# Hampshire Safeguarding Adults Board

Annual Report 2022-2023





## **Contents**

Welcome from the HSAB Chair	3
Reflections from the HSAB Independent Scrutineer	4
The structure and purpose of the Safeguarding Adults Board	6
How to report a safeguarding conern	8
Safeguarding activity in Hampshire	9
Report from the Principal Social Worker	12
Learning from safeguarding adults reviews	14
What have we done together to support our strategy?	18
Resident engagement	24
HSAB subgroup activity	26
Partner feedback	31
Communication, safeguarding events and training programme	32
Looking ahead	34
HSAB financial summary 2022-23	35

## Welcome from the HSAB Chair

### Welcome to Hampshire's Safeguarding Adults Board's Annual Report for 2022-23.

I am pleased to introduce the Hampshire Safeguarding Adults Board Annual Report for 2022-23. In last year's report I reflected on the significant and sustained pressures placed on our services and communities and the heightened risk of these to safeguarding vulnerable adults from abuse or neglect. It's fair to say that despite the lifting of most Covid restrictions, we have found that demands on all our support services have continued unabated against a backdrop of increasing living costs. In this context, the work of HSAB partners to ensure effective safeguarding arrangements across our health and care system remains a priority.

Despite the significant resourcing pressures and challenges faced by partners, there remains a relentless commitment to driving continuous improvement and delivering positive safeguarding outcomes. I remain extremely grateful for the commitment and dedication of all agencies – statutory, non-statutory, voluntary and those more specialist in nature, who demonstrate an exemplary shared commitment in keeping safe those who are most vulnerable.

The engagement from Board and subgroup members ensures openness, trust, and honesty. Our shared goals and values, along with regular communication and constructive challenge, continues to be the golden thread that enables us to operate effectively in a challenging context.

We have continued to experience an overall increase in the volume of Safeguarding Adult Reviews (SARs). The Board now has a dedicated

SAR Coordinator to ensure that we can meet the increased activity, disseminate learning, and provide assurance on action plans.

Learning and continuous improvement remains a priority for the HSAB. Aside from the learning from SARs, we commissioned a Stakeholder Survey which was open to those accessing services, staff and all members of the public. The feedback included the voices of people that we support, which has helped the HSAB to understand what is important for people and to plan the operational delivery of our strategic priorities. During this year we have delivered several multiagency training sessions. All of these have been particularly well attended with over 400 participants. The HSAB team attended several carers' information events in different areas of the county, with engagement from over 100 local carers.

Looking ahead, work scheduled to refresh and update our ever-popular website will only enhance our reach. The website, along with our social media channels, continue to support us to deliver our key messages.

Finally, it is important for me to acknowledge the work and commitment of our front-line practitioners, for their dedication and professionalism in these challenging times. We can all be proud of the commitment to joint working and the incredible efforts made every day to keep services and people safe within Hampshire.

#### **Graham Allen**

Hampshire Safeguarding Adults Board Chair Deputy Chief Executive and Director of Adults' Health and Care, Hampshire County Council

# Reflections from the HSAB Independent Scrutineer

The independent scrutineer provides objective scrutiny and challenge and acts as a constructive critical friend, aiming to promote reflection and development.

Effective safeguarding support with adults who have care and support needs requires a focus on both safety and wellbeing.

Making someone safe doesn't always lead to fulfilment of what's important to them. There is a necessary balance between rights and risks in making safeguarding work well for people. It involves making a connection with the individual and their circumstances, whether in front line practice or as a Safeguarding Adults Board (SAB). Connecting with people's experiences is central to the SAB's role in gaining assurance of the effectiveness of safeguarding arrangements.

The Board is building a picture of what matters to people. It is learning from a recent safeguarding adults stakeholder survey as well as engaging in conversations with individuals in our communities. This work builds on significant feedback from families and others, offered during work on Safeguarding Adults Reviews (SARs). The Hampshire Safeguarding Adults Board (HSAB) recognises this as a vital and ongoing part of its business, including in informing strategic priorities.

Multiagency audit of practice would provide further insight. Frontline staff and professionals can give important feedback too about what's working well, the challenges that exist, and about where support is needed. Recognising and exploiting this insight is also an area for future development.

This annual report reflects complexity in the breadth of safeguarding responsibilities and emphasises the need for collective action and accountability. The SAB must make sense of that complexity to arrive at a set of core priorities. It is positive that it does this with careful reference to the available evidence base and by considering where its assurance and support can have the greatest impact. At the same time, it maintains flexibility of approach to respond to the impact on safeguarding responsibilities of emerging issues such as the cost of living crisis.

Learning from SARs is a substantial and valued aspect of the SAB's evidence base and of its assurance and development work. This report shows that there is strong local commitment for this statutory duty. There is real determination and work underway in the SAB to support and gain assurance that lessons have been learned and there is ownership and accountability for associated actions – however, this continues to be challenging both locally and nationally.

The SAB continues to develop the data and information it needs in its assurance role. For example, both local and national data have shown that developing a consistent understanding of how to identify and act on safeguarding concerns should be a SAB priority. More work is needed locally and elsewhere to achieve and demonstrate this shared approach in practice.

Roundtable discussions over the past year have not only contributed to shared commitment to activity related to SAB priorities. These cross-partnership conversations assist too in developing a SAB culture which is transparent, honest, mutually challenging, and makes the SAB ready to discuss and work collectively. This culture fosters effective partnership working and it has developed substantially over the past year.

There is determination among SAB members and subgroups to work out how best to tackle the Board's priorities so that they have the potential to make a real difference in people's lives and support effective safeguarding. The HSAB website is a practical demonstration of its commitment to supporting learning and development and offers tools to support and inform front line practice.

#### Jane Lawson

**HSAB Independent Scrutineer** 

# The structure and purpose of the Safeguarding Adults Board

The Care and Support Statutory Guidance (DHSC, 2023) confirms that 'the main objective of a SAB is to assure itself that local safeguarding arrangements and partners act to help and safeguard adults in its area' who meet the safeguarding criteria (Care Act 2014).

The Care Act 2014 requires partner agencies to work together to protect adults at risk of abuse and neglect. It details how partners should work together to reduce risk, so that concerns are identified and reported and those who have a statutory duty to enquire, act in a timely, person centred and coordinated way.

"Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the 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."

Care and Support Statutory Guidance, 2023, DHSC

### 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.

The Hampshire Safeguarding Adults Board has a Chair and an Independent Scrutineer, who provide objective scrutiny and challenge and act as constructive critical friend, aiming to promote reflection and improvement. The HSAB acts as the key mechanism for agreeing how agencies will work together effectively to safeguard and promote the safety and wellbeing of adults at risk and/or in vulnerable situations. HSAB is supported in its work by a number of subgroups with each operating to terms of reference and an agreed work plan which focuses on the delivery of HSAB strategic objectives and priorities. We run some of our subgroups jointly with the other neighbouring local Safeguarding Adults Boards where we share common priorities and objectives.

### The three core duties of HSAB are to:

- Develop and publish a strategic plan, setting out how we will meet our objectives and how our members and partner agencies contribute
- Publish an annual report detailing how effective our work has been
- 3. Commission Safeguarding Adults
  Reviews (SARs) for any cases which
  meet the criteria set out in Section 44,
  Care Act, 2014

Key aspects of the role of the HSAB include to: Oversee and lead adult safeguarding across the locality, setting strategic objectives, and will be interested in a range of matters that contribute to the prevention of abuse and neglect.

- Seek assurance that SAB partners understand and engage in their role to challenge each other and other organisations where evidence suggests their actions, or inactions, are increasing the risk of abuse or neglect.
- Maintain effective links with wider partnerships who should consciously cooperate to reduce duplication and maximise efficiency.
- Whilst these are some key aspects of the role; there is a wide range of ways in which the SAB contributes to effective safeguarding. These are set out in statutory guidance (14.134-139).
   www.gov.uk/government/publications/ care-act-statutory-guidance/care-andsupport-statutory-guidance

# How to report a safeguarding concern

An adult safeguarding concern should be raised with the local authority where there is a 'reasonable cause to suspect that the adult may have needs for care and support (whether they are receiving care and support or not) and where there is reasonable cause to suspect that the adult is at risk of or experiencing abuse or neglect.

HSAB Safeguarding Concerns Framework. 4LSAB Safeguarding Concerns (hampshiresab.org.uk)

You can find out more about adult safeguarding here: Adult Safeguarding Animation - 4LSAB - YouTube

**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 Hampshire County Council Adult Services on 0300 555 1386. Opening times and 'out of hours' numbers are below.

For more information about how to report non-urgent concerns, visit Adults Health and Care advice here: Contact Adults' Health and Care | Health and social care | Hampshire County Council (hants.gov.uk).



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

This section reports the Safeguarding activity recorded within Hampshire over the last year.

Hampshire is a large and diverse county, bringing together city, coast and country. It is home to 1,409 million people. The county of Hampshire is governed by a County Council and 11 District and Borough Councils.

Hampshire is home to

1,409 million people

Compared to England, Hampshire has an older population structure, with a greater proportion of the population

aged 50 years or older.



Over the last five to six years healthy life expectancy has

# decreased for both males and females.

This suggests people overall are living longer in poor health.



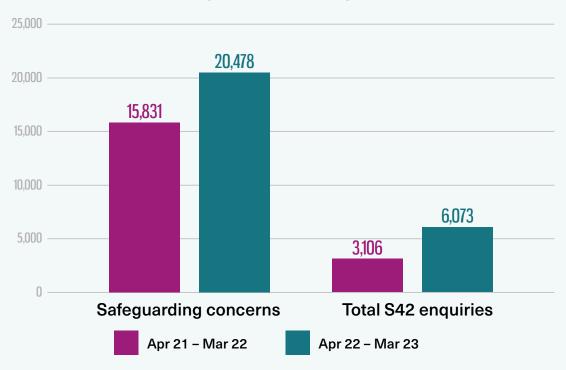
It is estimated that

1 in 4 adults

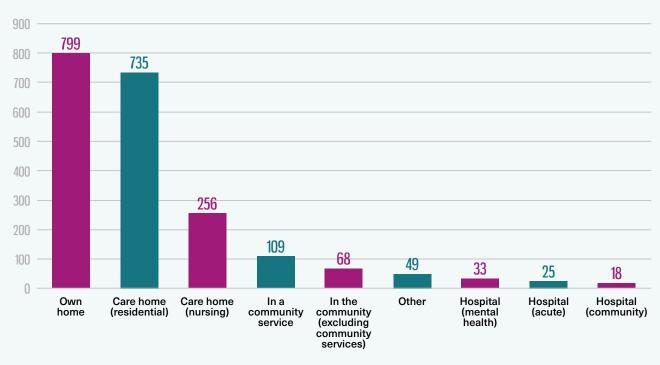


will experience mental health problems. Mental illness is the single largest cause of disability in England.

### **Comparison of S42 enquiries**

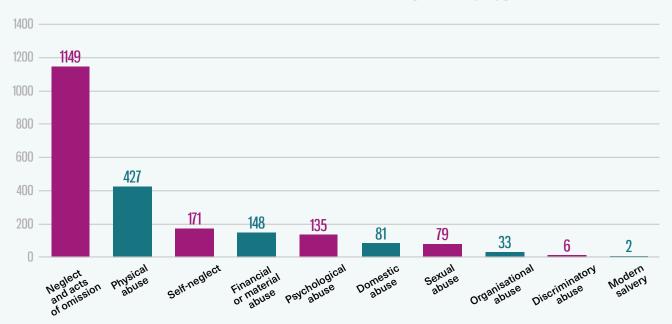


### **Location of risk**



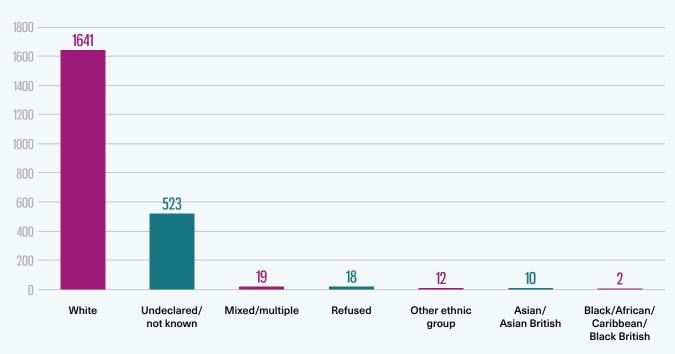
2021/2022 SAC data

### **Count of concluded section 42 enquiries by type**



2021/2022 SAC data

### Individuals involved in S.42 enquiry by ethnicity



2021/2022 SAC data

# Report from the Principal Social Worker

A key focus for Hampshire County Council's Adults' Health and Care (AHC) during 2022-23 was to translate key system learning from Hampshire Safeguarding Adults Reviews into practice improvement.

Two priority areas are outlined here, both of which demonstrate how AHC continues to deliver on the HSAB's strategic priorities, supporting effective multi-agency working to safeguard adults.

### **Enhanced Support Service**

In response to learning from the thematic self-neglect SAR, AHC undertook a sixmonth pilot to trial a new Enhanced Support Service to engage individuals where there were safeguarding concerns, primarily in relation to self-neglect, hoarding and a risk of homelessness. The aim of the Enhanced Support Service (EHS) is to mitigate immediate risks and work in a strengthsbased way to enable people to strengthen independence. The EHS seeks to promote engagement with services over a period of up to 12 weeks, with onward referral to other agencies for longer term work where required.

The pilot demonstrated significant benefits including improving links with services in the community, strengthening independence, and onward referral for social care assessment. Following the success of the pilot, the Service has been rolled out to community teams and is now available for adults already known to AHC as well as new referrals.

### **Case study**

A referral was received into MASH from the Police who reported concerns about an individual living in poor conditions, struggling with their mental health, autism and experiencing anti-social behaviour from others in the neighbourhood. The individual had historically not engaged with services and a referral was made to the Enhanced Support Service. The Support Worker enabled the individual to access their GP and have an assessment of their mental health, which resulted in a treatment plan and ongoing mental health support. The individual's mental health and home environment improved, and they were supported to access educational opportunities

### Introducing the Risk Assessment and Escalation process and panel

SAR learning highlighted that working with acute or complex risk can be one of the most challenging areas of practice. Opportunities for improvement were identified in how risks were assessed and escalated, with limited systematic governance in the management and mitigation of known risks. This impacted staff wellbeing, with practitioners feeling personally responsible for holding risks.

During 2022, AHC introduced a new Risk Assessment and Escalation process, Risk Escalation Panel, practice guidance and training. Risks for eight adults have been escalated to the panel, five of which have been heard on multiple occasions due to the severity and complexity of risks, which include domestic abuse, hoarding and self-harm. Complex considerations relating to mental capacity is also a recurring feature and challenge.

"I have found the whole process helpful. The tool outlines the risks and has its own escalation process. The meetings are informative and a good platform to have open honest discussions about holding the risk and who we can access in other services to escalate and to consider if there are other options we have not considered. Escalation by Head of Service and Director when needed has been helpful and achieved better outcomes."

**Adult Social Worker** 

# Learning from safeguarding adults reviews

A key statutory duty of the SAB is to carry out safeguarding adult reviews (SARs) under Section 44 of the Care Act.

The purpose of the SAR is to gather the facts about a case and how agencies worked together, for lessons to be identified, and improvements made across the safeguarding system. The aim is to achieve better outcomes for adults who have care and/or support needs and who may be at risk of, or experiencing, abuse or neglect.

Where criteria for a SAR is not met, the Learning and Review subgroup may recommend other learning activity. This can include recommending single agency learning.

### **SAR** referrals

The number of referrals received by the HSAB Learning and Review subgroup have continued to increase in 2022. The HSAB has introduced a SAR Coordinator role to support SAR activity and to ensure continued focus on learning from SARs.

The table below shows 23 referrals have met the criteria for SAR since April 2019; to date 16 have been commissioned with seven to be commissioned in 2023-24 – four of which will be included as a thematic SAR.

Year	April 2020 – March 21	April 2020 – March 21	April 2021- March 2022	April 2022 – March 23
Number of SAR referrals received	15	15	17	29
Number of referrals that met criteria for SAR	3	7	5	8*
Number of SARs commissioned	2	7	2	5

The difference between the number of referrals that meet SAR criteria and the number of SARs commissioned is due to:

- Partner capacity to respond to volume of SARs and to support the implementation of learning
- Some SARs have been included in thematic SAR commissions

### SARs published April 2022 - March 2023

There have been no SARs published in the 2022/2023 financial year. All published SARs can be found on the **Hampshire Safeguarding Adults Board website**.

### Other SAR Activity April 2022 – March 2023

Learning activity has focused on the findings of the Self Neglect Thematic SAR and the Sam SAR published in March 2022.

### The Self Neglect Thematic Review

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.

Significant work has been undertaken across the partnership in response to the learning identified. Some examples of action taken so far include:

- The four Local Safeguarding Adults Board multi-agency Hoarding Guidance was updated in June 2022.
- Risk assessment and management guidance is being reviewed and updated as part of the four Local Safeguarding Adults Board Hoarding and Multiagency Risk Management policy reviews.
- HSAB coordinated the delivery of eight sessions on the Local Government Association guidance 'understanding what constitutes a safeguarding concern?', which were attended by multiagency representatives.
- Partners provided assurance of their agencies' ability to develop and deliver trauma informed approaches in practice. Some partners are continuing to develop this and the HSAB will seek further assurance.
- Hampshire County Council Multiagency Safeguarding Hub have completed improvements in referral processes and identification of self-neglect concerns.

Activity to deliver on the HSAB's strategic priorities will continue to address areas for improvement, including strengthening the approach to advocacy in Hampshire for adults with care and support needs.

### 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 coordinated way to support Sam through transition to adulthood.

Agencies have been working together to implement improvements across the system in response to the learning identified. Some examples of action taken so far include:

- A multiagency framework for managing risk and safeguarding people moving into adulthood was developed and is being implemented across Hampshire, Isle of Wight, Portsmouth and Southampton.
- Partners started to work together to consider how advocacy could be used more frequently and effectively to support people.
- The Escalation protocol is being reviewed by the four Local Safeguarding Adult Boards to ensure this is responsive and to strengthen conflict resolution in a timely way where there are differing professional views.
- The Integrated Care Board have a S117 team in place which supports the Care
  Planning Approach and people included on the dynamic support register. This is an
  NHS England register of people with learning disabilities and/or autism who may need
  higher input from services and who may be at risk of being admitted to a specialist or
  mental health hospital.

There will remain a continued focus on the full learning identified within the safeguarding adult review.

#### Four SARs are currently ongoing:

SAR one	This case includes learning relating to understanding the adult's care and support needs within a family context, responding to neglect within a family setting, managing and escalating different professional views about risk, the Court of Protection process, and ensuring statutory advocacy is used to support hearing the adult's voice.	
SAR two	This case includes learning relating to barriers to effective communication of safeguarding concerns, risk assessment, making safeguarding personal, professional curiosity and hidden harms.	
SAR three	This is a thematic gap analysis including three cases. It will focus on the area of self-neglect and how the safeguarding system is working in this area currently.	
SAR four	This case will consider learning relating to the use of the family approach and identifying and supporting unpaid carers in Hampshire.	

### The Systems Improvement Learning Framework subgroup

Hampshire, Portsmouth, Southampton and the Isle of Wight Safeguarding Adult Boards have been working together with partners to develop a framework, bringing together learning from SARs which will support a shared understanding of wider themes. This can then inform the development of strategic priorities and plans, as well provide key information about targeted areas of prevention and intervention across the four areas. Ultimately this work aims to support improved system outcomes for adults with care and support needs who are at risk of or experiencing abuse or neglect.

# What have we done together to support our strategy?

### Progress on our strategic priorities

At the beginning of last year, the HSAB held several development days as well as a stakeholder event. Through these sessions, multiagency partners and people who use health and care services worked together to co-produce a new set of Strategic Priorities. These are set out in our three year Strategic Plan, available on our website.

Stakeholders also worked together to help shape an operational plan of how to achieve our shared priorities during the first year of delivery.

This section provides an overview of key activities undertaken to deliver on our three priorities.

### Key themes raised at the Stakeholder event were:



**Other key themes included:** Proactive, carer voice, safeguarding survey, resilience, proactive help, information, quality support, professional curiosity, professional literacy, respecting service user views, breaks for carers.

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

### **Embedding safeguarding concerns**

Drawing on national work undertaken by the Local Government Association, the HSAB Independent Scrutineer supported a round-the-table engagement event to explore what more could be done among partners and the wider public to facilitate a shared understanding of concerns.

This is so that where safeguarding concerns exist they can be positively addressed. When concerns are raised with the local authority they are able to draws on a range of organisations to resolving the situation. The 2022-23 stakeholder survey again highlighted this as a key area of work.

#### Key messages from the roundtable - Safeguarding concerns

- Being clear and having a shared definition of what a concern and an enquiry are can give greater confidence to raise concerns and to challenge and escalate where necessary across agencies.
- It can help practitioners to explain to people they support what a safeguarding concern is and how to raise it with the Local Authority.
- More can be done to ensure the persons views and wishes are heard.
   Often the 3rd sector is well placed to support the person with this.
- Everyone has a responsibility to ensure the person is at the centre of safeguarding plans and support.
- A partnership approach to safeguarding concerns and enquiries can be strengthened to remove the 'fear' quite often associated with the term 'safeguarding.'

### Understanding Black and Minority Ethnic people's view on safeguarding concerns

The HSAB 2021 stakeholder survey identified that whilst most respondents felt comfortable reporting abuse or neglect, confidence was lower among service users and BAME respondents. Most respondents felt that a lack of knowledge about contacts was the

main barrier to reporting concerns, whilst BAME respondents felt that an understanding of what constitutes abuse and neglect was a greater issue. To understand better BAME perspectives, the HSAB hosted a multi-agency round-the-table engagement event.

### Key messages from the roundtable - Ethnic diversity

- There is a need to further define and develop cultural competency training and resources available to all partner agencies.
- Welcome and introduction materials, resources, and delivery arrangements for life in the UK should be reviewed based on recent experience with a strong focus on rights, responsibilities, and the law.
- Increase awareness among professionals of access to and support and available regarding ethnic minorities.
- Collaboration with voluntary and community partners, including faith and community leaders, is key to facilitate trusted engagement and integration activities.

### Qualitative research to gain deeper insight into expectations and experiences of safeguarding support

A research proposal has been developed to understand people's perceptions and experiences of initial engagement with safeguarding support, and to explore what barriers prevent people reaching out for support and how these might be addressed.

Priority two: 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.

### **Review of Advocacy**

HSAB partners engaged in a round-the-table engagement event to examine how well we understand, offer, and use advocacy to identify ways to improve this so that individuals are supported to understand their rights, express their views and be heard.

The session considered learning from three local SARs, as well as a sample of SARs from the national SAR library, and used prompts from the Local Government Association's best practice briefing 'Strengthening the role of advocacy in making safeguarding personal' to stimulate discussion.

### **Key messages from the roundtable - Advocacy**

- A need for advocacy to be better understood; for advocates to be involved in appropriate and timely ways, taking account of people's legal rights to advocacy and the statutory duties to refer.
- Understanding the significant contribution that advocacy can make in safeguarding people in health and social care provider settings.
- A need for a continued partnership approach to governance that supports the potential role of advocacy in effective safeguarding and making safeguarding personal.
- Commissioners play a vital role in ensuring the right advocacy service is available at the right time.
- Clearer understanding of local data around advocacy is needed.

### **Professional curiosity guidance**

A 7 minute guide was developed and shared on the HSAB website.

### Supporting good practice in self-neglect

Following completion of a self-neglect thematic SAR in 2021-22, HSAB partners engaged in a multi-agency session to explore further key system practice challenges and how these may be addressed.

### Key messages from the roundtable - Self-neglect

- If someone is making unwise decisions, agencies will still work together to safeguard the person whilst respecting their autonomy. This is sometimes a complex balance to achieve.
- Support agencies are key to building relationships and supporting the person to express their views and wishes.
- A clearer understanding is needed for when to engage the Court of Protection to make best interest decisions on behalf of someone who lacks capacity.
- A clearer understanding is needed of the impact alcohol and substance use can have when a person is experiencing self-neglect with regards to their ability to make informed decisions and take actions to protect themselves.

# Priority three: 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.

- 4LSAB MARM Review was undertaken involving extensive consultation completed through the 4LSAB Policy subgroup
- 4LSAB Family Approach was reviewed in partnership with the Hampshire Safeguarding Children Partnership Board

The Board will review and test how we are challenging and holding each other to account by building on five foundational blocks underpinning the strategic plan.

This will ensure we remain focused on delivering our core statutory responsibilities and are evidence led in prioritising resources to drive improvement in safeguarding practices and outcomes for people, making the greatest impact where it matters most.

Tracking compliance with our statutory duties

Scrutinising data and performance indicators

Seeking feedback from people – server users, carers, families and staff

Undertaking self-assessment and bespoke audits

Working more effectively in partnership

## Resident engagement

Between February and March 2023, the Hampshire Safeguarding Adults Board (HSAB) ran a public survey to inform the safeguarding work undertaken by the Board and its partners.

As well as asking about respondents' understanding of safeguarding, the survey asked about people's experiences of supporting others with care and support needs, as well as their experiences of services that support adult safeguarding. Respondents were invited to make suggestions for improvements to safeguarding services in Hampshire. In total 198 responses were submitted to the survey.

### **Key headlines included:**

Proximity to a potential abuse/neglect victim appeared to be the main factor in how confident someone would be to report it – generally people were very confident to report concerns about family or close friends, but less confident regarding neighbours, colleagues, and non-close friends.

Respondents generally did not feel less safe because of the cost of living crisis, although organisations supporting people with care or support needs tended to believe this was the case.

The main reasons people might avoid reporting concerns involved potential repercussions for the adult at risk, and the possible desire of the individual concerned for it to not be reported.

Respondents were quite likely to feel that people with care or support needs felt listened to and involved in safeguarding enquires, but less likely to believe they felt at the centre of them – suggesting that individuals might feel engaged with, but not a key element of, these processes.

The majority of those supporting people with care needs in their job responded that they would seek help if harmed by someone they cared for – however, only about half of those supporting an adult they know in a personal capacity would seek help if harmed by them.

While organisations supporting people with care and support needs generally felt that these people felt safer as a result of these enquiries, this view was held less often amongst Individuals with, or supporting people with, care and support needs.

These key messages will be used to inform the co-production of the 2023/24 operational delivery plan. Where we intend to respond to key learning from this survey and build on our work to hear what's important, challenging and working well for the people in our communities.

## **HSAB Subgroup activity**

The HSAB and 4LSAB Subgroups have continued to support the delivery of HSAB strategic objectives and priorities.

Some subgroups are jointly run with the other neighbouring local safeguarding adults boards, where we share common priorities and objectives. Here is a snapshot of: Key achievements, challenges and their future focus as we remain committed to grow and deliver on our 2022 -2025 Strategic plan.



### **HSAB QUALITY ASSURANCE SUBGROUP**

### **Key achievements**

- Increased membership of the subgroup has enabled wider discussions with partners
- An open and honest forum for discussion where everyone's voice is heard, there has been a cultural shift which embraces challenge and solutions to risks identified, increased accountability and professional discussions taking place when we identify something isn't right.
- Reflection on S42 conversion rate and number of Safeguarding concerns reported, work completed to support better recording and risk assessments. This included wider discussion around CQCs and neglect by omission of care and pushing the agenda to ensure the Board are more informed on what is happening.

- Improvement of data reporting
- Greater links with Public Health and specifically early death rates

### **Key Challenges**

 Continued pressure on services including staff pressures and austerity cuts can have an impact on Safeguarding and on engagement with HSAB, however the group is committed to facing these challenges

- To continue to improve overall data quality and narratives provided by partners
- To evidence how agencies are proactively addressing risks and actively audit areas of risk to avoid assumption

## 2 HSAB STAKEHOLDER SUBGROUP

### **Key achievements**

- Delivered several carer engagement events across the county
- Drew upon the expertise and experience of stakeholder members to contribute to Task and Finish groups as well as Round the Table discussions
- Pivotal in reviewing and the creation of the Stakeholder survey

### **Key Challenges**

Reshaping of the subgroup due to members capacity

### **Future focus**

 Consider and embed key messages from the Stakeholder survey

### 3

### **HSAB LEARNING AND REVIEW SUBGROUP**

### **Key achievements**

- Decision tool has been developed and successfully implemented to support robust consideration and recording of the Section 44 duty
- Process changes have been made to support the increase in volume of SAR activity coming through
- Increased membership to support wider knowledge base
- · Four SARs have been commissioned
- Movement away from recommendations for the board to consider following the completion of reviews, to questions for the board, facilitating additional depth of reflection

### **Key Challenges**

- Escalation in referrals and recommendations for SARs, resulting in increased pressure on partner agency resources
- Effectively achieving assurance that learning has been embedded within organisations

- Training on SAR process and SAR outcomes
- Annual learning summary from the LRS to be implemented for partner dissemination
- Four board SAR decision making audit

## 4 4LSAB POLICY SUBGROUP

### **Key achievements**

- All policies developed and reviewed by the subgroup aim to promote best practice, making safeguarding personal and risk management
- Key Policy and Guidance Documents developed or updated this year:
  - Large Scale S42 Safeguarding Enquiry Protocol
  - Homelessness Guidance
  - Framework for Managing Risk and Safeguarding People Moving into Adulthood

Revised Hoarding Guidance

### **Key Challenges**

 Learning identified through national and local case reviews often result in the need for new guidance or revisions to existing guidance, partners are committed to prioritise this work and support practice but acknowledge this work can take time

### **Future focus**

- Finalising review of Multi Agency Risk Management Framework
- Family Approach Toolkit

## 5

### **4LSAB HOUSING SUBGROUP**

### **Key achievements**

- Reviewed terms of reference in light of change of group from HSAB to 4LSAB
- Production of Homelessness Guidance and successful launch via a lunch and learn session
- Reviewing impact of 'cost of living crisis' on Housing, especially in relation to refugee and host family situations

### **Key Challenges**

 During the year there has been an increase in partner engagement, despite challenges of time constraints

- Impact of cost of living on affordability of housing and maintaining properties
- Continue to support the housing sector in responding to safeguarding concerns
- Embed the homelessness guidance and that homelessness is not just a housing issue

## 6

### **4LSAB FIRE SAFETY DEVELOPMENT GROUP**

### **Key achievements**

- Publication of the Fire Safety Development Group Thematic review 2019-21 and Learning briefing
- Between April 22 and March 23 the Fire Safety Development Group conducted 15 case reviews for fire incidents where a serious injury or fatality occurred. 75% of incidents reviewed involved an individual who was living alone and 88% were male. 25% of cases were known to Adults Health and Care. For further information: FSDG-Learning-Briefing-Nov-2022.-FINAL-.pdf (hampshiresab.org.uk)
- Training from Hampshire and Isle of Wight Fire and Rescue Service through the 4LSAB's and to individual partner organisations raises professional awareness and knowledge to identify, assess and manage fire risk

### **Key Challenges**

Learning identified in Fire Safety
 Development Group case reviews can identify themes of a similar nature. There is a challenge regarding the confidence and assurance that partners are reviewing the learning and embedding positive changes in practice.

- Two workstreams of the 2 Fire Safety Development Group priorities for 2023 – 2025:
  - To provide assurance that the Fire Safety Framework and case review learning, has been embedded in practice within agencies across the 4LSAB
  - To engage with the Care Quality
     Commission across the 4LSAB area
     to seek assurance of fire risk management
     within domiciliary care providers
     and the promotion of the 4LSAB
     Fire Safety Framework

## 7 4LSAB HEALTH SUBGROUP

### **Key achievements**

- Extended the subgroup from Hampshire to a 4LSAB group to achieve consistency across services and areas
- Progressing a review of practice guidance when supporting adults who report non-recent abuse
- Creating an environment for system learning, identifying risks and examples of good practice

### **Key Challenges**

 Delivering an equal service for the priorities of all four boards needs consideration. The group is in it's first year and will continue to strengthen its functions

- Engage with the scoping around safeguarding concerns and opportunities to strengthen awareness across all healthcare settings
- Development of health supervision strategy to empower practitioners to further develop skills and knowledge to ensure safeguarding practice is personal for the adult they are supporting

## Partner feedback

# What has the HSAB done to support you with this work, what's positive about working with HSAB?

46

Business manager, independent scrutineer and board manager actively support the subgroup and the work it completes. Clear links with HSAB that allows the two way flow of information and work."

44

Peer challenge is actively encouraged and occurs on a regular basis."

46

The admin support has been invaluable alongside the professional discussions and debates I have had with the HSAB team. The positive and supportive culture is a welcome bonus."

44

Attendance from HSAB at the subgroup is always good and their contribution to the work of the group has been valuable."

46

The wonderful board team! As partner agencies, there is a strong and effective working relationships between members and the board team, collaborative working throughout all that we do."

46

The board continue to provide a supportive foundation for the work we do, including calls to action and inclusion in the wider safeguarding partnership within Hampshire."



The HSAB has consistently supported the aims and objectives of the Fire Safety Development Group (FSDG) since 2019, and has been a consistent and effective member of the FSDG contributing to the reviews and the workstreams but also providing overall Governance of the group (along with the other 3 Boards). The HSAB has been very supportive and proactive in raising the awareness of fire risk in the safeguarding arena and ensuring that the workstreams of the FSDG are communicated and shared widely across the HSAB area, and therefore implemented into partner agency practice."

# Communication, safeguarding events and training programme

The HSAB aims to promote awareness and understanding of abuse and neglect among service users, carers, professionals, care providers and the wider community.

It works to generate community interest and engagement in safeguarding to ensure "Safeguarding is Everyone's Business". It does this through an active training calendar, attending stakeholder events and communicating via its website, social media and presence at partnership boards, meetings and forums across the 4LSAB area of 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 2023.

National Safeguarding Week (21-27 November 2022) allowed the HSAB to shine a spotlight on different aspects of abuse and themes relating to adults at risk.

It has made me challenge my own ways of working.

In 2022-23, the 'See it Stop it' App has been downloaded 480 times. Since release downloads number 5884.



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 speaker
was incredibly
knowledgeable and
delivered the session
at a good pace.



# During the week, HSAB social media reached a total of 15,415 people (615 on Facebook and 14,800 via Twitter).

Through the Stakeholder Subgroup, the HSAB resource stand was brought to six Carer's Information events in different areas of the county, with engagement from 107 local carers. The resources were also brought to three Social Worker conferences run by Hampshire County Council.

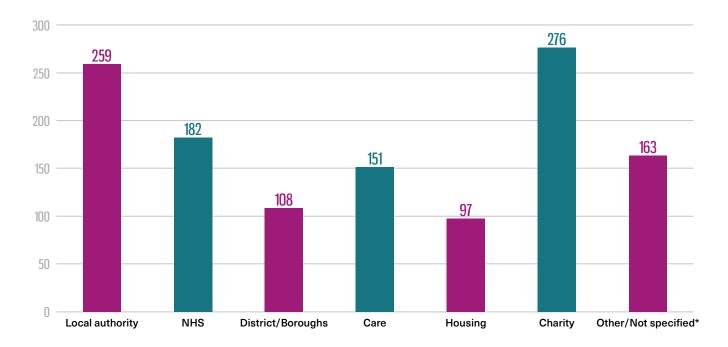
Where possible, the HSAB jointly commissions training with other partnerships, such as the Hampshire Safeguarding Children Partnership, and our neighbouring Local Safeguarding Adults Boards. The HSAB's Learning and Development Strategy (2020-23) can be viewed on the HSAB website.

In 2022-23 the HSAB delivered six multi-agency training events, with attendees totalling 433.

The HSAB also contributed to three Family Approach training events run by the Hampshire Safeguarding Childrens Partnership, and eight Safeguarding Concerns virtual seminars run jointly by the four local Safeguarding Adults Boards.

These workshops are brilliant, very useful and informative.

### BREAKDOWN OF ATTENDEES BY SECTOR FOR COURSES RUN IN 2022-23



\*Attendance from Fire Services, Police and Education have been amalgamated into other.

# Looking ahead

Having completed the first year of the Strategic Plan we now look towards 2023/24 and development of our new operational plan. This will be co-produced through collaboration with Board members and a range of wider partners, including reference to the recent public survey. It will be evidence based including reference to SARs completed and underway, This will support a plan that is flexible, responsive and impactful to ensure the plan remains flexible and responsive to evidence and feedback, deliverable and impactful. We will build on the good progress made, and insights gained, during year one and keep focused on our foundational blocks, ensuring these continue to support delivery.

Key priorities for the coming year include:

- Co-producing the 2023-24 operational plan through a HSAB member Development Day and delivering this, measuring progress and impact building on our existing priorities and considering whether new priorities are identified
- Engaging in SARs, and ensuring that learning is acted on and embedded within practice
- Completing the HSAB Multi Agency Self-Assessment, supporting the SAB's main objective of assurance and demonstrating transparency and provoking mutual challenge.
- Embedding new System Improvement and Learning Frameworks so we can keep track of recurrent challenges, specific areas of learning and make progress on these so we achieve better outcomes.

- Continuing to work closely with our subgroups as they develop and grow
- Completing research into people's experiences and understanding of safeguarding using those insights to inform practice.
- Delivering key training to partners through a comprehensive and relevant HSAB training offer
- Refreshing the HSAB website to better connect with people and communities, staff and professionals because safeguarding needs to be everyone's business.
- Engaging in future Care Quality Commission assurance of Local Authority social care and Integrated Care System delivery

Continuing from last year we will remain focused in our commitment 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, connecting with front line staff for feedback on their experience of safeguarding.

# HSAB financial summary 2022-23

The Board continues to work efficiently delivering value for money, avoiding duplication, and partnering with neighbouring Safeguarding Adults Boards where appropriate.

The Board successfully sought contributions from partners although the vast majority of funding is from the three core statutory partners, with Hampshire County Council holding the largest share.

### Core budget income 2022-23

Income source 2020-21	Amount (Rounded, £)
Hampshire County Council	166,000
Hampshire and Isle of Wight Integrated Care Board	65,000
Hampshire Constabulary	27,000
Wider Partners	33,500
Total	£291,500