# Hampshire Safeguarding Adults Board

## Annual Report 2021-2022

Hampshire County Council

HSAB
Hampshire Safeguarding Adults Board

# Contents

# Welcome from the HSAB Chair

## Welcome to Hampshire's Safeguarding Adults Board's Annual Report for 2021-22.

The past twelve months have offered little respite from the significant and sustained pressures placed upon the broad range of services across our communities, and the heightened risk of these to safeguarding vulnerable adults from abuse or neglect.

The Covid-19 pandemic continued to compound existing challenges throughout the year and particularly over the winter months. Health and social care system partners faced ongoing recruitment and retention challenges alongside high demand, placing extreme pressure on services. Alongside this, our collective services supporting residents across Hampshire have continued to see not only the new challenges presented by the pandemic, but also the impacts of global political issues. These have ranged from evacuees from Afghanistan and Ukraine, through to soaring living costs resulting from the national and global economic situation.

In all these issues our collective response and underlying commitment is to our residents and seeking to keep vulnerable people safe. Despite our many challenges, these noble aims have remained at the forefront of our intentions and actions.

However, impacts continue to be felt as seen, for example, through an increasing volume and complexity of safeguarding concerns, and in the increase in the number of referrals for Safeguarding Adult Reviews (SARs). This year we have published three SARs – one of which looked across six individual cases of self-neglect.

"Health and social care system partners faced ongoing recruitment and retention challenges alongside high demand, placing extreme pressure on services."

Learning from these tragic cases, and from our response to the pandemic more widely, remained a priority for the HSAB. We took time to review our safeguarding response and invited others to help us improve key areas of safeguarding practice. Notably, I was delighted to engage Professor Michael Preston Shoot in a whole system workshop focused on adult safeguarding and homelessness. The HSAB Housing Sub-group also produced a paper, available on the **HSAB website**, exploring experiences of homelessness within Hampshire and highlighting the importance of taking trauma-informed, joined-up responses.

Our improvement work was further supported this year through an enhanced focus on Quality Assurance, led by the HSAB Quality Assurance sub-group providing regular monitoring and analysis of key safeguarding performance data. This approach is helping to enhance the culture of the HSAB through supporting greater openness and accountability. Enhancing Board culture and effectiveness was the focus of our first HSAB Development Day in November and is a priority I remain fully committed to. This is why we have undertaken extensive engagement on the development of the HSAB's Strategic Plan, giving all partners the opportunity to shape our priorities for the coming year whilst keeping at the fore feedback from residents and those representing the voice of people who use services and their carers.

Our key achievements and areas for future focus are outlined in this report and I would like to thank all partners for their steadfast commitment and contributions to delivering our shared aims and improving safeguarding outcomes for Hampshire's residents. This collective effort has been shaped and sharpened by the ongoing support and challenge of the HSAB Independent Scrutineer, for which I am grateful. I am also deeply grateful for the commitment shown by all our HSAB Members: non-statutory, statutory and more specialist organisations. I was particularly pleased to welcome members from previously unrepresented sectors and an Expert by Experience, on behalf of those using services provided by other HSAB members.

The HSAB's work was further enriched through partnering closely with the Safeguarding Adult Boards for Southampton, Portsmouth and the Isle of Wight. Joint endeavours over the past 12 months resulted in the creation of guidance on modern slavery and human trafficking, a new multi-agency fire safety framework, joint safeguarding homelessness guidance and information on transitional safeguarding. In the context of wider health and care reforms, I hope we will continue to work in partnership for the benefit of our most vulnerable residents.

## Graham Allen

**Chair, Hampshire Safeguarding Adults Board**

**Deputy Chief Executive and Director of Adults' Health and Care, Hampshire County Council**

# Welcome from the HSAB Independent Scrutineer

**As Independent Scrutineer, I work alongside the HSAB providing objective challenge and supporting its development.**

> **...there must be an emphasis on connecting with communities and people, to raise awareness and to enhance resilience.**

There has been significant openness and engagement across the HSAB in developing how it works as well as what it works on. HSAB has identified, and is working to strengthen, aspects of SAB culture that are important foundations for effective safeguarding. These include hearing the range of voices of members and stakeholders, establishing and working together on co-produced priorities, connecting SAB sub-groups firmly into a shared vision and priorities, looking outwards and learning from the wider (and local) evidence base in adult safeguarding, and recognising challenge as positive and responding constructively.

The SAB conducted surveys across stakeholders and its membership. This is illustrative of a renewed commitment to inclusivity. Building on this is important, through facilitating and responding to feedback and challenge from people who may need safeguarding support and from the wider community. The SAB has indicated this is a priority going forward.

I referred in last year's annual report to the significance within SAB's responsibilities of the role in prevention and early intervention. In this context too there must be an emphasis on connecting with communities and people, to raise awareness and to enhance resilience. The Safeguarding App developed in the last year by the HSAB is one part of this engagement.

The HSAB increasingly makes sure that it connects with the wider evidence base as well as local learning. Over the past year this included drawing on national work on homelessness and self-neglect. HSAB has contributed to and drawn on national research and development on Safeguarding Adults Reviews (SARs). The HSAB demonstrates continued commitment to developing its approach to how and when SARs are carried out and to a focus on the extent to which the learning impacts practice and outcomes.

> **"...the effects of the pandemic will continue to be significant for HSAB..."**

A new approach to improvement and learning connects learning from SARs with information from data and other sources. This is important for accountability and assurance. It supports evidence-based decision making on SAB priorities. Board and wider stakeholder workshops will shape local priorities, informed by these insights.

There has been a necessary HSAB focus and positive progress on quality assurance this year. Seeking assurance that local safeguarding arrangements and partners help to protect adults from abuse and neglect is the main objective of a SAB. Engaging (as above) with people and communities is part of this. Further development, such as through greater use of case file audit, targeting areas highlighted (for example by SARs or in data), will further support this. Making greater use of the NHS Digital national Safeguarding Adults' Collection (SAC data) in identifying priorities and as a 'can opener' to dig deeper on local issues will also support progress.

All this development has taken place in the challenging context presented by the Covid-19 pandemic. The HSAB has engaged with national work led by the Local Government Association to support learning from this and local alertness to the impacts and risks for safeguarding adults presented by the pandemic. As I said last year, the effects of the pandemic will continue to be significant for HSAB, 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

**HSAB Independent Scrutineer**

# Hampshire – our local patch

## Hampshire is a large and diverse county bringing together city, coast and country.

It is home to **1.409 million people**, with slightly more women (51%) than men. Hampshire is among the least deprived places in England, but there are pockets that fall within the most deprived areas of the country.

Compared to England, **Hampshire has an older population** structure, with a greater proportion of the population aged 50 years and over and a lower proportion of working age, 20 to 44 years.

- Young people (aged 0-19 years) make up 22.6% of the population compared to 23.6% nationally.
- Hampshire has fewer young working age people (aged 20-44 years) compared to England as a whole; 27.9% in Hampshire compared to 32.4% in England.
- Older people, aged 70 years and over, make up 16.6% of the population compared to 13.4% nationally.
- 1.4% are in the 'oldest old' over 90 years population age group compared to 0.9% in England.

**CITIZENS ARE LIVING LONGER IN POORER HEALTH** – men spend just over 13 years and women spend nearly 17 years of their lives in ill health or needing high levels of support.

**LIFE CIRCUMSTANCES ARE BECOMING MORE UNEQUAL** – in deprived areas men live nearly seven years less and women live nearly five years less than those in the least deprived areas of Hampshire.

**THE POPULATION IS AGING, AND PEOPLES NEEDS ARE GETTING MORE COMPLEX** – over the next five years, the number of residents aged 75 or over is expected to increase by 23%; the number of people aged 18-64 years predicted to have a moderate to serious physical disability is projected to increase by 3%, and the number of people aged 18 years and over predicted to have a learning disability is projected to increase by 11%.

# What is safeguarding?

## The Care Act 2014 Statutory Guidance confirms that "Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect" (14.7).

It is about people and organisations working together to prevent and stop both the risks and experiences of abuse or neglect, whilst at the same time making sure that the adult's wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action. This must recognise that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear or unrealistic about their personal circumstances'.

**Abuse and neglect can take various forms** including physical abuse, domestic abuse, sexual abuse, psychological or emotional abuse, financial or material abuse, modern slavery, discriminatory abuse, organisational or institutional abuse, neglect and acts of omission and self-neglect. Appendix one contains more information about each of these. **The HSAB has also produced a video that helps to explain abuse and neglect and how to report a concern. It is available here: Adult Safeguarding Animation – 4LSAB – YouTube**

The Care Act 2014 introduced **Safeguarding Adults Boards** and gave them the responsibility to seek assurance that there are effective local safeguarding arrangements. These include: to publish an annual report and strategic plan, to commission Safeguarding Adult Reviews, and to hold partner agencies accountable for how they work together to protect adults from abuse and neglect.

The Care Act 2014 requires partner agencies and services to work together to protect adults at risk of abuse and neglect. Joined up safeguarding processes and practice ensure that:

- joint working prevents, reduces or delays the risk of harm to the adult;
- safeguarding concerns are identified and reported to support the adult; and
- those who have a statutory duty to enquire, act in a timely, person centred and co-ordinated way.

Under **Section 42 of the Care Act**, the local authority has a responsibility to undertake an **Enquiry** where there is a concern that an adult with care and support needs is unable to protect themselves when experiencing or at risk of abuse or neglect. If the criteria in Section 42(1) are met, then the local authority must conduct an Enquiry and decide on any action under section 42(2).

Any Enquiry should include an attempt to gain the views of the adult at risk as to what is important to them and what they would like to happen, providing any necessary support such as an advocate. This is called **'Making Safeguarding Personal'**. If the adult at risk has the capacity to make a decision, their wishes must be respected. However, this view must be balanced with an assessment of the risks and an agreement reached as to how these risks will be monitored and managed.

## WHAT THE CARE ACT 2014 STATUTORY GUIDANCE SAYS ABOUT SECTION 42 ENQUIRIES

**4.17** Local authorities should not limit their view of what constitutes abuse or neglect, as they can take many forms and the circumstances of the individual case should always be considered.

## DEPRIVATION OF LIBERTY SAFEGUARDS (DOLS)

If a person needs protective measures to be put in place to keep them safe and is assessed as having lost capacity to make decisions about that particular area, either the local authority or the Court of Protection, depending on the circumstances, can authorise a Deprivation of Liberty Safeguards (DOLS). This gives the service or individual who provides care to a person legal authority to restrict their liberty in a specified way in order to keep them safe. There are strict criteria as to what is appropriate when putting such measures in place. This area currently sits within safeguarding adults in the local authority. The DOLS legislation is due to be replaced by the implementation of Liberty Protection Safeguards.

## THE SIX STATUTORY PRINCIPLES OF ADULT SAFEGUARDING

1. **Empowerment:**
   People being supported and encouraged to make their own decisions and informed consent.
2. **Prevention:**
   It is better to take action before harm occurs.
3. **Proportionality:**
   The least intrusive response appropriate to the risk presented.
4. **Protection:**
   Support and representation for those in greatest need.
5. **Partnership:**
   Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.
6. **Accountability:**
   Accountability and transparency in safeguarding practice.

# Safeguarding is everybody's business


**THERE IS SUPPORT, EMPOWERMENT AND ACCESS TO SOME FORM OF JUSTICE OR RESOLUTION FOR PEOPLE EXPERIENCING ABUSE OR NEGLECT**

# The structure and purpose of the Safeguarding Adults Board

**The Care Act 2014 Statutory Guidance confirms that "the main objective of a SAB is to assure itself that local safeguarding arrangements and partners act to help and protect adults in its area" who meet the safeguarding criteria (chapter 14.133).**

It has a Chair and an Independent Scrutineer who acts as a 'critical friend' to the Board. The HSAB acts as the key mechanism for agreeing how agencies will work together effectively to safeguard and promote the safety and well-being of adults at risk and/or in vulnerable situations.

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'. It agrees objectives, sets priorities and co-ordinates strategic development.

> "The HSAB aims to promote awareness and understanding of abuse and neglect"

> It oversees and leads adult safeguarding across the locality and will be interested in a range of matters that contribute to the prevention of abuse and neglect.

## WHAT THE CARE ACT 2014 STATUTORY GUIDANCE SAYS ABOUT THE ROLE OF THE SAB

**14.134** The SAB has a strategic role that is greater than the sum of the operational duties of the core partners. It oversees and leads adult safeguarding across the locality and will be interested in a range of matters that contribute to the prevention of abuse and neglect. These will include the safety of patients in its local health services, quality of local care and support services, effectiveness of prisons and approved premises in safeguarding offenders and awareness and responsiveness of further education services. The SAB will need intelligence on safeguarding in all providers of health and social care in its locality (not just those with whom its members commission or contract). It is important that SAB partners feel able to challenge each other and other organisations where it believes that their actions or inactions are increasing the risk of abuse or neglect. This will include commissioners, as well as providers of services.

**14.135** The SAB can be an important source of advice and assistance, for example in helping others improve their safeguarding mechanisms. It is important that the SAB has effective links with other key partnerships in the locality and share relevant information and work plans. They should consciously cooperate to reduce any duplication and maximise any efficiency, particularly as objectives and membership is likely to overlap.

The HSAB meets quarterly and is supported by a Board Manager and a small operational delivery team. Its work is delivered through a number of sub-groups, several of which are run jointly with the neighbouring Local Safeguarding Adults Boards for Southampton, Portsmouth and the Isle of Wight 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 and local adult safeguarding forums. Further information on the HSAB sub-groups can be found on the **HSAB website**.

# How to report a safeguarding concern

## A safeguarding concern is raised where there is reasonable cause to suspect that an adult who has, or may have, needs for care and support is at risk of, or experiencing, abuse or neglect. Care Act 2014 Section 42 (1) (a) and (b).

If you are concerned that you or another adult is being neglected, harmed, or abused in any way, please do not ignore it. Any suspicion of abuse or neglect should be reported to Hampshire County Council Adults' Health and Care.

Further contact information can be found on the **Adults' Health and Care help and support webpage.**

- **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 available via the help and support page.

The HSAB **'See it Stop it App'** is available from the **HSAB website** to support with decision making and guidance on what you should do with any concerns you have, as well as contact information to get advice and support.

**0300 555 1386**
Monday to Thursday 8.30am to 5pm
Friday 8.30am to 4.30pm

**Out of hours 0300 555 1373**
Monday to Thursday 5pm to 8.30am
Friday 4.30pm to Monday 8.30am

# Safeguarding activity in Hampshire

## Safeguarding Adults Collection (SAC) data has been collected and published by NHS Digital since 2013.

It reports on the statutory duties of local authorities under the Care Act to safeguard adults from abuse or neglect. It is published annually as a set of national, regional and local **data tables** and via an interactive **data dashboard** providing comparative data. The following extracts are taken from the most recent SAC data for the period 1 April 2019 to 31 March 2020 (published 2021).

### TABLE 1: COUNTS OF SAFEGUARDING ACTIVITY

| LAs | Safeguarding Concerns | Section 42 Safeguarding Enquiries | Other Safeguarding Enquiries | Total Enquiries |
|---|---|---|---|---|
| Hampshire | 12,875 | 1310 | 155 | 1465 |

### TABLE TWO: LOCATION OF RISK

| Location of risk | Number |
|---|---|
| Own home | 550 |
| In the community (excluding community services) | 40 |
| In a community service | 75 |
| Care home – nursing | 170 |
| Care home – residential | 390 |
| Hospital – acute | 20 |
| Hospital – mental health | 10 |
| Hospital – community | 5 |
| Other | 45 |

## TABLE THREE: SOURCE OF ABUSE

| Service Provider | Other – Known to Individual | Other – Unknown to Individual |
|---|---|---|
| 665 | 630 | 20 |

## TABLE FOUR: COUNT OF CONCLUDED SECTION 42 ENQUIRIES BY TYPE

| Type of abuse | Number | Percentage |
|---|---|---|
| Physical abuse | 285 | 21% |
| Sexual abuse | 40 | 3% |
| Psychological abuse | 100 | 7.5% |
| Financial or material abuse | 140 | 10.5% |
| Discriminatory abuse | 0 | 0% |
| Organisational abuse | 15 | 1% |
| Neglect and acts of omission | 620 | 46.5% |
| Domestic abuse | 50 | 4% |
| Sexual abuse | 0 | 0% |
| Modern slavery | 0 | 0% |
| Self-neglect | 85 | 6.5% |

## TABLE FIVE: INDIVIDUALS INVOLVED IN S.42 ENQUIRY BY AGE

| 18-64 | 65-74 | 75-84 | 85+ |
|---|---|---|---|
| 64 | 105 | 253 | 855 |
| 5% | 8% | 20% | 67% |

## TABLE SIX: INDIVIDUALS INVOLVED IN S.42 ENQUIRY BY ETHNICITY

| White | Mixed / Multiple | Asian / Asian British | Black / African / Caribbean / Black British | Other Ethnic Group | Refused | Undeclared / Not Known |
|---|---|---|---|---|---|---|
| 985 | c | 10 | 5 | 5 | c | 295 |

## TABLE SEVEN: INDIVIDUALS INVOLVED IN S.42 ENQUIRY BY PRIMARY SUPPORT REASON

| Physical Support | Sensory Support | Support with Memory & Cognition | Learning Disability Support | Mental Health Support | Social Support | No Support Reason | Not Known |
|---|---|---|---|---|---|---|---|
| 710 | 15 | 95 | 280 | 190 | 25 | c | c |

## TABLE EIGHT: MENTAL CAPACITY OUTCOMES FOR CONCLUDED S.42 ENQUIRIES

| Yes, they lacked capacity | No, they did not lack capacity | Don't Know | Not Recorded | Of the enquiries recorded as Yes, in how many of these cases was support provided by an advocate, family or friend? |
|---|---|---|---|---|
| 95 | 1,215 | c | c | 75 |

HSAB Performance Scorecards also highlight a rising trend in the rate of suicides compared to previous years. This follows the national suicide data upward trajectory of cases, and significant correlations being seen with those living alone (48% of total), unemployment (47%), self-harm (64%) and substance misuse (37-47%)[1].

1 2022 annual report from the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) **https://www.hqip.org.uk/resource/national-confidential-inquiry-into-suicide-and-safety-in-mental-health-annual-report/**

# Report from the Principal Social Worker, Hampshire County Council

## Adults' Health and Care (AHC) has embarked on an extensive programme of safeguarding practice improvement.

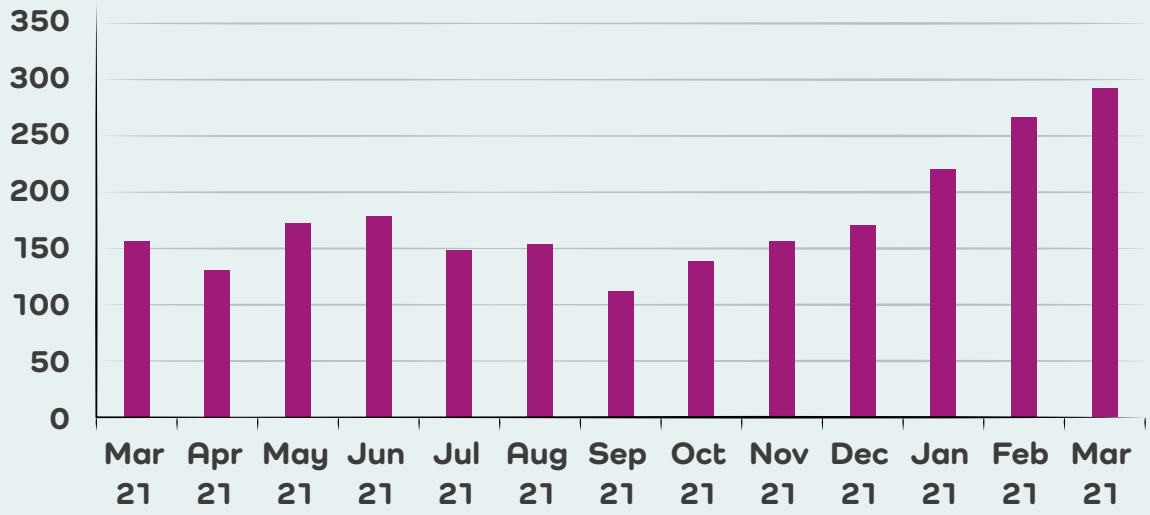
Key areas of impact from the past 12 months include:

**DOUBLING OUR SAFEGUARDING TRAINING**
All operational staff will be required to complete Section 42 Enquiries training within the next two years. A new training dashboard is in place to support better, more accessible monitoring of training uptake and currency. The suite of training was reviewed and updated to take account of new Multi-Agency Safeguarding Adults' Policy and Guidance.

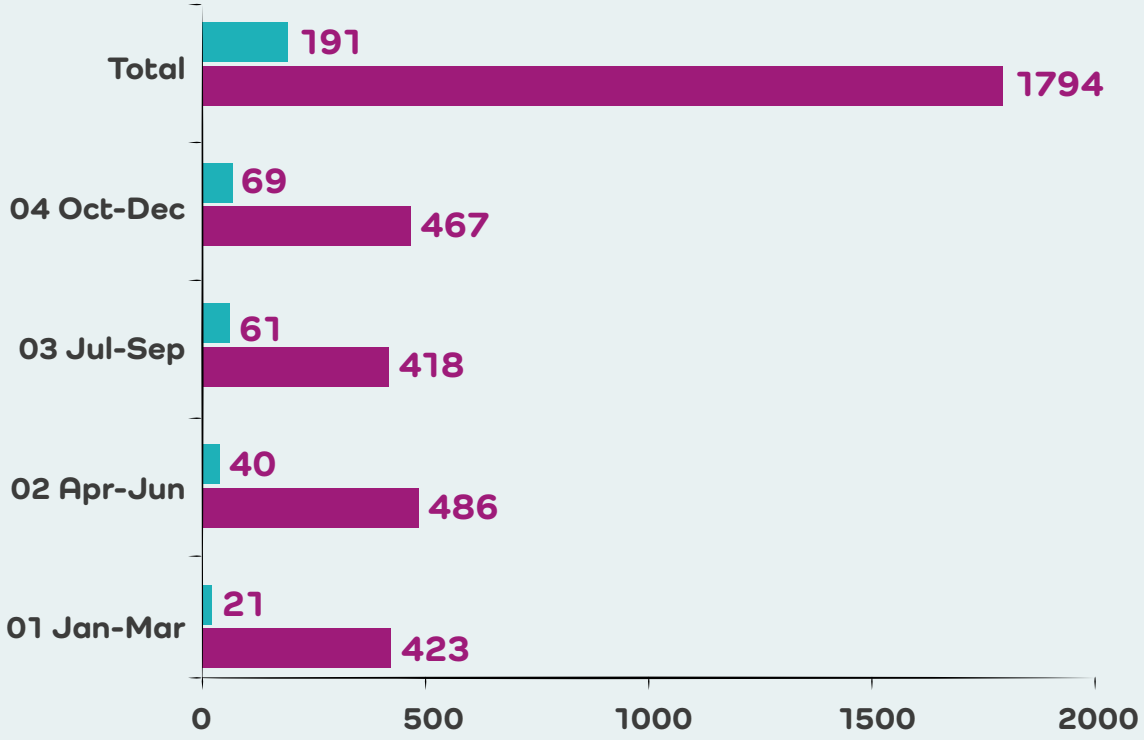
**TRANSFORMING OUR 'FRONT DOOR'** Processes within the Contact Assessment and Resolution Team (CART) and Multi-Agency Safeguarding Hub (MASH) are being reviewed and improved in response to learning from Safeguarding Adult Reviews and weaknesses highlighted through national SAC data. This has started to improve the rate of Section 42 Enquirers – from 156 in March 2021 to 291 in March 2022.

**INCREASED AWARENESS OF SELF-NEGLECT** Local and national data evidence that cases of self-neglect and acts of omission have increased. However, learning from recent local SARs indicated that situations of self-neglect were not consistently recognised as having met the criteria for a safeguarding intervention, and the broader advantage of a multi-agency perspective on the risks. As a result, the Department has worked to raise awareness across staff. This is taking effect as the number of recorded Section 42 Enquiries related to self-neglect increased from 21 cases in Q1 to 69 cases within Q4. By recognising self-neglect as safeguarding, people will follow a more structured pathway of professional support reducing the risk of anyone falling through a gap.

## NUMBER OF S42 ENQUIRIES OPENED IN SG MODULE - ALL SERVICES MARCH




## NUMBER OF S42 ENQUIRIES AND THE NUMBER OF THOSE RELATED TO SELF NEGLECT 2021



**PRODUCING NEW OPERATIONAL GUIDANCE TO SUPPORT MULTI-AGENCY RISK ASSESSMENT CONFERENCES (MARAC)** in partnership with Public Health and the Police. A new resource was also introduced to CART to ensure appropriate links through for adults in need of care and support who are victims of domestic violence.

**INTRODUCING A NEW SENIOR SOCIAL WORKER ROLE**

Social workers meeting a required standard of practice are renumerated for taking on professional lead roles. We now have 30 Senior Social Workers with a safeguarding lead role to ensure a good standard of practice within teams. National and local updates including themes from Safeguarding Adult Reviews are being embedded within the Senior Social Worker programme to help drive improvement.

**CONTINUING TO INVEST IN ATTRACTING AND RETAINING TALENT** including through the launch and delivery of our **Call to Care campaign**, although staff recruitment remains a significant challenge locally as it does nationally. Feedback from participation in the Local Government Association's Health Check – a survey of social work staff on the extent to which they view their employer as adhering to key standards – indicated that AHC staff saw strong supervision as a reason for staying. The Standard that ranked highest was having a 'strong and clear social work framework' whereas the lowest was Continuous Professional Development (CPD). In response, a social work conference is planned to celebrate and support staff CPD.

**SUPPORTING THE WIDER HEALTH AND CARE MARKET** through our commissioning and provider quality work. This included assisting providers to vaccinate their staff against Covid-19 and respond effectively to outbreaks where these did arise (often within settings where vaccination uptake was low). Support to the market will remain a key focus for AHC, particularly as we seek to navigate nationally driven social care **charging reforms** and introduction of the 'fair cost of care'.

**INTRODUCING A SAFEGUARDING PRACTICE AUDIT TOOL** within AHC, in relation to Section 42 Enquires, which includes an online questionnaire completed by practitioners and managers at regular intervals through the year, to support practice improvement.

# Learning from our Safeguarding Adults Reviews

**A key statutory duty of the SAB is to carryout Safeguarding Adult Reviews (SARs) as appropriate under Section 44 of the Care Act.**

The purpose of the SAR is to gather the facts about a case and make recommendations, in order that system partners can learn lessons and improve future practice to achieve better outcomes for adults at risk.

## EMERGING TRENDS – INCREASE IN SAR REFERRALS AND COMMISSIONS

The number of SAR referrals received by the HSAB Learning and Review sub-group, and the number of SARs commissioned, since 2019 have increased, coinciding with the Covid-19 pandemic. Whilst the number of referrals reduced in 2021, a significantly higher proportion (60%) of those referrals met SAR criteria resulting in a continuing high level of SAR commissions.

| | Jan 2019 – Dec 2019 | Jan 2020 – Dec 2020 | Jan 2021 – Dec 2021 |
|---|---|---|---|
| No. of SAR referrals received | 11 | 22 | 10 |
| No. of referrals agreed to meet criteria | 3 | 7 | 6 |
| Percentage of referrals that met SAR criteria | 27% | 32% | 60% |
| No. of SARs commissioned | **3** | **7** | **6** |

In the past year, the HSAB has published three SARs:

| The Vicky SAR | |
|---|---|
| **SAR report** | The report was published in September 2021.<br>**The full report can be found here.**<br>**The learning summary can be found here.** |
| **Overview** | Vicky was a young woman who was ambivalent about engaging with services at times. Vicky was exploited by people she thought were her friends, when her flat was taken over to sell drugs. Vicky died following a decline in her physical and mental health that worsened after she became homeless. |
| **Practice issues** | • **Safeguarding response to suspected cuckooing** had limited impact. (Cuckooing is the practice of taking over the home of a vulnerable person to establish a base for illegal drug dealing).<br>• **Ineffective multi-agency response** to Vicky's infringement of her tenancy responsibilities.<br>• **Lack of joined-up response** when Vicky became homeless and increasingly vulnerable. |
| **Key system learning** | • **Risks associated with an adult who is ambivalent about engaging with services** – adults who appear to have mental capacity and make 'unwise' decisions involving personal risks may still be vulnerable and find it difficult to access support.<br>• **Providing support packages for adults who are homeless** – homeless adults with care and support needs can be further disadvantaged when placed in emergency accommodation without a support package outside their 'home' area and usual network of support and services. |

| The Vicky SAR | |
|---|---|
| **Improvement actions achieved since publication of the SAR** | **Working with mental capacity**<br>• A new approach to training in relation to Mental Capacity Assessment (MCA) was developed within Adults Health and Care and a new online training platform was implemented for MCA by the Clinical Commissioning Group. Primary care master classes are to be offered alongside wider master classes.<br>**Developing communication pathways in primary care**<br>• The Clinical Commissioning Group is leading work to review information sharing across epilepsy and mental health services to improve access to records and effective communication.<br>**Strengthening preventative support for adults experiencing self-neglect and homelessness**<br>• Adults Health and Care is seeking to pilot a support service to work with people referred to the Multi Agency Safeguarding Hub due to a concern regarding self-neglect, hoarding, substance use, homelessness and linked issues where the individual may have needs under Section 42 of the Care Act. The aim is to support individuals to access support networks, to improve their social circumstances and prevent harm occurring.<br>• A poster in relation to homelessness to assist in awareness raising is in development by the Clinical Commissioning Group. This will be added to a resource library and shared at the four Local Safeguarding Adults Boards' Health sub-group.<br>**Working with risk and Multi Agency Risk Management (MARM)**<br>• Training for GPs now includes the Multi-Agency Risk Management framework and learning from Safeguarding Adult Reviews (SARs). This is further supported by podcasts, clinical supervision, and master class sessions. GPs are supported at MARMs by designated nurses and named GPs. |

| The Self Neglect Thematic SAR | |
|---|---|
| **SAR report** | The report was published in March 2022.<br>**The full report can be found here.**<br>**The learning summary can be found here.** |
| **Overview** | The SAR drew out learning from six cases where adults had sadly died in circumstances involving self-neglect, most of the deaths had taken place during the first year of the Covid-19 pandemic. |
| **Practice issues** | • Practitioners should identify **what type of engagement a person can tolerate** initially.<br>• **Professional curiosity** is needed, alongside identifying windows of opportunity to engage.<br>• **Practitioners struggle to assess capacity** when people misuse substances.<br>• **Executive capacity** (i.e., the degree to which addiction or other trauma stops the person acting on their decision) needs to be understood in each case. |
| **Key system learning** | • **Services should not disengage from high-risk self-neglect situations** on the assumption that the person is making a capacitated choice to refuse support.<br>• **Guidance is needed on balancing a person's rights** to privacy with the duty of care.<br>• Increased awareness is needed across agencies of the local authority **duty to assess care and support needs (Care Act 2014 s. 11)** if the person is at risk of abuse or neglect. |
| **Initial improvement actions** | • SAR Learning workshops have been arranged (spring/summer 2022).<br>• Training has included an increased focus on professional curiosity. |

| The Sam SAR | |
|---|---|
| **SAR report** | The report was published in March 2022.<br>**The full report can be found here.**<br>**The learning summary can be found here.** |
| **Overview** | Sam was a young man who experienced loss and trauma in childhood and struggled with mental health as a teenager, requiring input in hospital and residential school. The SAR identified ways in which local services could have worked more effectively in a more co-ordinated way to support Sam through transition to adulthood. |
| **Practice issues** | • There is a need for greater **understanding of trauma, re-traumatisation and trauma informed approaches.**<br>• A **holistic focus on the person** and the support they require to maximise their wellbeing is needed.<br>• **Better engagement with and support to carers** is needed including through an improved understanding of when to identify carers and refer them to the local authority for a carers' needs assessment. |
| **Key system learning** | • **Meeting eligibility criteria** and the **absence of a commissioned service** can present challenges.<br>• There is need to improve understanding and confidence across the system of **when to raise an adult safeguarding concern.**<br>• Awareness raising is needed across the system of the **adult's right to advocacy** in the community, and for detained patients.<br>• It is important to know what **domestic abuse services** are available, including for carers who need to protect themselves from abuse by a family member. |
| **Initial improvement actions** | • SAR Learning workshops have been arranged (spring/summer 2022). |

# Learning from our Fire Safety Reviews

**The four Local Safeguarding Adults Boards' Fire Safety Development sub-group continues to review and share learning from serious fire incidents to ensure effective inter-agency processes, procedures and preventative practices are in place.**

For the period of 1st April 2021 to 31st March 2022 a total of five fatal incidents occurred that met the Fire Safety Development sub-group criteria for review from within the Hampshire local authority area. It should be noted that for four of the fatalities reviewed, the cause of death is yet to be determined due to the cases currently awaiting Coroner's verdict. One of the fatalities has been determined as a fire fatality by the Coroner.

- For each of the cases, a review of the individual's risk factors, 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 for 2021-22:

- 60% of the incidents involved an individual who was living alone.

- The average age of the individuals involved was 77 (compared to 54 the previous year).

- For 80% of the cases the casualty was male (consistent with the previous year).

- 0% (none) of the cases were known to Hampshire Adults' Health and Care and in receipt of care and support services. This is a reduction from cases reviewed during 2020-2021, when 20% were known and in receipt of services.

- In 20% of cases high fire loading / hoarding conditions were identified (consistent with the previous year).

- In 60% of cases poor mobility was identified as a vulnerability factor. This is an increase from cases reviewed for 2020-2021 when 20% of cases identified had this vulnerability.

- In 20% of cases poor mental health was identified as a vulnerability factor. This is a decrease from 2020-2021 when 60% of cases identified had this vulnerability.

- In 0% (none) of cases substance misuse was identified as a vulnerability factor. This is a reduction from cases reviewed in 2020-2021 when 40% of cases identified had this vulnerability.

Reviews highlighted the following trends in the causes of fire incidents:

- 100% incidents reviewed identified the cause as 'accidental'.

- 20% of the incidents reviewed identified carelessness with smoking materials as the most likely cause. This is a reduction from cases reviewed for 2020-2021 when 40% of cases had this identified as the cause.

- For 20% of the incidents reviewed the cause of fire was either an 'electrical fault' or 'unattended cooking' resulting in an 'undetermined' cause.

- 60% of the incident reviewed identified 'electrical fault' as the cause of the incident.

Hampshire and the Isle of Wight 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 2021 to 31st March 2022 the Service completed 4,525 Safe and Well visits within the Hampshire local authority area. Over the same period, a total of 282 safeguarding concerns were reported by the Service to Hampshire Adults' Health and Care.

# Delivery against the 2021-22 Strategic Plan

## The HSAB's three key strategic priorities of Prevention, Protection and Learning have been responded to by partner agencies and the HSAB sub-groups over the past year.


Key achievements are detailed throughout this report. In addition, partners and sub-groups highlighted the following **areas of progress**:

Hampshire Police created an **Adult at Risk Strategic Delivery Plan** which has been shared and incorporated throughout the organisation. The plan was written following consultation and scoping to identify national best practice and cross references other strategic plans in relation to domestic abuse, self-neglect and mental health.

**Extensive organisational training** was provided within the Multi Agency Safeguarding Hub on ways that Police Officers can consider the needs of victims during initial contact, as well as throughout investigations. This supports Making Safeguarding Personal and the Victim's Charter, which remain central to the Police ethos.

Following on from the HSAB 2021 stakeholder survey, further messages from our Safeguarding Adults Reviews and feedback from stakeholders has emphasised the increasing importance of proactive support to **prevent carer breakdown** and occurrence of abuse or neglect. This will be an important focus during 2022-23.

The HSAB Health sub-group was repositioned as a four Local Safeguarding Adults Board sub-group for the Hampshire, Southampton, Portsmouth and Isle of Wight geography. The Clinical Commissioning Group continued to support their regular safeguarding chronicle – a newsletter packed with topical safeguarding updates.

The HSAB team worked with the HSAB Stakeholder sub-group to **review and relaunch the 'See it Stop it' App.**

A **series of roadshows** are planned which will be rolled out to community venues over the coming year to disseminate information and engage with local people.

A **dedicated homelessness session** was delivered with Professor Michael Preston-Shoot to raise awareness of learning from national Safeguarding Adult Reviews and research on safeguarding adults who face homelessness – and to consider how Safeguarding Adult Boards can promote positive practice. In addition, a discussion paper was produced by the Housing sub-group exploring the systemic barriers to achieving a more joined up response to adults who are homeless and face safeguarding risk, using case studies from across Hampshire.

In October 2021, the four Local Safeguarding Adults Boards worked together to support the Hampshire and Isle of Wight Fire and Rescue Service launch the newly developed **Fire Safety Framework**, which has drawn from valuable learning in respect of fatal fire incidents.

Throughout 2021-22 the work of the Quality Assurance sub-group has **strengthened its systematic analysis and use of data** from a variety of information sources to create a **culture of supportive challenge that drives improvement**. This was further supported by completion of the four Local Safeguarding Adults Board self-assessment audit and participation in the National Safeguarding Adult Boards Chairs' Survey.

The HSAB invested in strengthening Board culture and effectiveness through a series of **Board Development Days** held during the second half of the year, supplemented by a Board member survey of key priorities. Across these events Board members and wider stakeholders considered a broad range of evidence, shared their views on what they felt the Board should focus on strategically, and co-produced a revised set of strategic priorities and underpinning objectives.

**"Board members and wider stakeholders considered a broad range of evidence, shared their views on what they felt the Board should focus on strategically, and co-produced a revised set of strategic priorities and underpinning objectives."**

# Communication and partner engagement

**The HSAB Stakeholder sub-group continues to be the conduit for promoting awareness of safeguarding adults, involving all key stakeholders in developing a strategy to promote the awareness and prevention of abuse or neglect of adults at risk.**

The **'See it Stop it' App** was reviewed and refreshed by the Stakeholder sub-group and released in February 2022. This review included revisions around the ease of use as well as accessibility. Since the refresh, the App has been downloaded over 300 times. The App offers:

- Information about the signs and symptoms of abuse.
- Guidance on what you should do if you are concerned.
- Important telephone numbers.
- Information for professionals, including links to further information and useful websites.

The HSAB continued to foster close working with **neighbouring Safeguarding Adults Boards** and the Hampshire Safeguarding Children Partnerships, to align priorities, coordinate work programmes and training wherever possible. For example, the Housing and Health sub-groups now span the four Local Safeguarding Adult Boards across the whole pan-Hampshire area (Hampshire, Portsmouth, Southampton and the Isle of Wight).

The **HSAB website** continued to be a well-used source of information for partners and the wider public. The most popular webpage was the 'Learning from

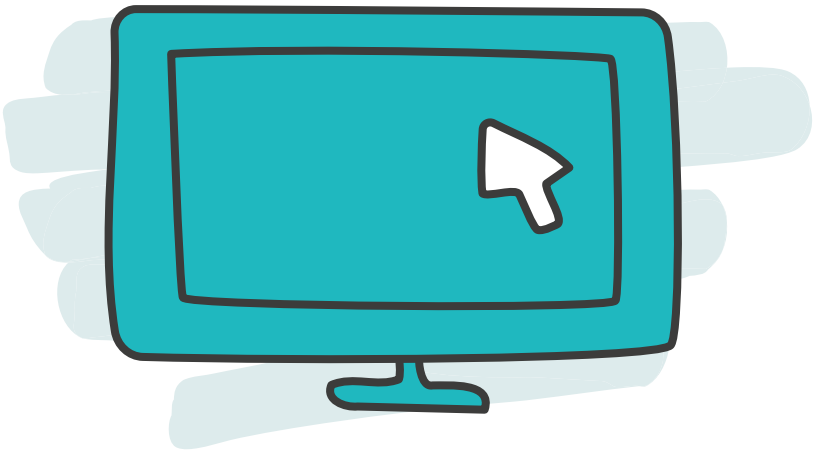
Experience database' which houses national and historical safeguarding reviews. The website will be refreshed during 2022-23.

**National Safeguarding Week** (15-22 November 2021) allowed the HSAB to shine a spotlight on different aspects of abuse and themes relating to adults at risk. In conjunction with the other three Adult Safeguarding Boards across the area, (Isle of Wight, Portsmouth and Southampton), themes were identified for the week that focussed on topical issues based on local experience and knowledge. Collaboration on these themes allowed the Safeguarding Adults Boards to 'speak with one voice' across the whole area, by sharing national and local material and promoting core messages across social media channels.

The themes were:

Emotional abuse and mental health, domestic abuse, fraud, scams and cybercrime, homelessness, safeguarding and you, loneliness and social isolation, prevention and safeguarding in local communities.

During the week, HSAB social media reached a total of 37,540 people (17,349 on Facebook and 20,191 via Twitter).



# Safeguarding events and training programme

## 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**.

During the course of the Covid-19 pandemic, the HSAB innovated to develop a virtual training offer, enabling its training programme to resume from January 2021. **In 2021-22 the HSAB delivered 17 multi-agency training events, with attendees totalling 1,183**.

The HSAB also contributed to three Family Approach training events run by the Hampshire Safeguarding Childrens Partnership.

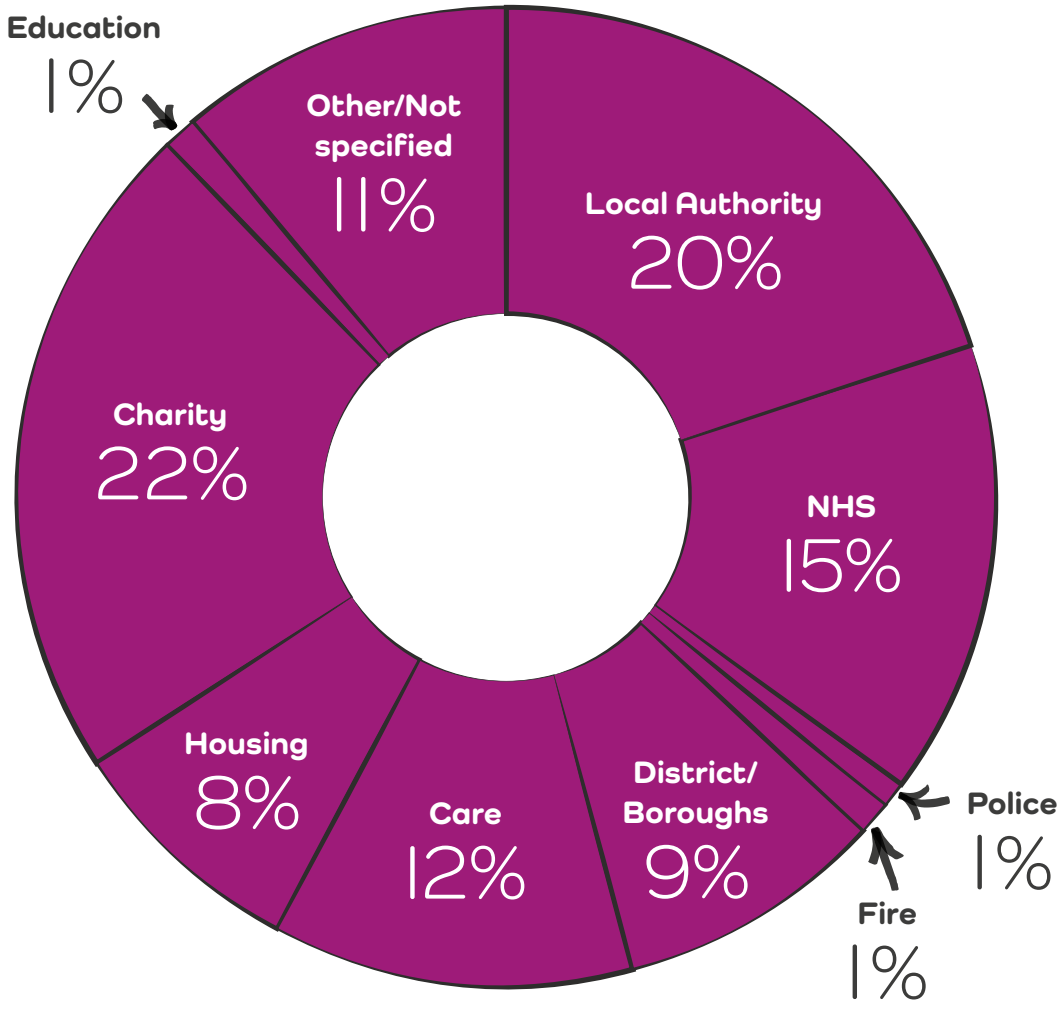
'Knowledgeable speakers who delivered well'

'These workshops are brilliant, very useful and informative'

'Real life case studies are relevant and relatable – good way of learning'

| Course topic | No. of sessions |
|---|---|
| Multi agency safeguarding policy briefing | 3 |
| Safeguarding adults lead network event | 1 |
| Financial abuse | 2 |
| Good practice in self-neglect | 2 |
| Safeguarding in transition | 2 |
| Homelessness and adult safeguarding | 1 |
| Safeguarding concerns guidance | 4 |
| Multi-agency risk management framework | 1 |
| Domestic abuse and adult safeguarding | 1 |

## BREAKDOWN OF ATTENDEES BY SECTOR FOR COURSES RUN IN 2021-22



# Looking ahead

**This annual report references a range of 'green shoots' – new beginnings which we must seek to nurture and grow over the coming year.**

> **We will continue to work in an agile way, recognising the need to respond effectively to new agendas and ongoing challenges.**

These include, for example, strengthening our approach to **quality assurance** and establishing a new **System Improvement and Learning Framework** to ensure that a wide variety of national and local information sources combine to support evidence-based decision making. The HSAB will also maintain its focus on staff training to ensure consistency in the quality of multi-agency responses to adults at risk, recognising that several partners have a substantial new workforce or face high turnover of staff.

We will continue to work in an agile way, recognising the need to respond effectively to new agendas and ongoing challenges. This will be particularly important considering the Government's **health and care reform agenda** and other significant, **anticipated legislative changes** including, for example, the introduction of Liberty Protection Safeguards.

HSAB will also continue to invest time and energy in developing further its **culture** and **inclusive approach**. This is foundational to successful delivery of our revised, co-produced strategic priorities for 2022-2025. These are to:

1. **Foster a shared understanding of what a 'safeguarding concern' is**, who to take concerns to and what will happen next.

2. **Empower people and those who help them** to draw on their knowledge and expertise to **make safeguarding personal**, listening and acting on people's insights and lived experiences.

3. **Support the effective identification, assessment and coordinated management of risk** in a way that balances different perceptions of risk whilst preventing or reducing the impact of harm.

**Across these priorities, we will maintain our focus on providing effective support to unpaid carers.**

**We will continue to review and test how we are doing, challenging and holding one another to account. We will do this by:**

- Tracking compliance with statutory duties
- Scrutinising data and performance indicators
- Seeking feedback from people – service users, carers, families and staff
- Undertaking self-assessment and increasing use of bespoke audits
- Working more effectively in partnership
- You can read our **Strategic Plan in full** on the **HSAB website.**

# HSAB Financial summary 2020-21

## This year the Board completed a review of its resources in response to an increase in core statutory responsibilities, particularly Safeguarding Adult Reviews.

The review highlighted that to sustain current activity levels, and deliver on its ambitions, the Board required an investment in its capacity. Engagement with the Board led to agreement to seek additional partner contributions for the coming year, which has been built into the 2022-23 budget.

The Board will continue to seek and take opportunities to work efficiently delivering value for money, avoiding duplication, and partnering with neighbouring Safeguarding Adults Boards where appropriate.

### CORE BUDGET INCOME AND EXPENDITURE 2021-22

| Income source 2021-22 | Amount (Rounded, £) |
|---|---|
| Hampshire County Council | 95,000 |
| Hampshire Clinical Commissioning Group | 39,000 |
| Hampshire Constabulary | 17,000 |
| **Total** | **£151,000** |

| Item | Expenditure 2021/22 (Rounded, £) |
|---|---|
| **Administrative costs**, including IT services and equipment, printing, stationary, postage, meeting venues and refreshments | 490 |
| Safeguarding Adult Reviews | 11,000 |
| Business management (staffing) | 175,000 |
| Independent Scrutineer | 22,000 |
| Staff travel | 50 |
| **Total** | **209,000** |
| **Net expenditure / income** | **58,000*** |

The HSAB Reserve Fund exists to support in-year costs not accounted for in the budget, allowing the Board to flex and respond to areas of increased activity in-year. These costs reflect investment in Board Management and Scrutineer capacity to deliver priority Board development work and were able to be met through efficiencies in non-staffing budgets.

## RESERVE BUDGET INCOME AND EXPENDITURE 2021-22

| Income source 2020-21 | Amount (Rounded, £) |
|---|---|
| Underspends carried forward | 52,000 |
| Safeguarding Adults Review (Accrual) | 10,000 |
| **Total** | **62,000** |

| Item | Expenditure 2021/22 (Rounded, £) |
|---|---|
| Administrative and communications | 2,900 |
| Staffing administrative support | 13,900 |
| HSAB website/hosting | 2,100 |
| Training | 1,000 |
| **Total** | **19,900** |

| | |
|---|---|
| **Net expenditure / income** | **42,100** |

# Appendix one

## What is abuse and neglect?

**Abuse and neglect can happen to anyone, whatever their circumstances and can be carried out by anyone. This could be family, friends, neighbours, paid staff, carers, or volunteers. It could also be strangers.**

| Types of abuse | Behaviours include |
|---|---|
| **PHYSICAL** | Hitting, slapping, pushing, kicking, misuse of medication, restraint, or inappropriate sanctions. |
| **SEXUAL** | Rape, indecent exposure, sexual harassment, inappropriate looking or touching, sexual teasing or innuendo, sexual photography, subjection to pornography or witnessing sexual acts, indecent exposure and sexual assault or sexual acts to which the adult has not consented or was pressured into consenting. |
| **PSYCHOLOGICAL** | Emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, cyber bullying, isolation or unreasonable and unjustified withdrawal of services or supportive networks. |
| **FINANCIAL OR MATERIAL** | Theft, fraud, exploitation, pressure in connection with wills, property, inheritance or financial transactions, or the misuse or misappropriation of property, possessions, or benefits. |
| **NEGLECT AND ACTS OF OMISSION** | Ignoring medical or physical care needs, failing to provide access to appropriate health, social care, welfare benefits or educational services, withholding the necessities of life such as medication, adequate nutrition and heating. |

| Types of abuse | Behaviours include |
|---|---|
| **DISCRIMINATORY** | Racism, sexism, or acts based on an adult's disability, age or sexual orientation or other protected characteristics. It also includes other forms of harassment, slurs, or similar treatment such as disability hate crime. |
| **DOMESTIC ABUSE** | Psychological, physical, sexual, financial, emotional abuse and so called 'honour' based violence by those who are or have been intimate partners or family members. |
| **ORGANISATIONAL ABUSE** | Neglect and poor care practice within a care setting such as a hospital or care home or in relation to care provided in someone's own home ranging from one off incidents to on-going ill-treatment. It can be neglect or poor practice as a result of the structure, policies, processes, or practices. |
| **MODERN SLAVERY** | Encompassing slavery, human trafficking, forced labour and domestic servitude. Traffickers and slave masters use whatever means they have at their disposal to coerce, deceive, and force individuals into a life of abuse, servitude, and inhumane treatment. |
| **SELF-NEGLECT** | Covers a wide range of behaviour including neglecting to care for one's personal hygiene, health or surroundings and behaviour such as hoarding. |

# Appendix two

## HSAB membership and key partners

### THE BOARD CONSISTS OF THE FOLLOWING MEMBERSHIP

Chair
Independent Scrutineer

### SUPPORT TO THE HSAB

Board Manager
Business 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 and IOW Fire and Rescue Service
Hampshire Care Association
Hampshire County Council Children's Services Department
Hampshire County Council Mental Health Department
Hampshire County Council Public Health
HMP Winchester
National Probation Service (South Central)
NHS Acute Hospital Trusts
NHS East Berkshire CCG
NHS England

# HSAB membership and key partners continued

## ASSOCIATE MEMBERS

NHS Frimley CCG
Solent NHS Community Trust
South Central Ambulance NHS Foundation Trust
Southern Health NHS Foundation Trust
Surrey and Borders Partnership NHS Foundation Trust
Trading Standards

## ADVISORY

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