4%** (**438** safeguarding concerns).

The increase is mainly due to a change in the recording process at point of contact which was implemented in April 2020. Whilst this makes it difficult to compare figures with previous years it does align our recording practice and places us in a good position for comparing data in the future.

Number of concerns which led to a Section 42 enquiry.

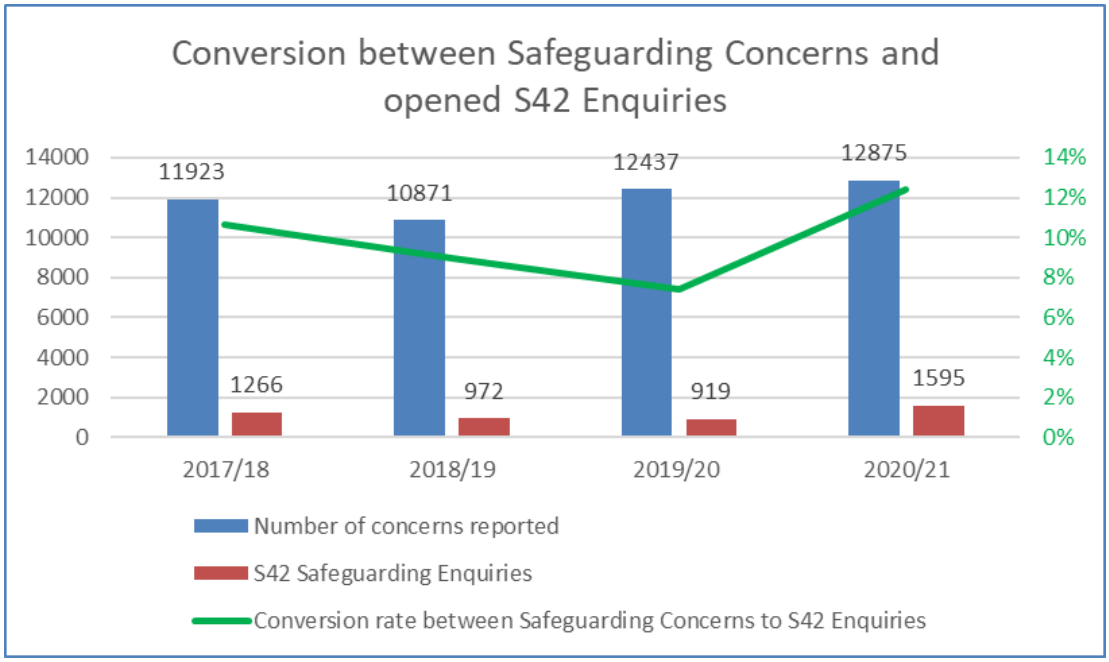
Of the **12,875** concerns reported, **1,595** resulted in a S42 safeguarding enquiry. This represents a conversion rate of **12%** of concerns that were reported progressing to an enquiry.

By adjusting previous years data to reflect the updated process change there has been a **5%** increase on the figures reported in the year 2019/20.

Table to show adjusted figures as a result of the process change.

Year	Adult Safeguarding Concerns recorded	S42 Enquiries opened	% conversion rate between safeguarding concerns recorded and S42 Enquiries opened
2018/19	10,871	972	9%
2019/20	12,437	919	7%
2020/21	12,875	1,595	12%

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.



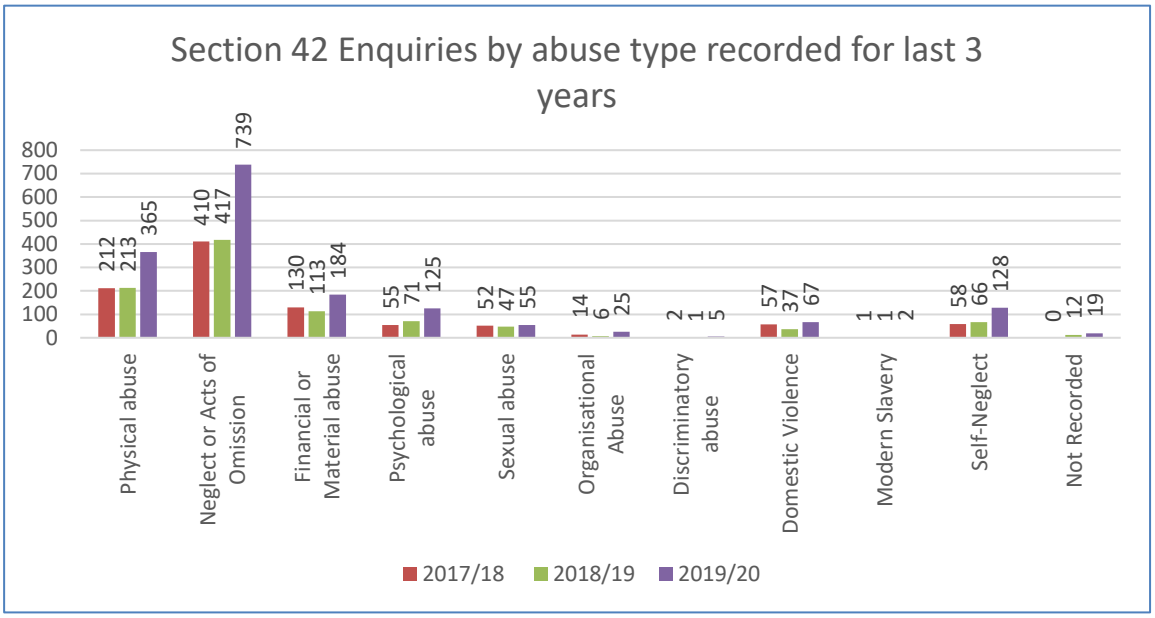
Types of abuse and needs

Of the Section 42 enquiries, there were **739** cases of neglect and acts of omission and **365** physical abuse enquiries. Together, these two categories represent **64%** of all concluded safeguarding enquiries and therefore, account for the majority of the concerns reported.

Types of abuse reported	**2018/19**	**2019/20**	**2020/21**
Physical abuse	212	213	365
Neglect or Acts of Omission	410	417	739
Financial or Material abuse	130	113	184
Psychological abuse	55	71	125
Sexual abuse	52	47	55
Organisational Abuse	14	6	25
Discriminatory abuse	2	1	5
Domestic Violence	57	37	67
Modern Slavery	1	1	2
Self-Neglect	58	66	128
Not Recorded	0	12	19
TOTAL	**991**	**984**	**1,714**

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 1,714 is larger than the 1,595 opened S42 enquiries, owing to the cases in which there*

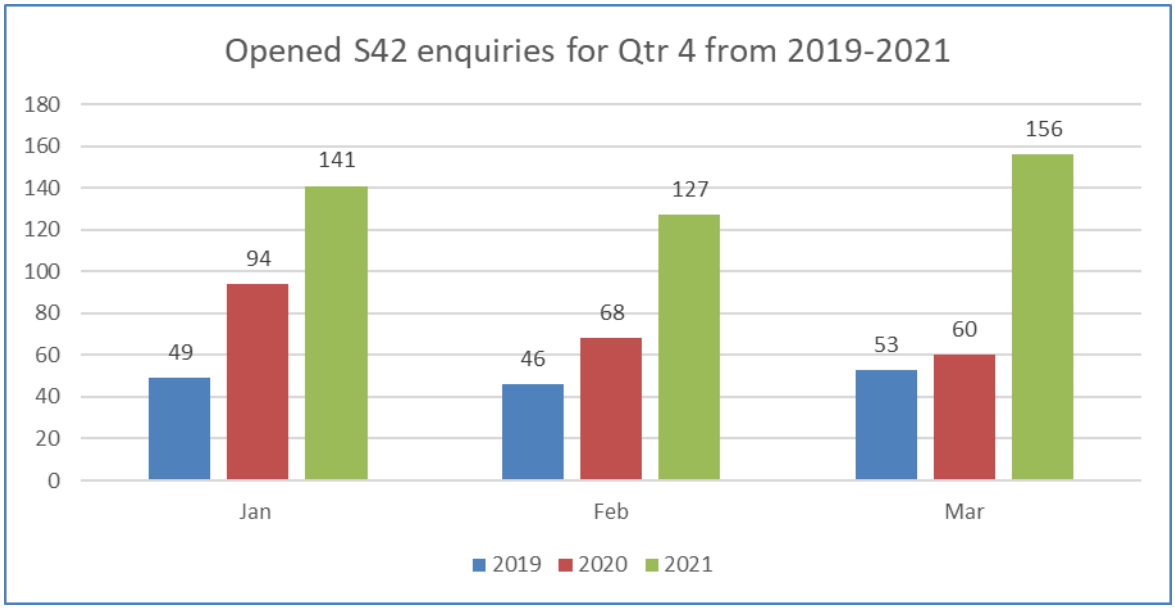
is more than one type of abuse recorded.



Comparison between 2020 and 2021 S42 Enquiries

The graph below shows the number of S42 enquiries which were opened in the period Jan-March 2021 (Qtr. 4) compared to the same period in 2020.

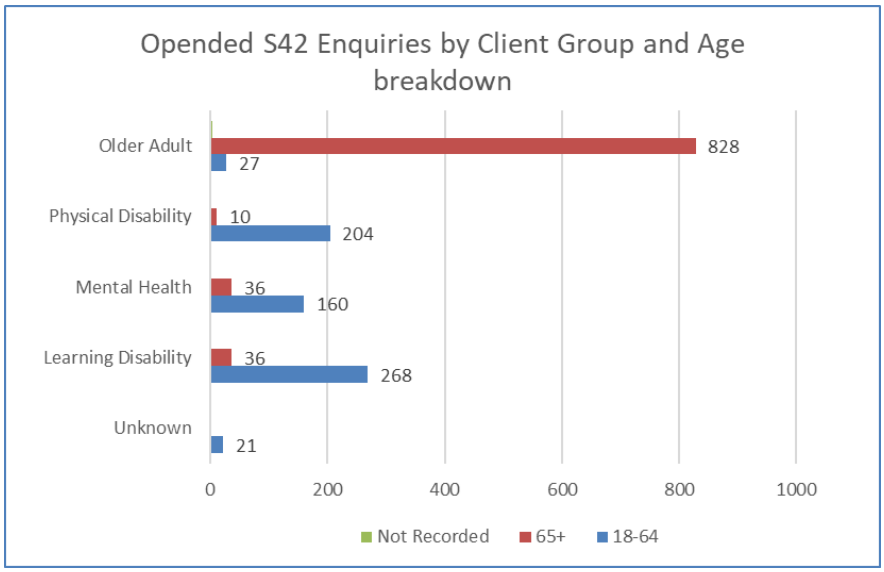
There has been an increase compared to last two years for all months shown.

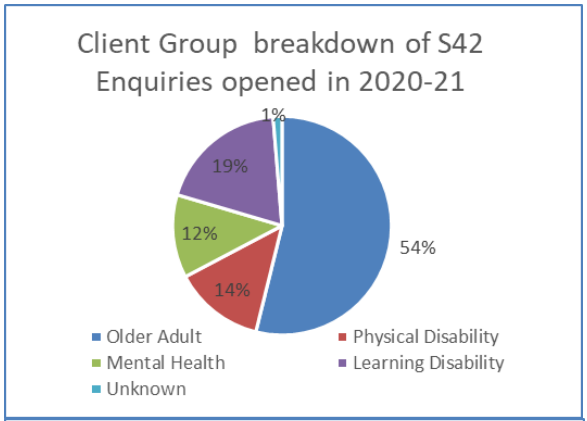


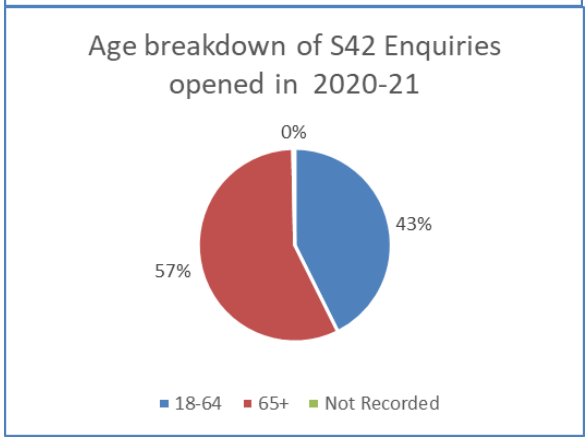
Demographics

Age

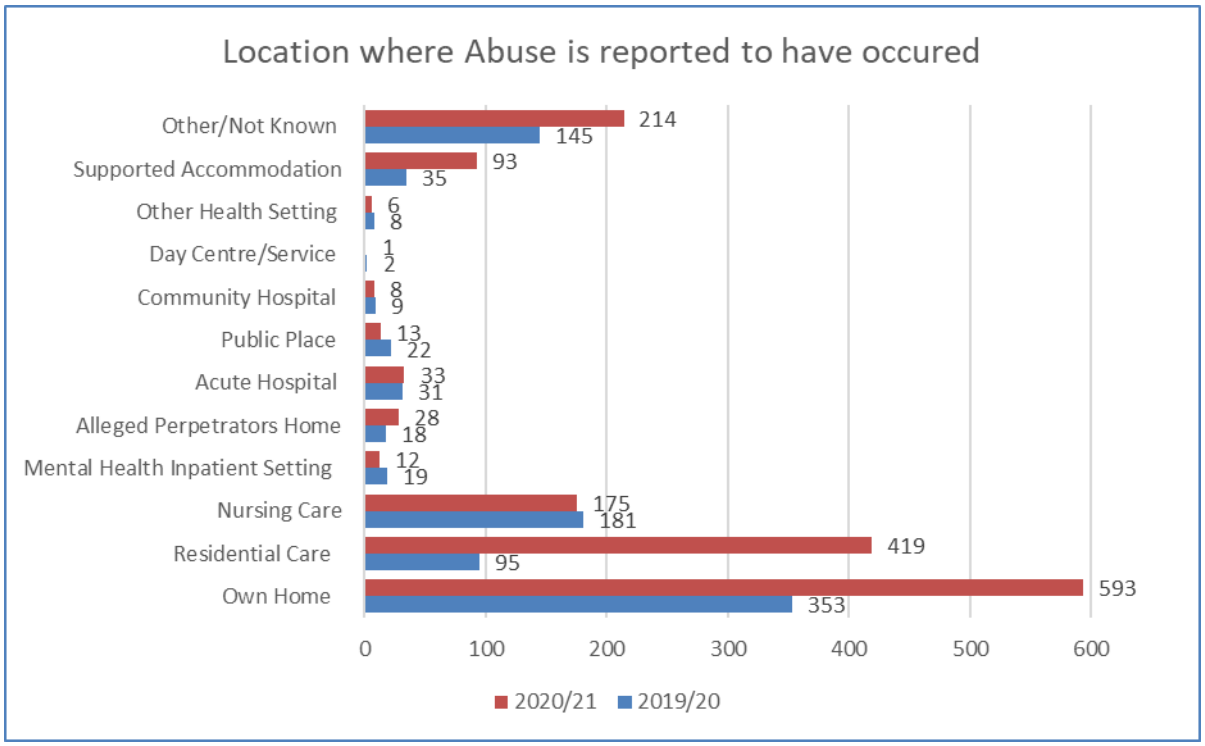
Continuing the pattern of previous years, the majority of adults having a Section 42 enquiry are older adults, that is, adults over 65 years old. This group accounts for a total of **57%** of all enquiries.







Location



Under half of adults, that is **37%** (595 S42 Enquiries), for which Section 42 enquiries were opened, 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 **37%** (594 S42 Enquiries) combined.

Opened S42 Enquiries	2020-21	
	Number	%
Own Home	593	37%
Residential Care	419	26%
Nursing Care	175	11%
Mental Health Inpatient Setting	12	1%
Alleged Perpetrators Home	28	2%
Acute Hospital	33	2%
Public Place	13	1%
Community Hospital	8	1%
Day Centre/Service	1	0%
Other Health Setting	6	0%
Education/Training/Workplace	0	0%
Supported Accommodation	93	6%
Other/Not Known	214	13%

Appendix F: Safeguarding Adult Review Referrals received referral sources 2020/21

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

- Communication Issues
- Complex Health Issues
- Domestic abuse
- Fire Death
- Hoarding
- Homelessness
- Learning Disabilities
- Medication
- Mental Health
- Murder and Suicide
- Old Age and Frailty
- Self-Neglect
- Substance Misuse

Referral sources:

Source	Number
Hampshire Police	5
Hampshire Adult MASH	3
Clinical Commissioning Groups	2
Acute Hospital Trust	2
Hampshire Fire and Rescue	1
HCC Adults Health and Care	1
Family/ Friend	1
Total	**15**

Vulnerability Type:

Vulnerability type*	Number
Mental health	10
Self-neglect	4
Hoarding	3
Complex Health Issues	3
Substance misuse	1
Frail older person	1
Homeless	1
Learning Disabilities	1
Domestic Abuse	1
Total	**25**

* In some referrals, more than one vulnerability type can be identified

Referral by month:

Referrals by month	Number
2020	
April	0
May	1
June	1
July	1
August	4
Sept	0
October	4
November	2
December	1
2021	
January	1
February	0
March	0
Total	**15**

From April 2020, we received a total of 15 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.

Appendix G: HSAB Learning Report

COVID 19 - What did we learn?

Safeguarding during COVID 19

Safeguarding adults with care and support needs has 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 as 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.

Duties and responsibilities relating to safeguarding adults have remained a statutory duty and Sections 42-45 of the Care Act 2014 that relate to safeguarding adults have not changed or been 'eased'. The local authority and HSAB have been required during the pandemic to offer the same level of safeguarding oversight but with an emphasis on proportionate responses and consideration given to the operational pressures providers and others are likely to be under.

The Care Act Easements guidance 2020 clarified that local authorities must continue to offer the same oversight and application of Care Act 2014 Section 42 duties as before, but that responses should be proportionate and mindful of pressures on social care providers.

Safeguarding concerns and risks have increased during the pandemic and so HSAB and partners across health and social care and other sectors are needing to continue to work to prevent and reduce the risk of harm to people with care and support needs, including those affected by COVID-19.

HSAB introduced a COVID 19 Assurance Framework to enable the Board and partner agencies to 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 its strategic plan accordingly in order to continue 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, the focus will be to continue work to prevent and reduce the risk of harm to people with care and support needs.

A key priority for the Board has been to gain assurance from partner agencies about how any impact of COVID-19 on local safeguarding arrangements is being managed. The HSAB COVID 19 Assurance Framework has enabled us to closely monitor the extent to which COVID 19 is impacting on people with needs for care and support and specifically, on the effectiveness of local safeguarding arrangements through HSAB meetings.

During COVID 19, the HSAB has maintained 'business as usual' as far as possible during the pandemic 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. The Board's business continuity plan included making a number of adjustments to working arrangements to ensure effective partnership working and to maintain progress.

Key Priorities

A focus on COVID-19 assurance, recovery and learning has been a key priority. There has been a focus on gaining understanding of key vulnerability factors and risks being experienced during the pandemic impacting on wellbeing and safety of individuals. These have included:

- Presentation of more complex care and support needs and/or safeguarding concerns requiring a higher level of support or intervention due to delays in seeking help.

- 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. HSAB has through its website and social media channels highlighted and raised the profile of this criminal activity as well as arranging for 2 x Financial Abuse awareness workshops to be scheduled as part of the 2021/22 HSAB training programme.

- Isolation both for people living in care homes and in their own homes which can increase the risk of abuse occurring and reduce the likelihood it will be reported and dealt with.

- Reduced contact with adults with care and support needs as a result of services such as day services or lunch clubs, closing 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.

- Further work around COVID-19 related deaths will be undertaken by Adults' Health and Care to understand the progression of the virus across all our care settings. Regarding learning disability specifically, the national Learning Disability Deaths Review Programme (LeDeR) has been incorporated into the work programme of the HSAB Learning and Review Subgroup in order to maintain clear oversight of deaths relating to adults with a learning disability. Additionally there is ongoing work being led by the Local Authority relating to assurance of safe hospital discharge during the pandemic will also be undertaken.

- Nationally, there has been a significant increase in deaths involving adults with a learning disability. From 10 April to 15 May 2020, 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-19 deaths in the Care Quality Commission (CQC) figures.

- Ensuring access routes to services are accessible given the current emphasis on digital access and the potential barriers this may pose to some sections of the population including older people, those with sensory loss, dementia, or other vulnerabilities.

There has also been an increased focus on prevention and early intervention. A key aim in this regard has been to integrate safeguarding and the prevention and intervention agenda across the continuum from the procurement of services through to delivery. This agenda is both promoted and supported by the 4LSAB Multi-Agency Risk Management Framework (MARM) and a key area of focus is to work to embed this approach across a range of activity including high intensity service users, complex hospital discharge, homelessness, safeguarding in transition, etc.

Policy and Guidance - what did we learn?

Having a 4LSAB Policy and Guidance subgroup enables the Board to have 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 published in June

2020. 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. HSAB has held several multi-agency briefings on the Multi-Agency Safeguarding Adults Policy, Guidance and Toolkit

In response to the gap in guidance on the types of circumstances giving grounds for concern and when they should be considered as a referral to the local authority, has been addressed through the publication in Oct 2020 of the 4LSAB S Multi-Agency Safeguarding Concerns Guidance. This guidance reflects the published ADASS/LGA Safeguarding Concerns Guidance published in 2020. Several workshops on the Safeguarding Concerns have been commissioned by the Board to support implementation of this Guidance.

Partner agencies were 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 particularly transitional safeguarding and homelessness. These topics have been added as work streams to the 4LSAB Policy Group's work programme. A cross sector multi-agency transitional safeguarding working group has been established which is developing a new process incorporating MARM, to be published in Autumn 2021. HSAB has also had the opportunity to contribute to the new national transitional safeguarding guidance which included a section on MARM with the work being undertaken on a multi-agency basis involving all relevant partners and stakeholders as appropriate.

The 4LSAB Safeguarding Policy and Guidance is reviewed and updated regularly (every 3 years) this has been undertaken on the framework as a whole. We have learned that this approach is time consuming and difficult to manage. Going forward it has been agreed that future updating will be managed as part of a rolling programme so that future reviews can be achieved in a more manageable and timely way.

Quality Assurance - what did we learn?

HSAB has re-established its own Quality Assurance Subgroup in order to provide better focus on Hampshire's key quality assurance key priorities. The Quality Assurance Framework has been updated as have a number of key tools. COVID assurance has and will continue to be an important area of focus. A number of quality assurance related activities are planned for the coming year including:

- Implementation of our Integrated Scorecard aligned to data collation and analysis for the National Safeguarding Data Insight Project.

- Organisational and Mental capacity Self Audits to be competed in Oct 2021.
- Implementation of a lean audit programme to enable the Board to gain
- assurance about embedding learning into practice from SARs e.g.MCA, transition and cross boundary working, responding to self-neglect.

The HSAB Quality Assurance Group has agreed an Integrated Scorecard to aid data collection and analysis in order to better understand the prevalence of and the patterns and trends in, abuse and neglect of adults with needs of care and support.

To support partner organisations, the HSAB has 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.

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 ofvCOVID-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, equal to the number received in the period 2019-2020. The issues raised in the referrals include concerns about self-neglect and hoarding, substance misuse, homelessness, Learning Disabilities and mental health, medication issues, communication issues, complex health issues, fire deaths, domestic abuse, old age and frailty, attempted murder and suicide. Of these, 7 cases have progressed to a review (all of which are currently in progress). Of these cases there are 6 being considered by way of a thematic review looking at an overarching theme of self-neglect.

Additionally, there are two cases from the previous reporting period that are nearing completion bringing the current total of open SARs to a total of 9. Family involvement wherever possible has been identified and included and consideration of advocacy arrangements applied were this has not been possible.

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 page 38. However, in such cases other learning exercises, either at an individual organisational or multi-agency level can be undertaken.

Given the current challenges presented by COVID-19, the Board has worked with Independent Reviewers to identify a rapid SAR approach to completing the reviews within a shorter timescale than usually expected. Once completed for each of the reviews, virtual ‘learning into practice’ will need to be arranged and provided for with the HSAB’s training offer.