Hampshire Safeguarding Adults Board

Safeguarding Policy and Practice Update June 2018

This bulletin provides a round up of recent national policy news, publications, consultations and articles relating specifically to adult safeguarding. A brief summary and link to the original webpage document is provided for each item.

Domestic Abuse	**HDAP Hampshire Domestic Abuse Strategy 2017-22 (updated May 2018)**
Published by: Hampshire Domestic Abuse Partnership	
This strategy has been updated to ensure it is inclusive of all victims and perpetrators of violence, abuse and controlling behaviour, but acknowledges that the prevalence of physical assaults from a partner or adult family member is higher among females than among males. Irrespective of gender or sexual orientation women experience more repeated physical violence, more severe violence, much more sexual violence, more coercive control, more injuries and more fear of their partner1. This strategy will also encompass the needs of children and young people and vulnerable adults who are affected by domestic abuse . **Publication date: May 2018**	

Mental Health	**Minding Our Future**
Published by: Universities UK (UUK)	
UUK's has published new guidance to improve the coordination of care between the NHS and universities so that all students can access the care they need. The guidance highlights that almost half of all school leavers now go on to university. With 75% of all mental illness developing by the age of 24 years, this can be a time of vulnerability for young adults. Research by the IPPR found that over the past five years, 94% of universities have experienced a sharp increase in the number of people trying to access support services, with some institutions noticing a threefold increase. The Office for National Statistics reports an increase in deaths by suicide in full-time students in England and Wales from 2006 until 2016. As students are becoming adults they are also taking on the challenges of higher education, independent living and making new friends. At the same time, they are moving between their homes and university. This means they may slip through the gaps in the health system when they are most vulnerable. **Publication date: May 2018**	

Forced Marriage	**My marriage, My Choice Toolkit**
Published by: Nottingham University	
My Marriage My Choice Toolkit is based on independent research commissioned/funded by the National Institute for Health Research and School for Social Care Research. In recognition of the particular needs of people with learning disabilities who may be, or have been, forced into marriage, the guidance specifically addresses assessing capacity to consent to marriage and draws upon research undertaken as part of the My Marriage My Choice project led by Rachael Clawson and research team. This practice guidance is part of a suite of resources which also includes: Summary of Findings (full, short and easy read versions); Case Studies Collection (real life experiences and challenges) and an Awareness Film. **Publication date: May 2018**	

Homelessness	Report: deaths of homeless people going unexamined

Published by: the Bureau of Investigative Journalism

Research by the Bureau of Investigative Journalism (BIJ) has highlighted that hundreds of deaths of vulnerable homeless people in England and Wales are going unexamined. Data gained from freedom of information requests has revealed that safeguarding adults reviews (SARs) have almost never been set up after homeless people's deaths. Nearly 300 homeless people have died since 2013, data previously compiled by the BIJ – as part of its Dying Homeless project. Of those deaths, 102 have occurred since October last year, an average of three people a week. The research shows that only eight SARs into homeless deaths have been undertaken since 2010. It also found that not a single official review has been launched into any of 83 recent deaths. In those cases, just one informal review had been launched. Homeless charities have warned that, with no formal count of deaths and with so few reviews, officials cannot determine why so many homeless people are dying and take action to prevent future deaths.

Publication date: May 2018

Learning Disabilities	Learning Disability Mortality Review Annual Report 2016-2017

Published by: NHS England

From 1st July 2016 to 30th November 2017, 1,311 deaths were notified to the LeDeR programme. Key information about the people with learning disabilities whose deaths were notified to the LeDeR programme includes:

- Just over half (57%) of the deaths were of males
- Most people (96%) were single
- Most people (93%) were of White ethnic background
- Just over a quarter (27%) had mild learning disabilities; 33% had moderate learning disabilities; 29% severe learning disabilities; and 11% profound or multiple learning disabilities.
- Approximately one in ten (9%) usually lived alone
- Approximately one in ten (9%) had been in an out-of-area placement

By 30th November 2017, 103 reviews had been completed and approved by the LeDeR quality assurance process. From the 103 completed reviews, there were 189 learning points or recommendations identified. In each review that identified one or more learning points, the average number of learning points and/or recommendations was 2.8. Thirty-six reviews (35%) did not identify any learning. The most commonly reported learning and recommendations were made in relation to the need for:

a) Inter-agency collaboration and communication
b) Awareness of the needs of people with learning disabilities
c) The understanding and application of the Mental Capacity Act (MCA).

Publication date: May 2018

Modern Slavery	Annual Assessment 2017 of the Modern Slavery Helpline
Published by: Unseen	
Unseen is a leading UK-wide modern slavery charity with the aim of ending slavery by supporting survivors, informing stakeholders and influencing system change. This report sets out an assessment of the UK wide Modern Slavery Helpline's first full year of operation. The assessment highlights the number of calls and web forms received during 2017 and the potential victims indicated as a result. During this period, the Helpline received 3,710 calls and 710 web forms. From these contacts, 4,886 potential victims were indicated, 1,271 modern slavery cases raised and 1,442 referrals sent to every law enforcement agency and a number of safeguarding teams. 54% of calls related to modern slavery cases were from victims themselves or from someone in direct contact with a victim. **Publication date: May 2018**	

Adult sexual exploitation	Adult Sexual Exploitation Operational Guidance (March 2018)
Published by: Hampshire key safeguarding partners	
Guidance on Adult Sexual Exploitation has been developed via a multi-agency operational forum involving Adults Health and Care, Hampshire Constabulary, Clinical Commissioning Groups, Southern Health Foundation NHS Foundation Trust, Inclusion Hampshire and service users working within the independent sector. It was signed off by the key agencies in early spring 2018. **Publication date: April 2018**	

Domestic abuse	Domestic abuse referral pathway for NHS staff
Published by: Hampshire Domestic Abuse Partnership	
The HDAP has developed a Domestic Abuse Referral Pathway for NHS professionals. The guidance reflects the NICE DVA Pathway which recommends that trained staff in antenatal, postnatal, reproductive care, sexual health, alcohol or drug misuse, mental health, children's and vulnerable adults' services should ask service users whether they have experienced domestic violence and abuse as a routine part of good clinical practice, even where there are no indicators of such violence and abuse. **Publication date: April 2018**	

Learning disability	Supporting older adults with a learning disability
Published by: Social Care Institute of Excellence	
This guidance covers care and support for adults with learning disabilities as they grow older. It covers identifying changing needs, planning for the future, and delivering services including health, social care and housing. It aims to support people to access the services needed as they get older. **Publication date: April 2018**	

Adult Mental Health	Approved Mental Health Professional Services
Published by: Care Quality Commission	
This briefing outlines the findings of a review carried out by the CQC in 2017 to identify themes that support or challenge the effective running of AMHP services. **Publication date: April 2018**	

Sensory Loss	Guidance on working with adults with acquired hearing loss
Published by: British Association of Social Workers (BASW)	
BASW has published new guidance to help social workers better support people with hearing problems. The Acquired Hearing Loss Practice Guidance includes suggestions for how social workers can help people suffering with hearing loss. There is a checklist for actions social workers should follow when working with someone who presents with hearing loss, and how social workers should undertake assessments. **Publication date: May 2018**	

DoLS	Final Government Response to the Law Commission's review of Deprivation of Liberty Safeguards and Mental Capacity
Published by: Department of Health and Care	
The government has announced it will legislate to replace the Deprivation of Liberty Safeguards (DoLS) with a new system to authorise the confinement of people in care arrangements they lack the capacity to consent to, when parliamentary time allows. In a parliamentary statement , social care minister said that the government had broadly accepted a replacement for DoLS – known as the Liberty Protection Safeguards – proposed by the Law Commission following a review of the law in this area commissioned by ministers, which reported last year. In its formal response to the Law Commission's proposals, the government accepted (or accepted in principle) 42 of 47 recommendations, with only one rejected – the proposed statutory codification of the law in relation to mental capacity and children – and four others deferred for consideration as part of the separate independent review of the Mental Health Act. Legislation to replace DOLs is not imminent as the government "wants to ensure that Liberty Protection Safeguards fit with the conditions and future direction of the health and social care sector, so we will continue to work through the detail of the recommendations and engage further with stakeholders particularly on implementation". As with DoLS, the LPS is designed to fulfil the UK's obligations (in relation to England and Wales) to have a system of safeguards for people who need to be deprived of their liberty to receive care and treatment but lack the capacity to consent, which complies with article 5 of the European Convention on Human Rights. The Liberty Protection Safeguards (LPS) would apply to deprivations of liberty in all settings, not just care homes and hospitals, as with DoLS. This would mean that it would no longer be necessary to apply for a Court of Protection welfare order to authorise deprivations of liberty outside of care homes and hospitals. Hospitals and CCGs would be able to authorise deprivations of liberty in England, not just councils, as with DoLS. The current best interests assessor (BIA) role, which coordinates the DoLS process, carries out the best interests assessment and is mostly performed by social workers, would be replaced by that of an approved mental capacity professional (AMCP). However, while a BIA is required in all DoLS cases, the AMCP would only be called upon to assess an LPS cases where it appeared that the person did not want to reside or receive care or treatment in the proposed care setting. In cases where the person did not object, the body responsible for the placement (a local authority, hospital, CCG or health board) would need to arrange the three assessments and then have them independently reviewed by an employee not involved in the case. As such the LPS would be a two-tier system of safeguards, unlike the DoLS, where there is a single system for all cases. **Publication date: March 2018**	

Mental health	Sexual exploitation and mental health briefing 2018
Published by: Research into Practice for Adults	
This guidance is aimed at local authority practitioners and managers who have a responsibility to safeguard people from sexual exploitation and anyone who might use social care services (and their families and carers). It explores the evidence relating to sexual exploitation and mental health with information about: • Signs of sexual exploitation. • How to effectively engage with people who are at risk of sexual exploitation. • The legislative and policy framework around sexual exploitation. • Personalised approaches to balance best practice with the situation, capacity, needs and wishes of the individual. **Publication date: March 2018**	

Safeguarding Adult Reviews	SCIE Safeguarding Adults Reviews Library
Social Care Institute of Excellence	
SCIE is launching a new Safeguarding Adults Review (SAR) library on its website that will contain reports and associated resources to support those involved in commissioning, conducting and quality assuring SARs. Safeguarding Adults Reviews (SARs) are a statutory requirement for Safeguarding Adults Boards (SABs). SARs can inform adult safeguarding improvement. They can identify what is helping and what is hindering safeguarding work, to tackle barriers to good practice. Commissioned by the Department of Health, the SAR library was developed jointly by Research in Practice for Adults (RiPfA) and SCIE, working closely with colleagues from the sector. **Publication date: March 2018**	

Safeguarding practice	Policing, Health and Social Care Consensus 2018
Published by: Joint Publication	
This consensus statement was developed by: Association of Directors of Public Health, Association of Police and Crime Commissioners, Clinks, College of Policing, Faculty of Public Health, Local Government Association, Nacro, National Association for Voluntary and Community Action, National Police Chiefs Council, NHS England, Public Health England, and the Royal Society for Public Health. It provides a focus for the police service, health and social care services and voluntary and community sector to work together to improve people's health and wellbeing, prevent crime and protect the most vulnerable people in England. **Publication date: February 2018**	

Illegal Money Lending	Illegal Money Lending Guidance for Health and Social Care Staff
Published by: Stop Loan Sharks	
This guidance provides useful information to health and social care staff on responding to illegal money lending and outlines the support and resources available to tackle this issue. **Publication date: January 2018**	

Pressure Ulcers	Safeguarding and pressure ulcer protocol guidance 2018
Department of Health and Care	
This guidance assists practitioners and managers across health and care organisations to provide caring, speedy and appropriate responses to individuals at risk of developing pressure ulcers. The guidance promotes a proactive preventative approach to reduce harm to individuals and secure efficiencies to the wider health and social care system. Where pressure ulcers do occur, this guidance offers a clear process for the clinical management of the removal and reduction of harm to the individual, whilst considering if an adult safeguarding response under section 42 of the Care Act 2014 is necessary. The guidance demonstrates that the focus on removing harm to the individual will usually be secured by speedy clinical intervention. The guidance highlights that broader issues of overall quality of care, management of a service, and training of staff will be of significant interest to commissioners, and the regulator the Care Quality Commission, as well as Safeguarding Adult Boards and Quality Surveillance Groups. There should be clear processes in every locality for communicating concerns to the relevant bodies. This guidance has been adopted by the 4LSABs across the SHIP area and has been incorporated into the local multi-agency adult safeguarding policy and guidance. **Publication date: January 2018**	

Adult Mental Health	Report: Mental health Act detentions may be symptomatic of a system under pressure
Published by: Care Quality Commission	
CQC has published the findings of its review regarding detentions under the Mental Health Act. The review concludes that the ongoing rise in detentions under Mental Health Act may be symptomatic of a system 'under considerable strain'. No single reason is identified as to why more detentions are being made under the Mental Health Act than ever before. Instead, the rise in detentions is linked to a range of different factors, which can vary across the country. Some of these are also indicators of a healthcare system that is under considerable strain. In the ten year period between 2005/06 and 2015/16, the number of detentions increased by 40% – from 45,484 to 63,622. As part of its role in monitoring the use of the Mental Health Act in England, CQC made a commitment to explore what could be causing this trend. CQC has done this by reviewing the available data, by visiting specialist mental health (independent and NHS) services, and by speaking to patients and to representative bodies to gather their views. **Publication date: January 2018**	

Safeguarding Adults – National Statistics	Safeguarding Adults Collection, Annual Report, England 2016-17

Published by: NHS Digital

This report details the number of adults subject to a section 42 safeguarding enquiry under the Care Act for the period 2016-17. The report highlights that there were 109,145 adults subject to an enquiry in 2016-17, compared with 102,970 the previous year, an increase of 6%. The findings are based on data collected from local authorities with responsibility for adults' social services.

A safeguarding concern is where a local authority is notified about a risk of abuse. Some of these concerns will lead to a section 42 enquiry, where the adult meets criteria under the Care Act 2014, or an 'other enquiry', where the adult does not meet the criteria.

In 2016-17, there were 364,605 safeguarding concerns raised, which equates to almost 1,000 per day nationally, the report found. Councils in the South East of England saw the highest number of concerns and enquiries, with 53,990 safeguarding concerns raised, and 24,615 enquiries carried out. In comparison, concerns were lowest in the North East of England, with 29,890 raised. However, this area had the highest number of concerns actioned by social work teams, with 64% converting into either a section 42 or other safeguarding enquiry.

Local authorities also reported a combined total of 151,160 adult safeguarding enquiries as starting the during the year, of which 133,265 (88%) were section 42 enquiries. Nationally, there were 61 of the 152 local authorities (40%) where all enquiries were categorised as a section 42. The highest proportion was seen in the East of England, where eight of the 11 councils reported 100% of their enquiries as section 42s. The figures on concerns and enquiries for 2016-17 were not comparable with the previous year as reporting this data was only made mandatory for councils last year.

The figures broke down the types of risk for section 42 enquiries that concluded during the year. Councils recorded 135,680 instances of risk in 2016-17, up 9% from 124,940 in 2015-16. All risk types saw an increase during 2016-17 in terms of raw numbers, the report said. Neglect and acts of omission accounted for the majority at 35%. In 48% of cases the source of the risk was known to the person, down 2% from the previous year. The proportion of risks attributed to service providers was 36%. Councils also submitted 123,720 records on the location of the risk of abuse. In 2016-17, the home of the adult at risk accounted for 44% of locations, while care homes – both nursing and residential – accounted for 36% between them.

The report also looked at the number of safeguarding adults reviews (SARs) that were held in 2016-17. A review must be arranged when an adult dies as a result of abuse or neglect, whether known or suspected, and in cases where the adult has not died, but the safeguarding board knows or suspects that they experienced serious abuse or neglect. There was an increase in the number of SARs held (22%), the number of individuals at risk who died (58%) and the number of individuals who suffered serious harm (20%). The highest proportion of SARs held in 2016-17 (36%) was in London.

Publication Date: December 2017

Making Safeguarding Personal	MSP Outcomes Framework
Published by: ADASS	
Making Safeguarding Personal (MSP) is a sector led initiative that aims to develop an outcomes focus to safeguarding work. The Making Safeguarding Personal Temperature Check 2016 included the recommendation (p29): "… an ideal type of outcomes measurement and reporting framework should be agreed, that can be offered as a template and a means for local authorities to measure MSP progress and compare themselves to each other." To support that recommendation, ADASS and the Local Government Association have appointed the Institute of Public Care at Oxford Brookes University and Research in Practice for Adults to develop an MSP outcomes framework that will provide a means of promoting and measuring practice that supports an outcomes focus for safeguarding adults work, including ways in which IT systems and processes can aid an outcomes approach. Oversight will lie with the MSP Informatics Task and Finish Group, which includes LGA, ADASS, NHS Digital and adult social care officers. IPC and RiPfA will work with the sector to develop an outcomes framework that gathers both qualitative and quantitative outcomes. It will help practitioners, teams, councils, Safeguarding Adults Boards (SABs) and their partners know how far they are making a difference to the safety and well-being of people who are at risk of, or who have suffered, abuse or neglect in their area. It is hoped that the framework will enable councils and SABs to better identify how practice is impacting on outcomes, indicate areas for improvement, and enable benchmarking and learning from others. This work will start in December through to January with a call for examples, followed by a 'deep dive' in February before developing and testing an outcomes framework in March 2018. **Publication date: December 2017**	

Making Safeguarding Personal	MSP - supporting increased involvement of services users
Published by: Local Government Association	
This resource underlines the way in which effective user involvement can support delivery of the six core safeguarding principles in practice as outlined in the Department of Health Care and Support Statutory Guidance. **Publication date: December 2017**	

Making Safeguarding Personal	Making Safeguarding Personal for Safeguarding Adult Boards
Published by: Local Government Association	
This resource is part of a suite of resources to support safeguarding adults boards and partners in developing and promoting Making Safeguarding Personal. It supports Boards both in their assurance role and in actively supporting and leading a culture change towards Making Safeguarding Personal. **Publication date: December 2017**	

Making Safeguarding Personal	Making Safeguarding Personal – What good looks for health and social care commissioners and providers
Published by: Local Government Association	
This resource is intended to support the joined up development of Making Safeguarding Personal across providers and commissioners in health and social care and signposts to sources of advice on fundamental principles for safeguarding adults which underpin Making Safeguarding Personal.. **Publication date: December 2017**	

Making Safeguarding Personal	Making Safeguarding Personal - What good looks like for the Police
Published by: Local Government Association	
This guidance sets out the headlines of what should be developed and worked on by the police – the essential steps – to make safeguarding personal. These essential steps are expanded on throughout the main body of the resource in section 4 with suggestions for how and why these steps should be achieved. A core message running through this resource is that these steps are already integral to core business in the police. **Publication date: December 2017**	

Making Safeguarding Personal	Making Safeguarding Personal - what good looks like for Advocacy Services
Published by: Local Government Association	
This resource aims specifically to outline and help shape the role that advocacy can play in Making Safeguarding Personal, by offering support to those who have duties to commission advocacy and to the advocacy sector in its delivery. This in turn will support people who use services and carers. **Publication date: December 2017**	

Making Safeguarding Personal	Making Safeguarding Personal - What good looks like for the Housing Sector
Published by: Local Government Association	
The housing sector plays a critical part in safeguarding adults, both on the front line and at a strategic level, as partners on safeguarding adults boards. It aims to support housing commissioners and providers to make safeguarding personal. **Publication date: December 2017**	

Mental Health	Independent Review of the Mental Health Act
Published by:	
The Government has commissioned a review of mental health legislation. This will consider and make recommendations on improving legislation and practice around the Mental Health Act. The review will seek the views of service users, carers, relevant professionals, and affected organisations. It will produce a report with recommendations for change in autumn 2018 **Publication date: December 2017**	

Health and Social Care	The state of health and social care 2016-2017
Published by: Care Quality Commission	
This report shows that the quality of health and social care has been maintained despite very real challenges. The majority of people are getting good, safe care, and many individual providers have been able to improve. However, future quality is precarious as the system struggles with increasingly complex demand, access and cost. The efforts of staff have largely ensured that quality of care has been maintained – but staff resilience is not inexhaustible, and some services have begun to deteriorate in quality. **Publication date: December 2017**	

HSAB Annual Report	HSAB Annual Report 2016-2017
Published by: Hampshire Safeguarding Adults Board	
This report outlines the activities of the Hampshire Safeguarding Adults Board's (HSAB) has undertaken to enable it to fulfil its statutory responsibilities regarding the strategic development and oversight of adult safeguarding across Hampshire. This report covers a one year period (1st April 2016 to 31st March 2017) and highlights the Board's progress and achievements in delivering its strategic priorities and objectives. The report provides a review of the Board's business plan highlighting challenges and also key achievements. It also outlines the areas requiring focus for the coming year. **Publication date: December 2017**	

Financial abuse	Top tips for responding to financial abuse and scams
Published by: Association of Directors of Adult Social Services	
ADASS has published guidance on protecting vulnerable adults from financial abuse and scams. This includes advice on how to spot the signs of someone responding to scams, how to talk to them, and how to prevent this form of abuse. The guidance also featured a case study about a gambling scam. **Publication date: November 2017**	

Family Group Conferences	Evaluating Family Group Conferences with adults
Published by: Research into Practice for Adults	
This practice tool aims to support practitioners and managers who are already running a family group conference (FGC) service for adults, and those who are considering developing a service. It provides an overview of the current evidence base regarding FGCs with adults; the complexities of measuring the impact of FGCs on outcomes for adults and their families and practical ideas to support the evaluation of the process and outcomes of an FGC service for adults. **Publication date: October 2017**	

Modern Slavery	Hampshire and IOW Modern Slavery Strategy 2017-2020
Published by: Hampshire Modern Slavery Partnership	
The Modern Slavery Partnership for Hampshire and the Isle of Wight is a multi-agency partnership chaired and facilitated by the Office of the Police and Crime Commissioner (OPCC). This strategy aims to tackle Modern Slavery in Hampshire and the Isle of Wight and has been developed in line with the Government's Modern Slavery Strategy as follows: Pursue - Prosecute and disrupt individuals and groups responsible for slavery Prevent – Prevent people from engaging in slavery Protect – Strengthen safeguards against slavery by protecting vulnerable people from exploitation and increasing awareness of and resilience against this crime Prepare – Reduce the harm caused by slavery through improved victim identification and enhanced support **Publication date: October 2017**	

PREVENT	Safeguarding and Radicalisation
Published by: Department of Education	
A report into a study funded by the Department for Education has analysed the response to radicalisation in 10 local authorities and identified a range of barriers to effective practice. The report highlights that radicalisation remains an "uncomfortable area of practice" for social workers and they have high levels of anxiety and uncertainty about managing such cases, according to government funded research: "Among frontline practitioners in particular there was a perception that both intervention and failure to intervene had the potential for serious repercussions in the event of something going wrong – both professionally and politically, or ultimately to the point of risking the safety of others". As a result of this – and a lack of clear guidance on how to handle these cases – social workers were less likely to respond to a case "flexibly" and take "'risks' or unorthodox approaches" in their interventions. Social workers also raised concerns about times when their interventions received external challenges, such as when a case was referred to courts, or family members or community organisations challenged the legitimacy of an intervention. While the report found all social workers had heightened concerns about getting things wrong in such cases, it identified differences between those social workers working in Prevent priority areas and those who had less exposure to radicalisation. **Published by: August 2017**	

Gambling and adults at risk	Adults at risk and gambling
Published by: Kings College	
Researchers at King's College London have researched how gambling-related harm may be affecting adults with care and support needs. Gambling is an increasingly popular leisure pursuit in the UK. Recent figures suggest that British gamblers spent a record £13.8bn on gambling in 2015-16, up from £7bn in 2006-7. Gambling is widely available and increasingly popular – opportunities to gamble include high street betting shops and arcades, bingo halls or casinos, and from the comfort of one's home using electronic devices. The increase of online and offline gambling products, widespread advertising of gambling, and the ease with which individuals can begin gambling are probably evident to everyone. However, the extent to which gambling is affecting people who are in touch with social work services, or how adults' services respond to gambling-related harm, is unknown. . Gambling is widely enjoyed as a social activity and most people are not harmed. However, gambling-related harm might be caused by participating in gambling activities, such as betting, bingo, scratch-cards, or fruit machines, and being unable to stop, spending excessively, or finding it addictive. Or, some people may get caught up in gambling scams, where scammers invite them to become involved in lotteries, prize draws, sweepstakes and premium rate, telephone prize scams. The gambling habits of family, carers, care providers, neighbours, friends, acquaintances, online contacts, or those in positions of trust may also lead adults with care and support needs to experience gambling-related harm. **Publication date: August 2017**	

Safeguarding practice	Coercive control tools and resources
Published by: Research into Practice for Adults (RiPfA)	
Social workers have been issued guidance on safeguarding people who are victims of controlling and coercive behaviour. The Department of Health has funded a set of tools to help practitioners respond to the issue, which experts say underpins domestic abuse and can be a heightened risk among people with care and support needs. The Serious Crime Act introduced a criminal offence of "controlling or coercive behaviour in an intimate or family relationship" in 2015. In light of the law change Lyn Romeo, the chief social worker for adults, commissioned Women's Aid and Research in Practice for Adults to produce a set of resources to help social workers tackle the issue. **Publication date: February 2017**	

Domestic Abuse	Domestic Homicide Review Analysis

Published by: Home Office

A Domestic Homicide Review (DHR) is a multi-agency review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by a person to whom they were related or with whom they were, or had been, in an intimate personal relationship, or a member of the same household as themselves. Since 13 April 2011 there has been a statutory requirement for local areas to conduct a DHR following a domestic homicide that meets the criteria.

Since April 2011, in excess of 400 DHRs have been completed. DHRs provide a rich source of information on the nature of domestic homicide, the context in which it occurs and, most importantly, in the lessons that can be learned from the tragic event. This analysis sets out what we know about domestic homicide and draws out common themes and trends and identifies learning that emerged across the sample of DHRs. The purpose of this analysis was to promote key learning and trends from the sample of DHRs with the aim of informing and shaping future policy development and operational practice both locally and nationally. This paper also reports on what is being done nationally to tackle these issues.

Publication date: January 2017

Domiciliary care	Domiciliary care and safeguarding

Published by: BBC

More than 23,000 allegations of abuse have been made against carers working in people's homes across the UK. The data comes from a Freedom of Information request submitted by the BBC Radio 4 programme File on 4. The United Kingdom Homecare Association, which represents 2,000 care companies, described the findings as "horrifying" and blamed cuts to local government budgets. The BBC asked every council in England, Scotland and Wales with responsibility for social care for the numbers of allegations of abuse and neglect made against home carers contracted by local authorities. In Northern Ireland, the BBC sent Freedom of Information requests to health and social care trusts. This revealed that between 2013-14 and 2015-16 there had been at least 23,428 safeguarding alerts across the UK, but only half the councils provided data. Most of the alerts related to care provided in England.

File on 4 discovered prosecutions were rare, with just 700 of the 23,428 alerts resulting in police involvement and only 15 prosecutions. The vast majority of alerts were raised about elderly people, with more than 9,700 involving people aged over 80 like Dora Melton, and 164 about people who were aged over 100. Councils were asked for the reasons behind the alleged abuse. They included:

- More than 12,300 alerts concerning neglect
- 2,400 reports of psychological abuse
- More than 3,400 alleged incidents of physical abuse
- More than 400 claims of sexual abuse

It was not possible to find out whether all these reports were valid and fully investigated. But the local government ombudsman, Michael King, said there was a growing problem over standards of home care. Ombudsman complaints about homecare rose by 25% last year to 372, and 65% of them were upheld.

Publication date: February 2017

Bulletin Compiled by Sue Lee, Strategic Partnerships Manager on behalf of the Hampshire Safeguarding Adults Board

June 2018