Hampshire Safeguarding Adults Board Meeting Thursday 13th September 2018

Present

Templeton, Robert (RT)	Independent Chair - Hampshire Safeguarding Adults Board
Lee, Sue* (SL)	Board Manager – Strategic Partnership Team
Ridley, Adrian* (AR)	Business Manager - Strategic Partnership Team
Allen, Graham (GA)	Director of Adults' Health and Care - Hampshire County Council, Adults Health and Care
Barrett, Mel (MB)	Chief Executive – Basingstoke Borough Council
Anderson, Angela (AA)	Head of Professional standards and regulations - Solent NHS Trust
Beckett, Darren* (DB)	Principle Trading Standards Officer - Trading Standards
Beney, Scott (SB)	Hampshire Constabulary
Boswell, Emma (EB)	Executive Director of Quality and Nursing - NHS North East Hampshire and Farnham CCG
Bowyer, Glenn* (GB)	Group Manager Community Safety - Hampshire Fire and Rescue Service
Butt, Sophie* (SB)	Service Manager - Hampshire Safeguarding Children's Board
Cockburn, Tracey* (TC)	Inspection Manager for Adult Social Care - Care Quality Commission
Courtney, Sara (SC)	Associate Director of Nursing. AHP and Quality - Southern Health Foundation Trust
Cruickshank, Helen* (HC)	Consultant in Public Health – Hampshire County Council
Gingell, Sally (SG)	Service Manager - Hampshire County Council

Gregory, Craig (CG)	Station Manager Community Safety- Hampshire Fire and Rescue Service
Hearsey, Kerry* (KH)	Chief Executive - Princess Trust for Carers
Kent, Amanda (AK)	Chief Executive – Speakeasy Advocacy
Lappin, Jo* (JL)	Head of Safeguarding, Quality and Governance - HCC Adults Health and Care
Ludick, Zena (ZL)	Operations Director Medicine – Hampshire Hospitals Foundation Trust
Maclean, Caz* (CM)	Associate Director of Safeguarding - Southern Health NHS Foundation Trust
Metcalfe, Jaki (JM)	Consultant Nurse - Central Safeguarding Adults Team, West Hampshire CCG
Mussett, Sarah (SM)	Assistant Director of Nursing (Quality Assurance) - NHS England
Phillips, Paul (PP)	Safeguarding Manager – South Central Ambulance Service
Roberts, Josephine (JR)	Head of Specialist Housing Solutions - Radian
Smith, Sarah (SS)	Tenancy Support Manager – Vivid Homes
Spencer, Louise (LS)	Associate Director Quality & Nursing - Hampshire Clinical Commissioning Groups Partnership (South)
Elvy, David (DE)	Senior Administrator – Strategic Partnership Team

*Denotes that the delegate is a voting member of the Board.

Apologies

Browning, Tom* (TB)	Head of Hampshire LDU - Hampshire Probation Service
Fairhurst, Cllr Liz (LF)	Executive Member – Hampshire Adult Services
Dibdin, Craig (CD)	Chief Superintendent - Hampshire Constabulary

Holder, Fiona (FH)	Head of Safeguarding – Solent NHS
Hull, Paula (PH)	Director of Nursing and Allied Health Professionals – Southern Health Foundation Trust
Leatherbarrow, Emma (EL)	Director of Partnerships - Healthwatch Hampshire
McNicholas, Ellen (EM)	Director of Quality and Nursing - West Hampshire CCG
Packham, Lesley (LP)	Director - Crown Home Care
Pearce, Juliet (JP)	Patient Safety Manager - University Hospital Southampton
Priest, Nicky* (NP)	Assistant Director of Nursing - NHS England (Wessex)
Szewczyk, Alison* (AS)	Deputy Director of Nursing - Frimley Park Hospital NHS Foundation Trust
Watson, Dave* (DW)	Head of Safeguarding Unit/Reviewing Service - HCC Children's Services
Winter, David (DW)	Chief Inspector - Hampshire Constabulary

Absent

Brandon, Jason* (JB)	Head - Hampshire County Council Mental Health
Cole, Debra* (DC)	Safeguarding Adults & Domestic Abuse Lead - Surrey and Borders Partnership NHS Foundation Trust
Date, Alice (AD)	Senior Probation Officer - National Probation Service
Pussard, Gail* (GP)	Interim Business Manager - Hampshire Care Association
Roberts-Bibby, Stephanie* (SRB)	Prison Governor - HM Prison Service
Ryan, Caroline* (CR)	Community Safety Manager - Safer North Hampshire
Smith, Ross* (RS)	Service User Representative
Thompson, Sarah (ST)	Head of Safeguarding – Portsmouth Hospitals NHS

Summary of meeting and actions agreed

Item Number	Summary of key actions agreed	Person responsible
1. Welcome and Introduction	RT welcomed all present to the meeting. Introductions were given around the room and apologies received were presented.	
2. Minutes and Matters Arising	The minutes of the Hampshire Safeguarding Adults Board meeting held on the 12th June 2018 were considered and agreed to be an accurate record of the meeting. Actions from 12/06/18: 2.01: A descriptor has been added to the HSAB agenda to show whether items are for information or for approval. This has also been clarified on reports. Item Closed. 2.02: The safeguarding acronym from SCAS was distributed in July. Item Closed. 2.03: Discussions have started around a STP workshop on safeguarding and the strategic direction for safeguarding. Item In Progress. 2.04: This item ties in with the work and recommendations from the fire service under the agenda. Item Closed.	
3. Gosport War Memorial Hospital Inquiry: Partner Agency Presentations	Presentations were provided from agencies on their response to the Gosport War Memorial Hospital Inquiry, with the purpose to update the Board and agree a way forward. Presentations would be made available as an appendix to these minutes. **Hampshire Partnership CCG** A presentation was given by NHS England and the Hampshire Partnership CCG. The Gosport Inquiry was published in 2018. The report provided a range of conclusions for	

	several organisations. No recommendations were given. The conclusions showed an underlying systematic failure to act appropriately from a range of partners. Regular contact has been kept with the General Medical Council to ensure that relevant questions are asked. The link between system and professional regulators is important. A cross-sector regulators forum has been set up with the CQC and comprehensive review and strategic work is taking place. Information sharing must be effective. Information governance and confidentiality can be a barrier to this. Future work must firmly establish that the same issues don't happen again. **Southern Health Foundation Trust** The presentation from South Health showed the actions and reflections taken as an organisation. Questions have been raised regarding prescribing practice in its wide sense and what is now in place. Team culture is important. Unstable leadership can lead to incidents. More information has been raised around early flags and staff are encouraged to challenge decisions when required. The impact of the report was less from the hospitals themselves, and more from the community. Family members are now involved in the decision making process for the planning of care. Each CCG will be running a peer review. Improvement panels are also being run. The Gosport report covers a specific period of time. There is now good work taking place, but it was queried about what was taking place during the time since the end of the reported period.	

	CQC Ursula Gallagher and Teresa Kippax from the Care Quality Commission joined the meeting via conference call. Background was given to the development of a regulatory approach. Inspection teams will instigate enforcement action when necessary. The CQC are working with partners on what needs to be done to keep regulations up to date. A group is being set up to consider the Gosport report and prepare a response. A publically available report on controlled drugs is planned for later in the year. Systems currently in place are being tested with data from the Gosport incident to check whether issues are being picked up now. Mapping the journey is important and the CQC is keen to be involved in conversations with the Safeguarding Boards and hear what others have identified in this case. Hampshire is one area where the CQC have undertaken a Local System Review. Conversations have been held around the learning and recommendations from the report. There are opportunities and challenges for the system to consider, and feedback is always appreciated. **HCC Adults Health and Care** It is important that work is done together, and this session could act as a conduit to discussions. Presentations have been received by the Quality Surveillance Group, who will also be brining examples of work undertaken.	

	A letter has been distributed to all NHS providers to ensure that all syringe drivers are removed. Assurance will also be needed that these are being removed from nursing homes. **Hampshire Constabulary** The voice of the family is a key focus. Family-centred policing is important, and we must not become complacent. A group has been set up to scrutinise the Gosport report. Kent and Essex have also been involved in the investigation, with transparency being a key objective. The investigation parameters had been set very locally, where the scale of the issue had not been taken on board. **Board discussion** It was discussed how the Board could pull together and map the work of its member organisations. The Board has started to run regular meetings working with the other local Safeguarding Boards. Annual or Biannual attendance to the Quality Surveillance Group could be arranged, along with a regular agenda item for Board meetings. Individual organisation actions have been taken and wider work now needs to take place. A meeting specifically focussed on Learning from Deaths has been arranged, with part of the focus being on putting together a coordinated response. Assurance is needed across partners, and duplication needs to be avoided. A large focus will be on the reports received, but also on the robustness of systems in place. The CQC can support this work with provision of data. The Board can feed into the work done by the CQC nationally. The voice of patients must be embedded in the process, including available advocacy.	

	The Board would hold meetings with the other local Boards. A map of local services and systems would be produced and distributed to members. This would be reported on at the December Board meeting. It would be important to take care and not negate any current issues.	**SL**
4. CQC Local Systems Review update	A presentation was given on the CQC Local Systems Review. The presentation would be available as an appendix to these minutes. These reviews have been very different from the usual programme and covered the system as a whole. An extensive 12-month action plan has been produced. Thanks were given to all involved in the process. It would be important to ensure that the connection is made with the Safeguarding Board. Updates on the action plan can be given in six months time.	
5. SAR Thematic Review action plan update	The Health Subgroup held an extraordinary meeting to discuss the SAR thematic review action plan. Four workshops are due to be run over two days to look at key recommendations around hospital admissions, processes and discharge. The Mental Capacity Act was discussed at the last Board. This is being approached on a 4LSAB basis, and the process has been agreed by the other boards. Letters regarding six key messages have been distributed to all Board members. Partners will be asked to undertake an MCA self-audit, additional to the Safeguarding Self-Audit. This will be coordinated across the four Boards to avoid duplication. It is the recommendation from the SAR Thematic Review that the MCA Toolkit is adopted across Hampshire. This has been agreed by the four Boards and Hampshire County	

	Council will be reviewing the tool. The tool will be shared as soon as possible. HCC are leading on a workstream around transition. A spreadsheet update has been received with a number of key aspects around transition becoming integral in planning. Contingency arrangements are planned. Transition to and from acute hospital care was one aspect highlighted. This has been added to actions for Health. Family and carer involvement has also been added. Market development has made an increase in supported living, allowing less need for crisis transition. There is a lot of positive work taking place across agencies. It was recommended that the SAR and Thematic Review feed into the Learning from Deaths Forum. There is potential for duplication with the existing Mortality Group meeting. Mapping work must still be undertaken, but the role of the meeting must be agreed to avoid duplication. There is an opportunity to have one overarching vulnerability toolkit. This would an overarching strategy with links to specific guidance. A multi-agency forum to develop a strategy and guidance around vulnerability is taking place. It is hoped that this will reduce duplication between children and adults work.	
6. HSAB Annual Report	The HSAB Annual Report was distributed to Board members. This has been presented as an accountability statement. A Priority themes paper was also distributed. The Board is now two years into the Strategic plan. The report outlined achievements against the strategic objective. Significant progress has been made on joint working with the other local boards and the Hampshire Childrens Board. Recognising the pressures on partner agencies, several subgroups have been looking into joint 4LSAB working. There is more to be done around the priority theme of Making Safeguarding Personal.	

	An extended meeting in December will serve as development day for the Board. Priority themes include recommendations arising from the SAR reports. Some have been included to reflect emerging themes. Feedback on the report was welcomed prior to publication. The report is a statutory responsibility for the Board and will be made available for the general public. Initial feedback was generally positive. It was felt that it would be useful to include examples of work that went well, and some that did not go well. Work taking place thematically is a positive move. A positive offer could be made to the STP to cover work around safeguarding and help avoid duplication. The Board is a statutory body, and safeguarding work needs to be owned here. 4LSAB work is progressing. The Board needs to start looking wider than this also. Responses and feedback on the report from other organisations will be useful. Board members will be responsible for cascading the report within their organisations once finalised. Feedback should be received by the Board by the end of October. Case studies from Board members to include in the report would be useful.	**ALL**
7. Chairs Report	The Chair's report would be distributed as an appendix to these minutes. A few key points from the report were raised: A toolkit has been published by the College of Policing.	

	There continues to be audits around safeguarding personnel through the LGA. This needs further promotion. Skills for Care have produced a competencies for Chairs guide, including a 360 review template. Board members would be asked to review RT's role as Chair. The National Chairs Network have produced as Chairs Audit. A response may be needed for the LGA Green Paper. If no response is given, the voice of safeguarding could get lost. The deadline for this is approaching. The LGA paper asks a series for questions. The local authority will be responding and could share this response with the Board. SKIE is undertaking work with faith and communities. SKIE are also producing a library of SARs, and assigning local SAR champions. In this region these will be SL and Emma Coleman from the IOW Board. Locally, a number of 4LSAB workshops have been held and work is coming together.	
8. Partnerships update	**HFRS** An update was given on the review of fire deaths. The presentation given would be available as an appendix to these minutes. Thanks was given to members of the Board for their support. Statistics were provided for the cases from 2015-18 that were analysed. A standardised audit tool has been produced and shared. It was felt that there was not a need for a partnership review. The report will be for all of Hampshire and the IOW. Learning from the review needs to be embedded into practice.	

	A 4LSAB Fire Safety Group has been proposed and work is in progress to set this up. Near-misses are difficult to obtain information on, but the Fire Safety Group could work with health providers around data. Capacity needs to be ensured to deal with an influx of referrals from Safe and Well. A representative from the HSCB will be on the group. Risk analysis and factors need to include children and multiple occupancy. The location of fires is important to consider in risk analysis, with the example given of flats compared with detached houses. Setting up the Fire Safety Group requires 4LSAB agreement, and this will be on the agenda for the next Inter-Authority Working Group. A multi-agency forum will be needed to move this work forward.	
9. Plenary	RT thanked Josephine Roberts for all her hard work with the setting up of the Housing Subgroup.	
Next Meeting	**4th December 2018, 9.30 – 15.30** **Cams Hall Estate Golf Club, Fareham, Hampshire, P016 8UP**	

Hampshire Safeguarding Adults Board – October 2017

Rolling Action Log

Meeting Date:	Ref:	Action Narrative:	Who:	Timeline:	Update:	Status RAG:
12th June 2018						
~~12/06/18~~	~~2.01~~	~~Draw up overarching report on recommendations to the Board.~~	~~SL/AR~~	~~September 2018~~		~~**Green: Closed**~~
~~12/06/18~~	~~2.02~~	~~Share safeguarding acronym from SCAS, covering fire, with the Board.~~	~~PP~~	~~September 2018~~		~~**Green: Closed**~~
12/06/18	2.03	Discuss STP workshop around safeguarding and strategic direction for safeguarding.	JL/RT	September 2018		**Amber: In Progress**
~~12/06/18~~	~~2.04~~	~~Add in Triggers and fire risks to the guidance on raising safeguarding concerns.~~	~~SL~~	~~September 2018~~		~~**Green: Closed**~~
13th September 2018						
13/09/18	3.01	Board to produce a map of local services and systems and distributed to members.	SL	December 2018		**Red: To Action**
13/09/18	3.02	Feedback on the Annual Report should be received by the Board by the end of October.	ALL	October 2018		**Red: To Action**