



Hampshire Safeguarding Adults Board Strategic & Business Plans

April 2016 to March 2021

“Safeguarding is everyone’s responsibility”

Hampshire Safeguarding Adults Board Strategic Plan 2016 - 2021

About the Hampshire Safeguarding Adults Board



The Hampshire Safeguarding Adults Board (HSAB) is a statutory, multi-agency partnership coordinated by the local authority, which oversees and leads adult safeguarding across the Hampshire County Council (HCC) area. HSAB's main objective is to gain

assurance that safeguarding arrangements locally and its partner organisations act work effectively individually and together, to support and safeguard adults in its area who are at risk of abuse and neglect.

The HSAB also has an interest in a range of matters that contribute to the prevention of abuse and neglect including the safety of patients in its local health services, quality of local care and support services, effectiveness of prisons and approved premises in safeguarding offenders and awareness and responsiveness of further education services.

Our purpose

HSAB's remit is to set priorities, agree objectives and to coordinate the strategic development of adult safeguarding across the HCC area. It is the key mechanism for agreeing how local agencies will work together effectively to safeguard and promote the safety and wellbeing of adults with care and support needs who are at and/or are in vulnerable situations. Under the Care Act 2014, HSAB is required to publish a strategic plan (developed in consultation with local communities) and an Annual Report. The HSAB also acts as an important source of advice and assistance, for example in helping others to improve their safeguarding arrangements.

Our membership

The Board has an independent chair that is responsible for ensuring that all organisations contribute effectively to the work of the Board. The Chair provides accountability for the work undertaken by the HSAB by way of reports to relevant strategic committees and boards. The HSAB is made up of wide range of statutory, community and voluntary organisations which includes representatives from Hampshire County Council, police, clinical commissioning groups, NHS providers, emergency services, district and borough councils, independent care providers, housing, advocacy, service users and carers, etc.

HSAB also has links with a wide range of other strategic forums and partnerships including the Hampshire Children's Safeguarding Board, Community Safety Partnerships, PREVENT Board, Domestic Abuse Partnership, Modern Slavery Partnership, Learning Disability Partnership, Health and Wellbeing Board and Health Watch in recognition of the strong synergies between the work of the HSAB and many of these forums and to minimise duplication and maximise efficiencies, particularly as objectives and membership are likely to overlap.

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

Our vision

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

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



- Safeguarding adults at risk and their carers is everyone's business and responsibility;
- All organisations and local communities have a responsibility to ensure that they foster a culture which takes all concerns seriously, and enables transparency, reporting of concerns and whistleblowing;
- All staff and volunteers in whatever the setting have a key role in preventing abuse or neglect occurring and in taking prompt action when concerns arise;
- Adults at risk and their families, carers or representatives must have access to information regarding the standards, quality and treatment they can expect to receive from any individuals (paid or unpaid), services or organisations involved in their lives;
- A 'Making Safeguarding Personal' approach is essential in order to ensure that any support offered or provided is person centred and tailored around the needs, wishes and the outcomes identified by the adult. The person at risk at the centre of any safeguarding process must stay as much in control of decision making as possible;



- Personalised support is for everyone, but some people will need more support than others to make choices and manage risks. Making risks clear and understood is crucial to empowering and safeguarding adults;
- All organisations must have processes aimed at preventing abuse from occurring in the first instance and to enable support to be offered at an early stage.
- When abuse does take place, it must be identified early and dealt with swiftly and effectively, and in ways that are the least intrusive and most proportionate.
- People supporting adults with care and support needs and/or their carers must have the appropriate level of skills, knowledge and training to safeguard adults from abuse; and
- It is vital that clear processes are in place to identify learning from serious cases so that lessons can be used to improve partnership working in order to prevent a similar event in the future.

Six Principles from the Government Policy on Adult Safeguarding (Department of Health May 2013)

The Government has published principles to be used by local authority adult social services, the NHS, Police and other agencies for both developing and assessing the effectiveness of their local adult safeguarding arrangements. These also describe, in broad terms, the desired outcomes for adult safeguarding, for both individuals and agencies.

These principles have been formally adopted by the Hampshire Safeguarding Adult Board and its partner agencies with safeguarding responsibilities and they are incorporated into the local multi-agency adult safeguarding policy and guidance:

Six Safeguarding Principles

Principle	Description	Outcome for Adult at Risk
Empowerment	Presumption of person led decisions and informed consent.	<i>"I am asked what I want as the outcomes from the safeguarding process and these directly inform what happens."</i>
Prevention	It is better to take action before harm occurs.	<i>"I receive clear and simple information about what abuse is, how to recognise the signs and what I can do to seek help."</i>
Proportionality	Proportionate and least intrusive response appropriate to the risk presented.	<i>"I am sure that the professionals will work for my best interests, as I see them and will only get involved as much as needed and I understand the role of everyone involved in my life."</i>
Protection	Support and representation for those in greatest need.	<i>"I get help and support to report abuse. I get help to take part in the safeguarding process to the extent to which I want and to which I am able."</i>
Partnership	Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.	<i>"I know staff treat any personal and sensitive information in confidence, only share what is helpful and necessary. I'm confident professionals will work together to get the best result for me."</i>
Accountability	Accountability and transparency in delivering safeguarding.	<i>"I understand the role of everyone involved in my life."</i>

Our assurance and accountability framework

The Board has developed a framework for gaining assurance about the effectiveness of local safeguarding arrangements. This builds on the Government's six safeguarding principles and provides a number of key standards against which local agencies will be held to account:

Prevention and early intervention

- a) The Care Act 2014 places a duty on local safeguarding adults' boards to develop and implement a clear strategy around the prevention of abuse or neglect of adults at risk. Prevention is one of the core principles of safeguarding and as such forms a fundamental part of local adult safeguarding policy framework and arrangements.
- b) Critical to the vision in the Care Act 2014 is that the care and support system works to actively promote wellbeing and independence and does not just wait to respond when people reach a crisis point. It is vital that the care and support system intervenes early to support individuals, helps people retain or regain their skills and confidence, and prevents need or delays deterioration wherever possible. This approach applies equally to adult safeguarding.
- c) HSAB will maintain an overview of the prevention work taking place in the area and will maintain links with other strategic forums and plans to ensure this work ties in with their work.

These include links with:
 - The Health and Wellbeing Board, <http://democracy.hants.gov.uk/mgCommitteeDetails.aspx?ID=193>
 - Hampshire Safeguarding Children's Partnership, <https://www.hampshirescp.org.uk/>
 - Quality Surveillance Group, <https://www.england.nhs.uk/publication/quality-surveillance-groups-national-guidance/>
 - Community Safety Partnerships, <https://www.hants.gov.uk/community/saferhampshire>
 - Police and Crime Commissioner's Office <https://www.hampshire-pcc.gov.uk/>
 - Care Quality Commission. <https://www.cqc.org.uk/>
- d) In May 2015, HSAB published a strategy on prevention and early intervention which recognises there are a number of essential building blocks relating to prevention and early intervention which it will use to gauge the effectiveness of local agencies:
 - People are informed of their rights to be free from abuse and supported to exercise these rights, including access to advocacy;

- Access to good universal services, such as community safety services;
- Needs and risk assessments undertaken to inform people's choices;
- Availability of a range of options for support to keep safe from abuse tailored to people's individual needs;
- A well-informed public which has confidence that concerns will be responded to, and appropriate support provided;
- Availability and use of a range of approaches and tools to identify risks at an earlier stage and to prevent situations developing to a crisis point;
- Availability of clear confidentiality and information sharing arrangements within and across agencies to enable concerns to be shared appropriately and in a timely way; and
- Commissioning for better outcomes and effective quality monitoring.

An effective safeguarding system

a) The Care Act 2014 creates a new legal framework for how Local Authorities and other parts of the system should work together to protect adults at risk of abuse or neglect. Partners must agree how they will work together and the roles they will play, to keep adults at risk safe. This policy, guidance and toolkit outlines the local response to this requirement.

b) In Hampshire, the main statutory agencies - Local Authorities, Police and NHS organisations – are committed to working together to both promote safer communities in order to prevent harm and abuse and to deal with suspected or actual cases effectively. We believe that people at risk are best protected when procedures between statutory agencies are consistent across local agencies.

c) The HSAB has outlined below what it considers are the essential building blocks of an effective safeguarding system and will use these to gauge the effectiveness of local agencies:

- An open, transparent and learning culture within and across organisations;
- A well-trained workforce operating in a culture of zero tolerance of abuse;
- Staff awareness and training to improve recognition of abuse and reporting including whistleblowing policies;
- All organisations appropriately report and act on safeguarding concerns;
- Adherence to national and locally agreed (single and multi-agency) frameworks and policies;
- Availability of a range of approaches and tools to promote prevention and early intervention to prevent situations developing to a crisis point e.g. wellbeing trigger tools and multi-agency risk management framework, etc.;

- All organisations appropriately report and act on safeguarding concerns;
- Availability of an effective framework for confidentiality and information sharing across agencies to enable the appropriate and timely sharing of concerns;
- Meaningful service user and family involvement and engagement in the safeguarding process with the Making Safeguarding Personal approach embedded in everyday practice across all organisations;
- A balance is achieved between protecting people and respecting their right to make decisions for themselves;
- Adherence to the 'duty of candour' and all adverse incidents are appropriately reported and investigated;
- The safeguarding process is proportionate and used appropriately and is not used as a substitute for:
- The responsibilities of care providers to provide good quality and safe care;
- Commissioners regularly assuring themselves of the quality and safety of the services they commission;
- Effective governance arrangements with local services;
- Regulators ensuring regulated providers meet required standards and taking timely enforcement action when necessary and;
- The core duties of the police and other agencies to prevent and detect crime and protecting life and property.

Governance and learning

- HSAB believes that when service users experience poor outcomes it is important that all services reflect on the quality of their services both internally and collaboratively, so that they are able to learn from their practice and that of others in order to improve local safeguarding practice.
- The essential building blocks of effective governance arrangements are outlined below and will be used to gauge the effectiveness of local agencies:
- Robust internal quality monitoring and governance systems to detect and respond to poor care the outcomes of which lead to improvements in service delivery;
- Availability of a joint NHS Serious Incident Requiring Investigation (SIRI) process to enable an overarching investigation across more than one health organisation.

- Commissioners have robust quality monitoring and oversight processes which identify under-over reporting, repeating patterns, thematic reviews to capture patterns and learning.
- Alignment of governance processes – internal care governance processes are linked up with other and with HSAB multi-agency learning and review processes;
- Agencies evaluate the impact of learning from investigations and reviews and this includes an analysis of the lessons Identified;

Governance and learning

- Availability of thematic and trend information highlighting emerging themes relating to a range of client groups with information used to inform service planning and development and to undertake targeted work;
- Service user's experiences and their feedback is used to inform service planning and development;
- Effective single and multi-agency learning and review processes to identify learning from serious cases;
- Governance processes are aligned and streamlined to avoid duplication and to provide a multi-agency perspective and holistic picture - an integrated approach will identify multi-agency learning and improvements;
- Mechanisms are in place to share learning and to apply this in practice;
- There is evidence that changes, and improvements have been made to services as a result of lessons gained from reviews leading to improved outcomes for service users;
- Effective communication and joint working across health and adult social care commissioning organisations in response to critical events; and
- Relevant local and national frameworks are used to support the delivery of action plans developed in response to serious events.



Making Safeguarding Personal

- a) HSAB has adopted the principle of 'no decision about me without me' and means that the adult, their families and carers are working together with agencies to find the right solutions to keep the person safe and to support them in making informed choices.
- b) A person led approach leads to services which are: person centred and focused on the outcomes identified by the individual; planned, commissioned and delivered in a joined-up way between organisations; responsive and which can be changed when required.
- c) Personalised care and support is for everyone, but some people will need more support than others to make choices and manage risks. A person led approach is supported by personalised information and advice and where needed, access to advocacy support.
- d) Making Safeguarding Personal (MSP) is about responding in safeguarding situations in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety. It is about seeing people as experts in their own lives and working alongside them with the aim of enabling them to resolve their circumstances and support their recovery.
- e) MSP is also about collecting information about the extent to which this shift has a positive impact on people's lives. The essential building blocks of an effective Making Safeguarding Personal approach are:
 - The person is involved from the beginning of the enquiry (unless there are exceptional circumstances that would increase the risk of abuse);
 - The outcome the person is seeking is addressed from the start of, and throughout, the safeguarding process. At the end of the process, the person is asked if all their outcomes have been met prior to the safeguarding enquiry being closed;
 - Adults who have substantial difficulty in being involved, and where there is no one appropriate to support them, have access to an independent advocate;
 - The adult is helped to understand their situation and what is needed to keep him or herself safe now and in the future in order to build the person's resilience and capacity to protect themselves from harm should a similar situation arise in the future; and
 - The support needed by the adult to recover from the abuse experienced is actively addressed as part of the safeguarding process.

Priorities for 2016 - 2021

This Plan highlights the HSAB's strategic priorities and objectives over the next five years. A number of factors have helped to shape and influence these priorities including:

- The Board's review and evaluation in March 2016 of its progress in achieving its stated objectives in the HSAB Business Plan. This review highlighted a number of 'wrap around' themes and areas requiring further development;
- Response to national and local events which provide a focus on governance including the Mazars Review, national mortality reviews relating to adults with a learning disability, the Transforming Care Programme, etc;
- Requirements in the Care Act 2014 relating to Making Safeguarding Personal and the need to embed this approach within and across organisations;
- Findings of a survey (undertaken by HSAB in January 2016) of local people on their views about adult safeguarding generally and the key issues they feel the Board needs to focus on. Over 175 organisations (and individuals) took part in this survey and their responses highlighted further work is needed around improving awareness of adult abuse and neglect and how to report concerns. Feedback from the survey also highlighted a wide range of barriers to disclosing or reporting adult abuse. Greater support for informal carers and also the victims of abuse was flagged as an area the Board should be focusing on including the availability of advocacy and access to counselling services, information about support networks as a means of supporting victims in their recovery from abuse. The majority of respondents felt that the public and local communities have a key role to play in tackling adult abuse with one respondent summing this up as follows: "we need to invest in rebuilding community spirit and caring for others".

Delivery of the Strategic Plan

Delivery of the HSAB Strategic Plan will occur in three 3 key phases: Year 1 will focus on planning and preparation; Years 2, 3, 4, will focus on delivery and evaluation and finally in Year 5, the Board will review its activities and progress against its published objectives and will undertake planning and consultation to develop a new Strategic Plan for 2021 onwards. HSAB will achieve its vision through the working out of the following strategic priorities:

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

Implementation and Monitoring

A Business Plan has been developed which provides detail about how the Strategic Plan will be implemented over the next five years including our measures of success.

This Strategic Plan will be implemented through the work of HSAB's subgroups which will each focus on specific priorities and objectives. Progress against the Plan will be reported to the Hampshire Safeguarding Adults Board at regular intervals and the HSAB Annual Report will provide an overview of the achievements made and will identify any areas for further development.

Any queries about this Strategic Plan can be directed to the Manager of the Hampshire Safeguarding Adults Board by emailing hsab@hants.gov.uk.

For more information about the work of the Hampshire Safeguarding Adults Board, the HSAB Strategic Plan or the HSAB's Annual Report go to: www.hampshiresab.org.uk.

HAMPSHIRE SAFEGUARDING ADULTS BOARD

The Hampshire Safeguarding Adults Board (HSAB) is a statutory body set up under the Care Act 2014. The Board consists of partner agencies which co-operate with each other in order to ensure that local safeguarding arrangements and partners act together effectively to protect adults in its area who have care and support needs. The HSAB also has a strategic role to oversee and lead adult safeguarding across the area it serves and is interested in a range of matters that contribute to the prevention of abuse and neglect such as 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 HSAB also acts as an important source of advice and assistance, for example in helping others to improve their safeguarding mechanisms. In order to fulfil responsibilities effectively, the HSAB has established effective links with a wide range of relevant strategic partnerships and plans in Hampshire and will share relevant information and work plans in order to reduce any duplication and maximise any efficiencies given that there are likely to be overlapping objectives and membership.

BUSINESS PLAN 2019/21

This Business Plan responds to the key priorities outlined in HSAB's Strategic Plan and explains the work the Board and its partner organisations will be undertaking during the first 3 years to ensure these priorities are realised. The business plan will be reviewed in 2019/20 in terms of the progress made and to provide a clear focus during the final 2 years of the HSAB strategy. The Board with the support of its subgroups, will take a leadership role in the delivery and quality assurance of partnership working in these areas. This Business Plan is designed to enable implementation and monitoring of actions in a clear and concise way. Progress against this plan will be reviewed and monitored by the Business Group, with Chairs of the relevant subgroups reporting on progress against their actions to this group. Where necessary and appropriate the Business Group will highlight areas of concern and good practice to the full HSAB Board meetings for further action.

Key themes running through all priorities

- Clear leadership and direction from the Board
- Safeguarding is everyone's responsibility
- Prevention, early intervention and transition
- Making Safeguarding Personal
- Strengthening engagement of all sectors and building networks
- Coordination and alignment with other strategic partnerships

The Hampshire Safeguarding Adults Board will achieve its vision through the working out of the following strategic objectives:

	Priority Area	Key actions	Owner	2019 update	Timescale and desired outcome
1.	Wide awareness of adult abuse and neglect and its impact and engaging local communities.	Themed campaigns to develop community awareness & engagement of abuse and neglect and its impact, to include joint, coordinated campaigns with other local boards.	Stakeholder Subgroup.	Year 1 - Financial Abuse. Year 2 - Self Neglect. Year 3 - Loneliness and Isolation. Year 4 – Homelessness. Year 5 – TBC.	Completed. Completed. Completed. To be completed 2020. To be completed 2021.
		Annual calendar of events.	Stakeholder Subgroup.	The Calendar has been created and is being updated as an ongoing piece of work.	Completed.
		Update HSAB publicity material - focus on breaking down barriers to reporting, personal responsibilities to speak out, 'building confidence' to report.	Stakeholder Subgroup.	Completed.	2020/2021 - Whilst this has been completed the review of any newly created HSAB publicity material will continue to form part of the subgroup work plan.
		Develop use of social media to promote awareness of adult abuse and neglect - website, quarterly newsletter, Twitter, Facebook, YouTube, etc.	Stakeholder Subgroup.	Twitter Account Setup and using a 'Buffer App' to set up future tweets. A HSAB Facebook Page and YouTube page have also been created. 1 Newsletter has been completed and distributed.	Completed. 2020/2021 - Development and increased frequency of the newsletters.

	Priority Area	Key actions	Owner	2019 update	Timescale and desired outcome
1.	Wide awareness of adult abuse and neglect and its impact and engaging local communities (continued).	Establish links with Neighbourhood Watch, Citizens Advice and other grass roots organisations – included in Stakeholder group.	HSAB Manager.	Links to the following have been so far made: Victim Support. Citizens Advice. Local Authority – sensory services.	2020/2021 - Further links will be progressed as further organisations are identified.
		Annual event.	Stakeholder Subgroup.	Two previous annual events held with the Children’s Partnership in 2018/19.	Completed – Jan 19. 2020/2021 - Annual events with key partners will continue to be considered for the HSAB.
		Development of the ‘Safeguarding Adult Lead’ Network and targeted work in the independent care provider, housing and further education sectors.	Stakeholder Subgroup.	The SAL Contact list has been reviewed by the Stakeholder group and additional organisations added in 2019.	2020/2021 - Whilst this has been completed, development of the SAL network will continue to form part of the subgroup work plan.
		Align activities with mainstream community safety approaches - disability hate crime, Prevent, domestic abuse, modern slavery, mate crime, honour-based violence.	HSAB Manager.	HSAB Manager is linked into local community safety groups and information and will continue to support these groups and the HSAB in aligning its activities.	2020/2021 - Ongoing.

No.	Priority Area	Key Actions	Owner	2019 Update	Timescale and desired outcome
2.	Prevention and early intervention – promoting wellbeing and safety and acting before harm occurs.	HSAB activity aligned with wider initiatives aimed at promoting wellbeing, prevention, early intervention and effective management of transition for 16+ age group.	Business Subgroup.	<p>Links and coordination across relevant partnerships and strategies.</p> <p>Website has information re: disability hate crime, Prevent, domestic abuse, modern slavery, mare crime. HBV etc.</p> <p>HSAB Safeguarding campaigns.</p>	2020/2021 - Partnership updates at every HSAB meeting (Ongoing).
		Work with partners to ensure prevention and safeguarding are included in new and emerging models of funding & service delivery.	4LSAB QA Subgroup.	<p>Self-Audit completed 2019 Key themes include:</p> <p>Use of MCA. Awareness of SAMA. MSP. Embedment of MARM.</p> <p>Partners provided feedback from the QA subgroup on key themes identified and recommendations.</p>	<p>2020/2021 - HSAB activity to be aligned to raise awareness and promote the themes. Topics to be considered for inclusion in the HSAB training programme.</p> <p>2021 - 4LSAB QA Subgroup to oversee the next Safeguarding Adult self-audit to check on improvements.</p> <p>Reports from partners to HSAB (Ongoing).</p>

	Priority Area	Key actions	Owner	2019 update	Timescale and desired outcome
2	Prevention and early intervention – promoting wellbeing and safety and acting before harm occurs (continued).	Familiarisation and training on the 4LSAB Risk framework – via HSAB learning and development programme.	HSAB Manager.	Several training sessions provided Hampshire wide as well as independent Health targeted sessions. 2019 Self-audit has highlighted that partners are still to fully embed 4LSAB framework within their own standard procedures.	2020 - Additional training sessions for to be arranged.
		Embed fire safety risk management into working practices to reduce people being killed or seriously injured in fires.	4LSAB Fire Safety Development Subgroup.	Newly formed Fire safety development group. Fire death thematic review and event learning strategy developed. Multi-agency fire safety framework document in development. Hoarding guidance document being promoted through the subgroup with launch event.	2020 - Multi agency fire safety framework document to be adopted.

No.	Priority Area	Key Actions	Owner	2019 Update	Timescale and desired outcome
2.	Prevention and early intervention – promoting wellbeing and safety and acting before harm occurs (continued).	Adult safeguarding learning and development programme (HSAB).	HSAB Board Manager.	Successful year with fully funded training provided on the following topics: Basic awareness. S42 training. MARM. SAL Network x 2 events. Financial Abuse. Family Approach. MSP.	2020 - It is planned to run another training programme.
		Work with partners to ensure prevention/safeguarding are included in new and emerging models of funding & service delivery (direct payments, care accounts, strengths-based approach).	Business Subgroup.	Business subgroup ensures links and coordination across relevant partnerships and strategies.	2020/2021 - Partnership updates at every HSAB meeting.
		HSAB multi-agency risk management framework is embedded in partner agencies and used as a tool to manage transition from 16+ years to adulthood.	4LSAB Workforce Development Subgroup.	This was included as part of the Family Approach protocol training. HSAB to consider in partnership with the HSCP if further training is required for 2020.	HSAB to consider in partnership with the HSCP if further training is required for 2020.

No.	Priority Area	Key actions	Owner	2019 update	Timescale and desired outcome
3.	Well-equipped workforce across all sectors.	Deliver a training programme reflecting HSAB priorities e.g. MSP, risk management and learning into practice.	HSAB Board Manager.	A high quality multiagency adult safeguarding training programme has now been in place for the last two years.	Completed. 2020 - A further programme of training for will be provided in line with Board Priorities and areas identified from the self-audit carried out.
		Develop approaches to promote service user involvement in training programme.	4LSAB Workforce Development Group.	To be contained within the 4LSAB training Strategy.	2020 – the 4LSAB WFD subgroup to consider this as part of their work programme.
			Stakeholder Subgroup.	To support with this key action through the Stakeholder Subgroup.	2020 - Stakeholder Subgroup to action.
		Build networks and partnerships with the safeguarding & partner organisational workforce leads.	HSAB Manager.	With 138 contacts, the SAL network continues to be a successful mechanism for reaching out to partners.	2020 – the 4LSAB WFD subgroup to link up with multiagency partners and training leads.
4LSAB Workforce Development Group.					

No.	Priority Area	Key actions	Owner	2019 Update	Timescale and desired outcome
3.	Well-equipped workforce across all sectors (continued).	Develop training web pages on HSAB website to support single agency training.	HSAB Manager.	The HSAB website continues to be very successful with over 83,000 page views between January and October this year.	2020 – Joint work between the 4LSAB Workforce Development Subgroup.
		Learning gained from serious cases is shared within and across organisations and this is used to inform and improve practice.	4LSAB Workforce Development Subgroup.	There will need to be joint work between the 4 SABs within the recently formed 4LSAB Workforce Development Subgroup regarding this.	2020 - Training programme runs financial year (Apr – Apr).
		Joint work with partners to develop a multiagency safeguarding training programme.	HSAB Manager.	Multi-agency training programme is in place which partners take an active role in.	Completed. 2020 - A further programme of training for will be provided in line with Board Priorities and areas identified from the self-audit carried out.
		Source/develop training materials, resources and innovative delivery methods.	HSAB Manager. 4LSAB Workforce Development Subgroup.	Different training methods have been tried and attendance and feedback from HSAB training events and workshops is monitored. The recent development of the HSAB social media channels can also be utilised.	2020 – Monitoring ongoing which includes regular review of training pages.

	Priority Area	Key actions	Owner	2019 update	Timescale and desired outcome
3	Well-equipped workforce across all sectors (continued).	Policy Group to formulate new policy and guidance in response new legislation and national/local developments.	4LSAB Policy Group.	Refresh of the 4LSAB Multi Agency Safeguarding guidance in progress for 2019.	2020 – Refreshed Policy to be launched.
		Learning gained from serious cases is shared within and across organisations and this is used to inform and improve practice.	4LSAB Workforce Development Subgroup.	Included in the multiagency training programme.	2020 - Training programme runs financial year (Apr – Apr).
				4LSAB coordinated learning events.	2020 – Coordinated 4LSAB events to be provided.
		Learning into practice events form part of the HSAB multi-agency learning and development programme.	Learning and Review Subgroup.	Themes to be identified and included in the training programme. Additional work is required to encompass this. There should be joint and single Board events.	2020 - Training programme runs financial year (Apr – Apr).
			4LSAB Workforce Development Subgroup.		
Housing subgroup to produce guidance on Homelessness.	Housing Subgroup.	To be actioned in 2020.	To be completed in 2020.		

No.	Priority	Key actions	Owner	2019 Update	Timescale and desired outcome
4.	Safeguarding services improved and shaped by the views of service users, carers and other stakeholders.	Independently facilitated MSP feedback pilot.	Stakeholder Group.	Required - Service users are at the centre of the safeguarding process which is driven by the outcomes they are seeking.	2020/21 – To be achieved.
MSP forms part of the HSAB multi agency training programme.	Required - User feedback tool is developed, and an MSP pilot undertaken in 2020/21.	2020 – to work with the local authority on a Service User feedback tool as a priority.			
Engagement and community participation - hold stakeholder events and undertake a stakeholder survey.	Evidence is available to show culture and practice is changing.	Stakeholder events were held in three localities previously and this will be repeated in late 2019 early 2020. Survey will commence early 2020.			
Mechanisms supporting co-production and service user and carer engagement in the work of the HSAB.	Board is inclusive and is representative of all local communities and interests.	2020 - Service users and carers involved in co-production. Mechanisms in place to consult with a wide variety of the community by taking work “out to them”.			

No.	Priority	Key actions	Owner	2019 Update	Timescale and desired outcome
4.	Safeguarding services improved and shaped by the views of service users, carers and other stakeholders (continued).	<p>Introduce the (MSP) approach across all agencies.</p> <p>Design and implement a pilot of an independently facilitated user feedback process on a sample of people who have received support through the safeguarding process.</p> <p>Develop a sustainable model for the MSP reviews going forward including the sourcing of funding to support this.</p>	Stakeholder Group.	<p>Board strategies, plans and guidance are informed by stakeholder views and feedback from stakeholder events and stakeholder survey (Stakeholder group to report to HSAB as and when carried out).</p>	<p>2020 - Service users and carers involved in co-production. Mechanisms in place to consult with a wide variety of the community by taking work “out to them”.</p>
		Explore a range of approaches to achieve meaningful involvement of service users and other stakeholders on the Board and work groups to ensure Board activities are informed by the voice of stakeholders.		A range of approaches are used to support co-production and the meaningful involvement and engagement of stakeholders.	2020 – Stakeholder subgroup Chair to report back to the HSAB as part of meeting reports.

No.	Priority	Key actions	Owner	2019 Update	Monitoring and timescales
5.	Clear, effective governance processes are in place within and across organisations.	<p>Undertake an annual multi agency themed audit on a priority topic (Year 1 - MSP).</p> <p>Partner organisations to carry out practice audits to ascertain level of MSP compliance.</p>	4LSAB Quality Assurance Group.	<p>The findings from multi-agency themed audits have been used to inform the work of the Board and these promote evidence-based practice.</p> <p>Evidence demonstrates that MSP, MCA and changing culture and a shift in practice towards the MSP approach.</p>	<p>Completed in 2019.</p> <p>The findings from multiagency themed audits have been included in the HSAB annual report.</p> <p>2021 next self-audit.</p>
		<p>Develop an Integrated Scorecard approach to gain a holistic overview of safeguarding risks across the 'system'.</p> <p>Benchmark local data against the HSAB Quality Assurance Framework, government 6 safeguarding principles and national comparator information.</p>		<p>4LSAB Multiagency Scorecard has been completed and is now in use.</p> <p>Use of the Scorecard has enabled HSAB to obtain a picture of the effectiveness of local safeguarding arrangements and is able to compare against other areas.</p>	<p>Completed.</p> <p>The scorecard should be used going forward by the 4LSABs for audit purposes.</p>
		<p>Develop processes to ensure responses and actions plans arising from serious cases are monitored and evaluated effectively.</p> <p>Formally adopt the HSAB Assurance and Accountability Framework (AAF).</p>		<p>Learning from serious cases lead to positive change and improvements across the whole system.</p>	<p>2020 - 4LSAB QA subgroup to develop an effective approach - evidence of changes and improvements made as a result of learning from serious cases.</p>

No.	Priority	Key actions	Owner	2019 update	Timescales and monitoring
6.	Learning from experience - mechanisms to gain learning from serious cases and promote service and practice improvement.	Commission and oversee the Mr C SAR linking issues to the previous 2 SARs of a similar nature. A thematic review to identify and address blockages.	Learning and Review Group.	HSAB fulfils its statutory duties under Section 44 of the Care Act (2014).	Completed 2018.
			Health Subgroup.		
		Commission and oversee future SARs and Partnership Reviews.	Learning and Review Group.	HSAB fulfils its statutory duties under Section 44 of the Care Act (2014).	2019/20 2 x SARs. 1 X Partnership Review.
		Health Group to develop a 'super SIRI' process to enable one combined investigation to be undertaken in cases involving multiple health organisations.	Health Subgroup.	A Joint document to be produced collaboratively for reviews undertaken by the health agencies to enable systems learning.	2020 – Health Subgroup to progress and report on progress with this.
		Commission and oversee the Mr C SAR linking issues to the previous 2 SARs of a similar nature. A thematic review to identify and address blockages.	Learning and Review Group.	HSAB fulfils its statutory duties under Section 44 of the Care Act (2014).	Completed 2018.
			Health Subgroup.		
Commission and oversee future SARs and Partnership Reviews.	Learning and Review Group.		2019/20 2 x SARs. 1 X Partnership Review.		

No.	Priority	Key actions	Owner	Success measures	Timescales and monitoring
6.	Learning from experience - mechanisms to gain learning from serious cases and promote service and practice improvement (continued).	Health Group to develop a 'super SIRI' process to enable one combined investigation to be undertaken in cases involving multiple health organisations.	Health Subgroup.	A Joint document to be produced collaboratively for reviews undertaken by the health agencies to enable systems learning.	2020 – Health Subgroup to progress and report on progress with this.
		Commission activities to ensure lessons from serious cases are shared and applied. Learning summary bulletins produced to ensure learning gained from serious cases is widely shared within and across organisations.	Learning and Review Group.	Learning from serious cases is shared widely –availability of opportunities to reflect on practice.	2020 – to progress this and publication of learning summaries every six months and following statutory and discretionary SARs.
		Learning into practice events included in HSAB training programme. Annual thematic review of local and national SARs.		'Learning into Practice' events incorporated into the HSAB multiagency safeguarding training Programme.	To take place in 2020/21.

No.	Priority	Key actions	Owner	Success measures	Timescales and monitoring
6.	Learning from experience - mechanisms to gain learning from serious cases and promote service and practice improvement (continued).	Establish mechanisms to evidence that services have improved because of lessons gained from investigations reviews and these lead to improved outcomes.	Learning and Review Group.	To establish that evidence from learning from serious cases is leading to improvements in practice and services.	2020 – 4LSAB QA subgroup to work with LRS to create impact evaluation reports.
			4LSAB QA subgroup.		
		Protocol to enable effective communication and joint working across health and adult social care in response to critical events.	Health Subgroup.	Effective communication and joined up approach amongst partner agencies in response to critical events.	2020 - Protocol to be produced for consideration across the 4LSABs.
HSAB Business unit to update the Learning from Experience Database to include post Care Act SARs.	Board Manager.	Access is available to up to date information about serious cases and learning from these to support evidence-based practice via the HSAB website.	Completed 2018. Ongoing requirement to keep the National SAR library up to date.		