Hampshire Safeguarding Adults Board

Annual Report 2023-2024

Hampshire County Council

HAMPSHIRE SAFEGUARDING ADULTS BOARD

Contents

Welcome from the HSAB Chair

I am pleased to introduce the Hampshire Safeguarding Adults Board (HSAB) Annual Report for 2023-24.

The report provides an overview of the work that the HSAB Team and all our multiagency partners have been progressing over this last year in line with our strategic priorities.

Across all services and service types that support people with health and care needs we are collectively seeing ourselves working to ever increasing demands and more complex needs across our population. Within the social care arena significant financial pressures relating to the costs and accessibility of commissioned care, workforce challenges and re-focussing of public service priorities into statutory service demands are inevitably leading to a system under pressure. Notwithstanding this, we still observe great person-centred practice here and across all HSAB partner organisations. Alongside the financial pressures all organisations are seeing, as provided by the social care example above, change continues to be a common theme for all services, and locally work has been ongoing by our NHS colleagues on 'Project Fusion' to bring together community, mental health and learning disability services across Hampshire and the Isle of Wight. Additionally, partners in Adults' Health and Care have also successfully implemented a new records management system for service users, resulting in a quicker and efficient way of recording contacts and data.

Despite all this, I am assured that all our partners remain engaged with the work of HSAB and are both dedicated and focussed on Adult Safeguarding as a priority area. The feedback from the many subgroups within the report, is heartening, though there is much we still need to achieve. Each of these groups operate to a terms of reference and an agreed work plan which focuses on the delivery of HSAB strategic objectives and priorities, demonstrating the ever increasing value of our partnership work.

This last year has seen a very significant rise in Safeguarding Adult Review (SAR) referrals to the HSAB. As a result, we have commissioned 10 SARs from which we want to understand how members of the SAB, or other persons with relevant functions worked together to safeguard the adult concerned. By understanding and sharing the learning identified we work to prevent similar occurrences from happening in the future.

You will also note within the report the work that the Board Team have done to raise awareness of abuse and neglect by a series of lunch and learn awareness sessions. These have been extremely well attended and will no doubt help to support our multiagency partners to recognise abuse and neglect and support them to understand where and how to refer their concerns and get help and support. The Team has supported several stakeholder events countywide, again raising awareness of abuse and neglect with the public and professionals attending.

This combined with a new website really helps to spread the word, and make sure that 'safeguarding remains everyone's business'.

Looking ahead, early next year we will be reviewing and refreshing our priorities for the HSAB, taking account of the many different threads of information that will allow us to reflect on the feedback from our service users and what is most important and will benefit them.

Finally, I need to let you know that this will be my last report as HSAB Chair. I have therefore had cause to pause and reflect on all the work competed since I took on the role in 2019. Above all, I wanted to express my gratitude to all our multiagency partners and the HSAB team that have supported me over these last few years. The HSAB team often working in the background, have supported me to coordinate and support the board's work allowing us to meet our statutory requirements and so much more. Their hard work and legacy means that I am able to leave the partnership in safe hands, not just fit for purpose, but committed, motivated and driven towards joint working and successful outcomes for the most vulnerable across Hampshire.

Graham Allen

Hampshire Safeguarding Adult's 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.

The commitment of members of the Hampshire Safeguarding Adults Board (HSAB) and its subgroups has remained strong in a context of significant change and financial pressures. The Safeguarding Adults Board dedicated team has put significant energy and enthusiasm behind this agenda. There is a real determination to engage with the challenges and complexities of achieving effective safeguarding support alongside people. The Board's strategic plan demonstrates that appetite to engage at all levels with some of the most complex aspects of safeguarding adults. This depth is demonstrated too in the ambitious learning and development programme provided by the SAB.

The Board's determination in leading effective safeguarding is in significant part driven by human accounts. Sometimes by tragic consequences when things have gone wrong. These situations are set out in Safeguarding Adult Reviews (SARs). A section of this report highlights the circumstances in which there is a statutory duty to undertake SARs and sets out a range of reviews that took place in 2023/4. The commitment to learning lessons in these circumstances is evident. These human accounts provoke deep concern and a motivation to make progress on the presenting issues.

The importance of a culture of transparency in the SAB cannot be overstated and is to be encouraged in all aspects of safeguarding adults. Not least in a cross partnership commitment to carry out the statutory duty to raise safeguarding concerns with the local authority, wherever they initially arise.

The SAB continues to work to meet the challenge of ensuring that the learning from SARs impacts practice. It seeks assurance that lessons are learned and that there is ownership and accountability for associated actions. It supports impact of learning on practice through its extensive learning and development programme. Where barriers to progress are located in wider, national systems the SAB seeks to influence those wider agendas. It is important that there is a dedicated member of Board staff to support this aspect of the work.

The extent to which learning from SARs translates into frontline practice is one aspect of Board assurance. Other data and information are important. A statutory reporting duty on safeguarding adults for Adults' Health and Care (AH&C) generates a national data set, but this doesn't offer all of the information necessary to help the SAB to target effort where it will most make a difference.

It is anticipated that a new AH&C records management system will support the Board with local information that will help in gaining greater confidence and assurance on significant aspects of safeguarding adults. Knowing more, for example about where and by whom safeguarding concerns are identified and raised with the Local Authority and where they are not, helps in targeting learning and development. Understanding more about support undertaken in prevention and early intervention is important. This is information which reflects partnership activity and which AH&C intends will be available to the Board in the coming year to support identifying priorities.

In last year's annual report, I highlighted the connection with people's experiences as central to the SAB's statutory role. This feedback from people in the community (including carers and those who may need support) about their experiences and the extent of understanding of available safeguarding support is arguably one of the most important aspects of SAB assurance of the effectiveness of safeguarding arrangements. In the past year the SAB has brought together what has already been learned (for example from SARs and from public surveys) and built on this through holding structured conversations with a range of community groups about their experiences and understanding of safeguarding. The challenge now is for the Board to act on that cumulative learning and to extend it.

Combining what we learn from all these insights is crucial, data and information, the learning from SARs and what people in the community tell us (both locally and nationally), in determining where developments are most needed and will be most impactful. These are tools the Board will use in determining priorities for next year.

A SAB culture which is transparent, honest and ready to challenge has developed substantially over the past year. Maintaining this is especially important within current resource challenges. These challenges bring heightened risks which must continue to be surfaced, discussed, and mitigated collectively.

Jane Lawson

Independent Scrutineer

The Structure and Purpose of the Safeguarding Adults Board (SAB)

The **Care and support statutory guidance (2023 DHSC)** 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 off 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 (HSAB) has a Chair and an Independent Scrutineer, who provide objective scrutiny and challenge and act as an independent voice, 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 sub-groups 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 sub-groups jointly with the other neighbouring three local Safeguarding Adults Boards where we share common priorities and objectives across all four local safeguarding adults boards (4LSAB).

The three core duties of HSAB are to:

1. develop and publish a strategic plan, setting out how we will meet our objectives and how our members and partner agencies contribute

2. 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)

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.'

You can find out more about adult safeguarding by watching **Adult Safeguarding Animation - 4LSAB.**

HSAB Safeguarding Concerns Framework (hampshiresab.org.uk)

If you or someone else is in imminent danger, phone the police on 999, or call them on 101 if it is not an emergency.

If your request is urgent and you need support in the next 24 hours, contact Hampshire County Council Adult Services on 0300 555 1386.

For more information about **how to report non-urgent concerns,** via telephone or online, visit the **Adults' Health and Care advice page.**

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

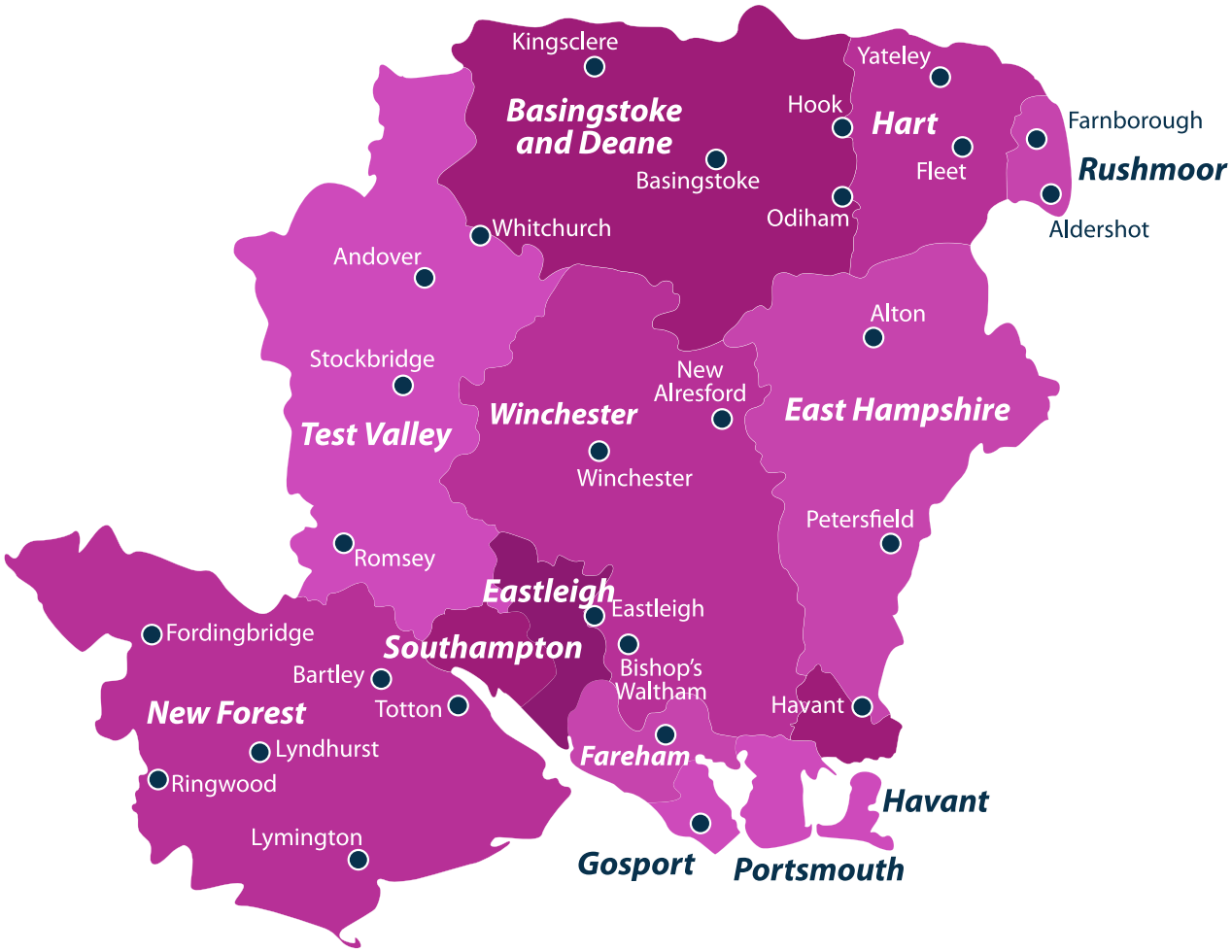
Out of hours 0300 555 1373
Monday to Thursday 5pm to 8.30am
Friday 4.30pm to Monday 8.30am

Safeguarding activity in Hampshire

Hampshire is a large and diverse county, bringing together city, coast and country. It is home to 1.409 million people, excluding Southampton, Portsmouth and the Isle of Wight, each of which are unitary authorities. The county of Hampshire is governed by a County Council and 11 District and Borough Councils.

The HSAB has three statutory partners. These are Hampshire County Council Adults' Health and Care, Hampshire and IOW Integrated Care Board and Hampshire and IOW Constabulary. This section reports key Safeguarding activity of the three statutory partners over the last year.

Safeguarding concerns are raised by all agencies and members of the public. Hampshire County Council Adults' Health and Care are the lead agency for co-ordinating these concerns and conducting safeguarding enquiries in Hampshire.



Hampshire County Council's Adults' Health and Care

Hampshire Adults' Health and Care work within Hampshire County Council's vision to serve the people of Hampshire with purpose and pride to improve lives today and for tomorrow.

Safeguarding adults at risk of abuse or neglect remains a core priority within that vision, underpinned by the Care Act 2014 and our organisational values of integrity and respect, professionalism, making a difference and continuous improvement.

The Download

'The Download' quarterly mandatory practice briefing sessions have been introduced for practitioners. They provide a summary briefing of key news, changes and updates, including policy and guidance, and learning from Safeguarding Adult Reviews, Local Government Ombudsmen findings etc. Two live sessions are available each quarter, with a session recording following the events for any staff unable to attend. This provides a valuable opportunity to ensure key learning and messages are delivered consistently to all staff.

LSSE and organisational abuse

Following the HSAB Round Table Conversation about safeguarding concerns and analysis of the SAC date, Hampshire County Council did some targeted work on updating our Large Scale S42 Safeguarding Enquiries (LSSE) policy and guidance and focused work on organisation abuse, aligning with the 4LSAB Large Scale S42 Safeguarding Enquiry Protocol.

SAC data shows that Hampshire have a high number of S42 enquires related to acts of neglect or omission, but comparatively low numbers of safeguarding concerns recorded as relating to organisational abuse.

Hampshire Adults' Health and Care Large Scale S42 Safeguarding Enquiry guidance (LSSE) supports practitioners with decision-making when managing concerns of organisational abuse. This provides a consistent and proportionate framework to effectively coordinate a multi-agency response to multiple safeguarding enquiries of organisational abuse. The organisational abuse guidance details the approach to be taken in Adults' Health and Care, including when it is appropriate to consider a Large Scale S42 Safeguarding Enquiry process as a proportionate response.

Hampshire County Council will continue to build on this development through performance monitoring and using the enhanced data available from CareDirector to build on our understanding of organisational abuse and responses in Hampshire.

CareDirector implementation

CareDirector records system better supports the complexities of social care work and strengths-based practice, and helps ensure Adults' Health and Care are fulfilling our statutory duties in a consistent way.

The improved recording format in CareDirector provides a clear view of what has happened when, and who is involved, via a new chronology tool. The new safeguarding form reflects our statutory duties, supporting legally literate practice and defensible decision-making, and putting the principles of Making Safeguarding Personal at the heart of the process. It also enables collection of statutory data that will be used as part of our CQC assurance.

The CareDirector safeguarding form provides a complete record, from safeguarding referral through to the completion of s42 safeguarding enquiries, meaning all relevant information regarding abuse and safeguarding responses are found in one place on the system. The form enables Adults' Health and Care to clearly report on how many safeguarding referrals meet the statutory definition of a safeguarding concern, and how many of these go on to meet the criteria for a s42 safeguarding enquiry. This will allow us to work proactively with referrers to understand where we are consistently receiving referrals that do not meet the definition of a safeguarding concern or identify where we are not receiving referrals.

Forthcoming Year's focus:

Launch of training: More Than a Mind

The More Than a Mind programme for practitioners moves beyond the fundamentals of understanding the Mental Capacity Act (2005) and equips practitioners to work safely and effectively with complex individuals and high-risk situations. The programme draws on learning from Safeguarding Adults Reviews, rooted in professional curiosity, robust assessment and multi-agency communication. The programme concentrates on four core skills; robust assessment of capacity when there is added complexity; determining best interests in situations where there is a high risk to welfare; mapping a strategy across different legislation and agencies; resolving disputes and understanding how and when to involve the Courts.

Hampshire Carers Joint Strategy 2024-2029

The Hampshire Carers Joint Strategy 2024-2029 has been developed through partnership working that has included a Sub-Group of the Hampshire Carers Partnership, local voluntary organisations, and statutory organisations including Hampshire County Council, Integrated Care Boards, NHS Foundation Trusts and Voluntary Sector Providers. The strategy was signed off in Hampshire Adult's Health and Care in February 2024 and is aligned with the wider Adults' Health and Care strategy, with new 'Working in Partnership with Carers' training now being rolled out for all staff.

The strategy is framed on three aims:

1. Identification and Recognition of carers
2. Supporting carers to access information
3. Having a life alongside caring

This further contributes to the HSAB workstream on empowering and informing people and those who help support them.

CQC readiness

CQC assessment of local authorities has a statutory footing that has created a new duty for the CQC to review local authorities' performance in discharging their adult social care functions under the Care Act 2014. CQC advise that assessing local systems is "a core strategic ambition to provide independent assurance to the public of the quality of care in their area."

CQC's primary focus is to "understand how care in a local area is improving outcomes for people and reducing inequalities in their access to care, their experiences, and outcomes from care" under four overarching themes:

1. Working with People
2. Providing Support
3. How the local authority provides safety in the system
4. Leadership

Each theme has 'quality statements' that local authorities must commit to, expressed as "we statements" that show what is needed to deliver high- quality, person centred care, and 'I statements' of what people expect based on Think Local Act Personal's 'Making it Real' framework

The CQC ran two 'Test and Learn' pilots with Hampshire County Council and Manchester City Council in 2022. Hampshire's CQC Test and Learn looked at two quality statements, with a 'good' rating achieved in both domains.

Since this time, Hampshire County Council have continued to work hard to look build on strengths and address areas of development identified, with a strengthened governance process to analyse and respond to themes and trends.

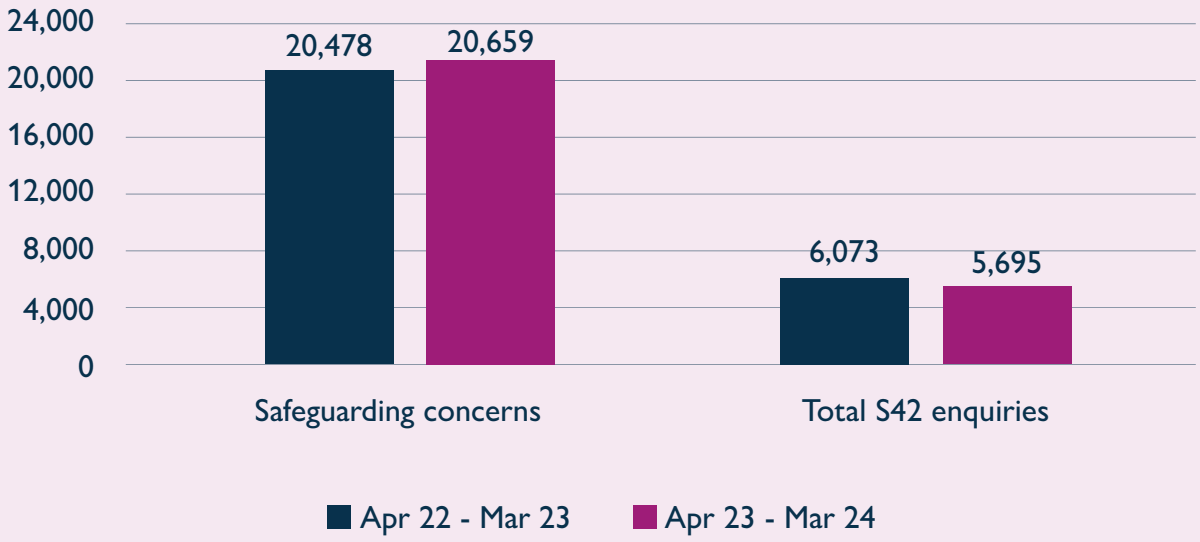
AHC Experience Feedback Surveys

A new feedback form introduced in May 2024 will ensure a wider range of voices will be heard telling us about their experiences of Adults' Health and Care.

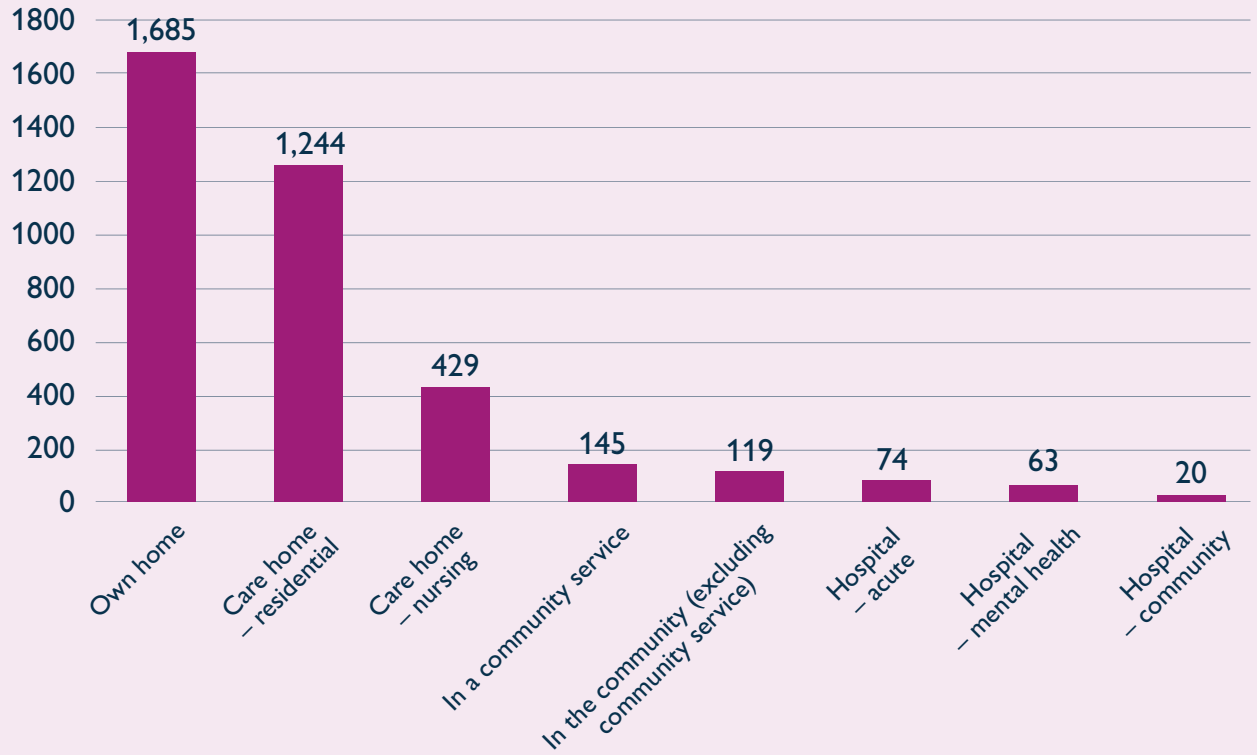
Findings from the surveys will be used to help shape and develop safeguarding practice, with each care group in Adults' Health and Care having a survey that relates specifically to peoples' experience of safeguarding processes. The surveys are based on nationally co-produced measures and have been influenced locally by feedback from staff and Hampshire's co-production networks.

The below graphs cover provisional data from the Safeguarding Adults Collection (SAC) for the period of 2022/2023

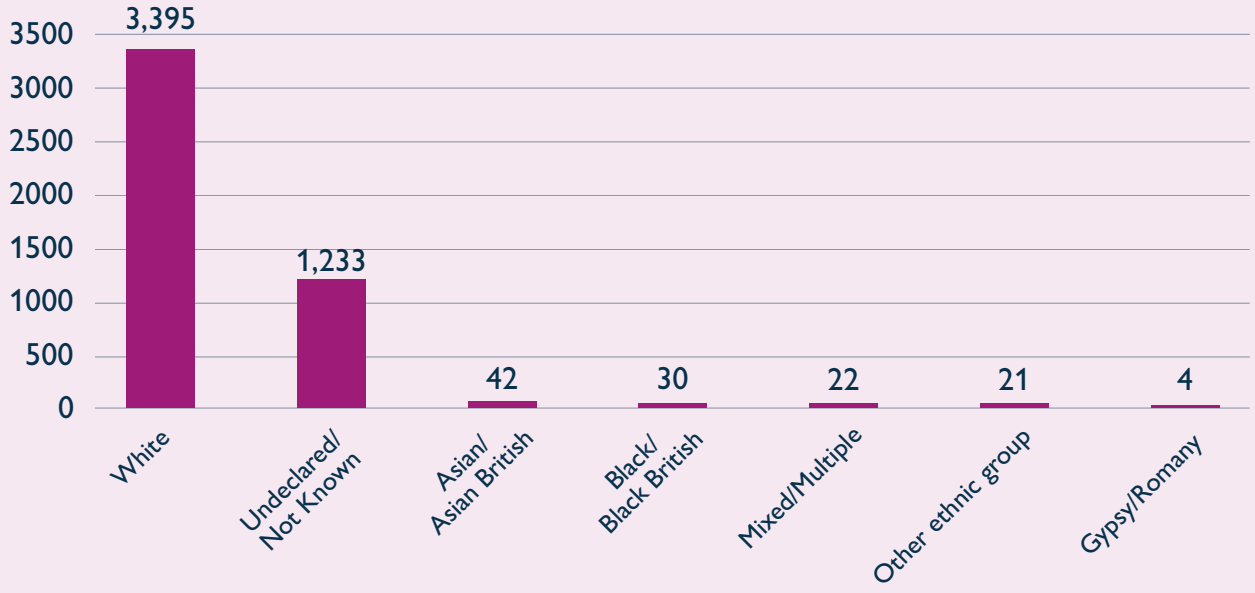
Comparison of S42 Enquiries



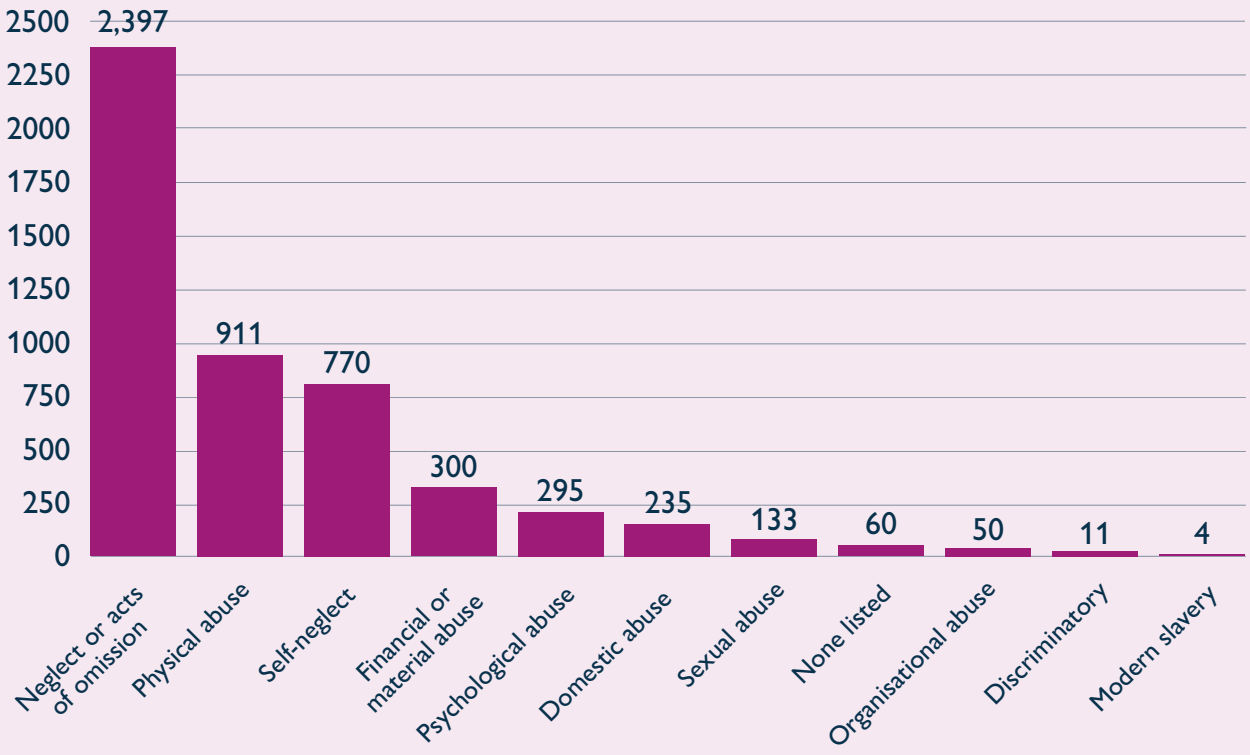
Location of Risk



Ethnicity



Abuse Type


2500
2250
2000
1750
1500
1250
1000
750
500
250
0
2,397
911
770
300
295
235
133
60
50
11
4
Neglect or acts of omission
Physical abuse
Self-neglect
Financial or material abuse
Psychological abuse
Domestic abuse
Sexual abuse
None listed
Organisational abuse
Discriminatory
Modern slavery

Hampshire and Isle of Wight Integrated Care Board

Statutory duties

- Hampshire and Isle of Wight Integrated Care Board (HIOW ICB) has completed the Prevent self-audit, Safeguarding Adult self-assessment, and the statutory section 11 audit. These audits provide assurance that the ICB are meeting required safeguarding standards in line with statutory requirements. Areas for improvement are identified and monitored through the integrated care system, safeguarding and children looked after committee and safeguarding partnerships.

- The named GP's led on the development, implementation and action planning of a section 11 self- audit for primary care, which encompassed adult and children safeguarding. Findings were scrutinised by the local safeguarding children's partnerships, the integrated care system safeguarding, and children looked after committee and the Integrated Care Board primary care committee. Areas for improvement are identified and will be monitored through the integrated care system safeguarding and children looked after committee.

- Continued representation at HSAB Board, subgroups and other partnership meetings including MAPPA, modern slavery partnership.

- Integrated Care Board are fulfilling statutory safeguarding responsibilities and functions.

Integrated Care Board

HIOW ICB led on the development of a safeguarding adults supervision strategy for the integrated care system with all NHS providers, represented and signed up to the Strategy. The strategy was launched on the 15 May.

Annual objectives have been agreed to achieve 4 priorities:

1. **provision of adult safeguarding supervision** – minimum standards of provision have been agreed which will increase over the three years of the strategy

2. **administration** – process to arrange and document supervision agreements and discussions have been identified for implementation

3. **training** – training for supervision supervisors is required, so methods to source and provide training will be scoped in the first year of the strategy

4. **celebrating success** – throughout the implementation of the strategy, successes and the impact of safeguarding practice will be shared with system partners, regionally and nationally

A portfolio group is being created to implement the objectives and gain assurance that the objectives are being achieved. Progress will be monitored through the ICB's Safeguarding and CLA Committee.

Multi-agency partner work

- ICB led a task and finish group to update the 4LSAB adults who disclose childhood sexual abuse guidance. Subsequently multi-agency partners added their roles to the document. Proposal for this to be approved by 4LSCP so that it becomes an 8 Board policy.

- Partnership working with the Local Authority around their review of Large Scale Safeguarding Enquiry policy and framework. This was to support the Local Authority in how the process impacted on partner agencies. Also, challenges offered where it was not clear whether new framework was followed as expected.

- Reporting will be more closely aligned to the safeguarding accountability and assurance framework enabling assurance to be evidenced more robustly and identifying future areas for improvement.

- Specialist safeguarding nurse was major contributor to the Emollients fire safety awareness campaign, led by the fire sub group.

- Specialist safeguarding nurse has formed a health fire portfolio group. The aim of this group is to ensure all health partners are working collaboratively to respond to fire risk and learning from fire related deaths.

- ICB continue to administer the South Coast Ambulance Service (SCAS) partner updates. Following the CQC inspection report published in 2022, there has been an ongoing action plan in place to improve internal safeguarding arrangements for SCAS. Good progress has been made with implementing the action plan, this has included referrals into the Local Authority and extensive training of SCAS staff as well as an extensive peer review. A new referral pathway is scheduled to come into operation in 2024.

Hampshire and Isle of Wight Constabulary

Hampshire & IOW Constabulary are committed to safeguarding the most vulnerable people within our communities and achieve this through a number of force-wide initiatives and the forces three priorities:

Relentless pursuit of offenders	Exceptional Local Policing	Putting victims first

Project Foundation

Local Neighbourhood Policing teams and partners are committed to Operation Foundation focussed on the monitoring and management of serial and repeat perpetrators of Domestic Abuse.

The project has provided clear supervision, close monitoring, and control over perpetrator behaviour, and is heavily focused on delivering interventions through partners such as the Hampton Trust and the Accredited Domestic Abuse Prevention and Treatment (ADAPT) programme.

Where perpetrators are not willing to engage, and or, change their offending behaviour, they are subject to control measures to prevent further harm. Officers also ensure there is a robust safeguarding plan in place for victims. The project outcomes have seen increased referrals to the Hampton Trust; Right to Know, and Right to Ask (under Claire's Law), as well as earlier arrests for offences committed by perpetrators. The DASH (Domestic Abuse, Stalking, Harassment and Honour Based Violence Assessment) Risk Indicator Checklist and bail conditions are also used to safeguard victims.

Operation Fortress

Neighbourhood Policing teams identify and support vulnerable adults who are at risk of being exploited and cuckoo'd by either local drug networks or County Line drug dealers. Engagement with vulnerable tenants is seen by police and partners as vital and is supported both by safeguarding measures and signposting - with a wide range of services such as: housing providers, Adult Social Care, Mental Health Services and Drug and Alcohol services. In cases where drug lines are resilient, execution of drug warrants, and partial and or full house closures, have taken place to prevent unwanted persons inside the address.

Violent Taskforce

The aims and objectives of the Violent Crime Taskforce are to reduce and prevent serious violence in Hampshire and the Isle of Wight by focussing on long-term serious violence hotspots and serious violence perpetrators, including Habitual Knife Carriers. They provide support and advice to Neighbourhood Policing Teams in relation to serious violence and knife crime and work closely with the Violence Reduction Unit to promote and enable problem-solving in partnership, making our communities safer.

MASH

The constabulary have invested heavily to ensure continuous improvement by providing crucial mandatory safeguarding training by subject matter experts in the Multi-Agency Safeguarding Hub (MASH). This training equips frontline officers with the necessary skills to identify and submit referrals for adults at risk within our communities. This is achieved through important ongoing collaboration with partners to ensure that these referrals are not only relevant but also of the highest quality, reflecting our commitment to protecting vulnerable members of our community.

Furthermore, our close ties with the force's Serious Case Review team enable us to swiftly address thematic issues highlighted in Safeguarding Adult Reviews. By promptly implementing changes to policy and practice, we ensure a proactive approach to safeguarding vulnerable adults and continuously strive to improve our response to their needs.

Challenge

The challenge remains for MASH around capacity versus demand and ensuring referrals are promptly shared with partners.

Future plans

In the near future we are looking at utilising robotics across our safeguarding teams to assist in gathering of information to inform risk assessments, speeding up sharing of information and ensuring adults at risk are quickly identified and safeguarded.

Learning from Safeguarding Adult Reviews

Safeguarding Adult 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, 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 2023/24.

Year	April 2020 – March 21	April 2021 – March 22	April 2022 – March 23	April 2023 – March 24
Number of SAR referrals received*	15	17	29	49
Number of referrals that met criteria for SAR	7	5	8	13
Number of SARs commissioned**	7	2	5	10 (Including two thematic reviews)

* A number of referrals will be in the initial information gathering and decision-making process, depending on the date the referral was received by HSAB.

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

- capacity to respond to the volume of SARs and time to support the implementation of learning from each SAR
- discretionary SAR learning activity does not always require commissioning

SARs published April 2023 - March 2024

All published SARs can be found on the **Hampshire Safeguarding Adults Board website**.
Some learning and the resulting improvement activity is applicable to more than one SAR.

Helen

This review includes learning relating to barriers to effective communication of safeguarding concerns, risk assessment, making safeguarding personal, professional curiosity and hidden harms

Improvement activity

- The 4LSAB Health Subgroup reviewed how hospital clinical teams are raising safeguarding concerns to ensure the process aligns with the guidance provided for raising safeguarding concerns.
- The **4LSAB Safeguarding Concerns** guidance will be reviewed by the 4LSAB Policy subgroup to ensure clarity for agencies about when and how to raise concerns.
- Assurance has been provided that primary care have safeguarding policies, leads and regular safeguarding meetings in place. Supervision to primary care has been strengthened and provided more regularly. Ongoing actions will be monitored by named GPs and assurance provided to HSAB.
- Inclusion Recovery Hampshire reviewed safeguarding training and provided assurance that this included guidance on raising concerns.
- NHS Hampshire and IOW Integrated Care Board have undertaken work to develop awareness of and support for those who experience or are at risk of domestic abuse, including guidance, a pathway and introducing Independent Domestic Abuse Advocates in some settings.
- Further improvement activity is planned to provide guidance relating to responding to adults who do not wish to engage with agencies, but where safeguarding risks remain.

Alex

This review 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, Court of Protection process and ensuring statutory advocacy is used to support hearing the adults voice.

Improvement activity	• Adults' Health and Care have undertaken a review of the use of statutory advocacy. Work is ongoing to ensure those who require advocacy support receive this. • A 4LSAB Multi-Agency Safeguarding Adults Escalation Protocol has been updated to provide guidance to agencies when managing different perspectives of risk. • Agencies have reviewed, and where required improved, the focus of safeguarding within supervision. • Multiagency training sessions are being developed to increase awareness of court of protection processes. Guidance and tools will be developed alongside these. Delivery is planned from Summer 2024. • A 7-minute guide to professional curiosity has been developed and published by the HSAB. Some agencies have provided additional training and guidance to their practitioners.

George

This review includes learning in relation to use of emollient products and fire risk.

Improvement activity	• The Learning and Review Subgroup are working together with relevant partners to agree an action plan to embed learning. Progress monitoring and assurance requests will be overseen by the HSAB. • Hampshire & Isle of Wight Fire & Rescue Service have launched an **emollients fire safety awareness campaign** in partnership with the NHS Hampshire and Isle of Wight Integrated Care Board and Community Pharmacy South Central.

Gillian

This review includes learning relating to the use of the family approach and identifying and supporting unpaid carers in Hampshire.

Improvement activity	• **The Whole Family Approach** guidance and toolkit has been reviewed and now includes consideration of all adults within the home, including adult children living with parents/carers. • Hampshire and IOW Constabulary have reviewed the national Public Protection Notice (referral submitted to other agencies when concerns are identified) and added a specific question to support the identification of carers. • There is ongoing work within agencies to review the robustness of carer policies, guidance and training to support practitioners to identify carers and provide any ongoing advice and support as necessary. This includes focusing on primary health care teams recognising carers. The HSAB will continue to monitor this work.

Self-Neglect Gap Analysis

This is a thematic gap analysis including 3 cases. Learning focuses on the area of self-neglect and how the safeguarding system is working in this area currently.

Improvement activity	• There has been significant focus on self-neglect and how the safeguarding system within Hampshire responds to this over the past 2 years. This has previously been reported in annual reports. • The Learning and Review Subgroup are working together with relevant partners to agree an action plan to embed new learning from this SAR. Progress monitoring and assurance requests will be overseen by the HSAB.

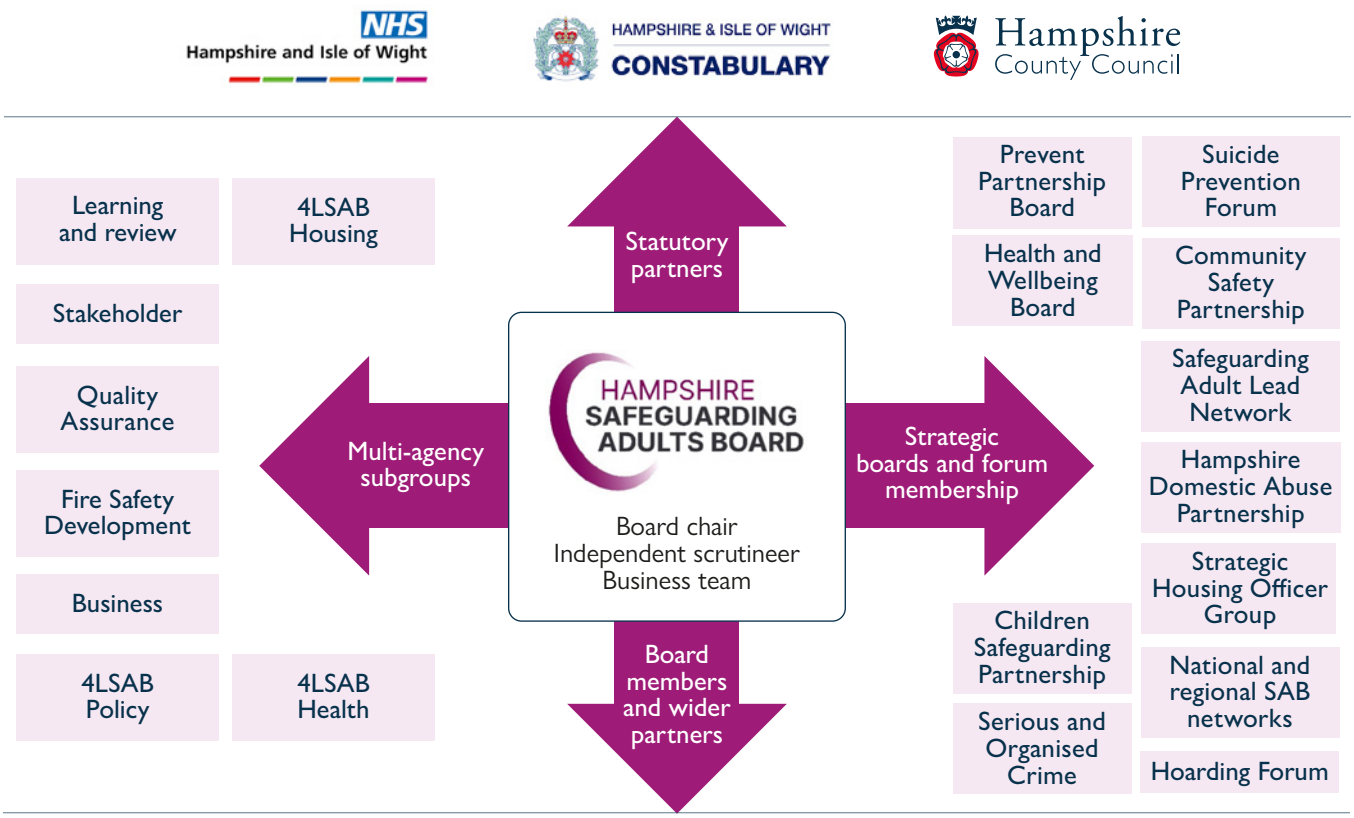
Other SAR Activity April 2023 – March 2024

Three SARs are currently in progress

SAR One	This review will consider learning in relation to 'cuckooing' and adult exploitation. The review includes the circumstances of 3 adults.
SAR Two	This review is being completed jointly with the Community Safety Partnership, as the criteria for a Domestic Homicide Review was also met. This review includes the circumstances of 2 adults.
SAR Three	This review is being completed jointly with the Community Safety Partnership, as the criteria for a Domestic Homicide Review was also met. This review includes the circumstances of 2 adults.

What have we done together to support our Strategy?

The HSAB works closely with a number of partners across the safeguarding system in Hampshire to achieve the strategic priorities. This includes Statutory partners, Board members, wider agencies, multiagency subgroups and other strategic boards and forums.



Progress on our Strategic Priorities

The HSAB held a development day to review the progress of our **strategic priorities**. Multiagency partners and people who use health and care services worked together to co-produce year two and three of our operational plan.

We have completed year two and are currently working on year three. Many of the workstreams had several areas to address, and progress on these is reflected throughout the annual report and below.

Our Strategic Priorities 2022 - 2025

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

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

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.

The Board will review and test how we are doing 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.

Foundational Blocks

- Scrutinising data with performance indicators
- Seeking feedback from people – service users, carers, families and staff
- Undertaking self-assessment and bespoke audits
- Working more effectively in partnership
- Tracking compliance with our statutory duties

Suicide Prevention

We have increased the information available for professionals on the HSAB website in relation to suicide prevention. This has included a main page link to **Connect to Support Hampshire** as well as sharing suicide prevention training with our network.

The HSAB team are also now represented at the Suicide Prevention Forum which is administrated by Public Health. There has been an increase in suspected suicide referrals into the Learning and Review Subgroup (LRS). Consequently, there is a plan to ensure communication to support a joined up approach with the lead Public Health Principle focusing on this area and LRS.

Service user voice

The Board is committed to hearing the voice of people within Hampshire, including those who have experienced abuse or neglect and the wider community. Below are three key examples of this, including Hampshire Perspective Adult Safeguarding Survey 2023, Safeguarding Research Project and Advocacy in Safeguarding Adult Reviews.

Hampshire Perspectives Adult Safeguarding Survey 2023

Hampshire Safeguarding Adults Board (HSAB) ran a public survey in March 2023. The key messages from this survey were reported in last year's annual report. In November 2023 a further survey was completed to reach a wider audience, to inform the boards operational plan. 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 607 responses were submitted from members of the Hampshire Perspectives Forum. Formed in September 2020, Hampshire Perspectives is the County Council's online residents' forum – a diverse group of people who share their views to help the County Council to shape services and make decisions that are right for local residents. Findings were similar to what we learned in March 2023, suggesting this group of stakeholders have a good understanding of public attitudes.

Key headlines:

Most respondents were aware of the term 'safeguarding', although awareness was lower than average amongst the males who responded.

The responses suggest that **respondents from ethnic minority groups were more likely than average to be able to identify abuse and neglect.**

Respondents were **generally able to correctly identify all of the provided examples of neglect and abuse,** although this was lower where the examples related to alcohol abuse and personal hygiene compared with examples relating to violence and extreme poverty.

It appears that ethnic minority respondents would have the greatest confidence reporting concerns. In comparison there was lower confidence amongst people with health issues or disabilities.

If people had concerns for their own safety they would most likely rely on personal acquaintances, such as friends or family.

If people were concerned about the safety of another person, respondents would be most likely to rely on professional support, such as police or healthcare workers.

Respondents were generally **most comfortable reporting safeguarding concerns that related to people close to them,** and less confident where concerns related to people outside their family and close friends.

Where barriers to reporting concerns existed for people, these most commonly related to possible repercussions, concerns about the wishes of the potential victim, and awareness what neglect and abuse look like.

Three in ten respondents would not be put off from reporting safeguarding concerns in any circumstances.

When asked how to improve reporting of safeguarding concerns, suggestions overwhelmingly related to publicising how people could do so, while comments also commonly mentioned giving assurances of confidentiality.

Many of these headlines have formed the basis for the workstreams on our 23/25 Operational plan, that supports our 23/25 Strategic Priorities they include:

- myth busting in order to reduce fear in relation to raising a safeguarding concern
- raising safeguarding awareness amongst those who employ PAs
- analysis of agencies with lower safeguarding concern referrals in line with statutory guidance
- empowering and informing people and those who help support them
- assurance around alcohol related services and alcohol dependency

We intend to respond to these key messages and build on our work to hear what's important, challenging and working well for the people in our communities. The wider Board are committed to ensuring that the learning from these surveys is embedded in our current and future strategic priorities. Ongoing assurance will be presented to HSAB.

Safeguarding Research Project

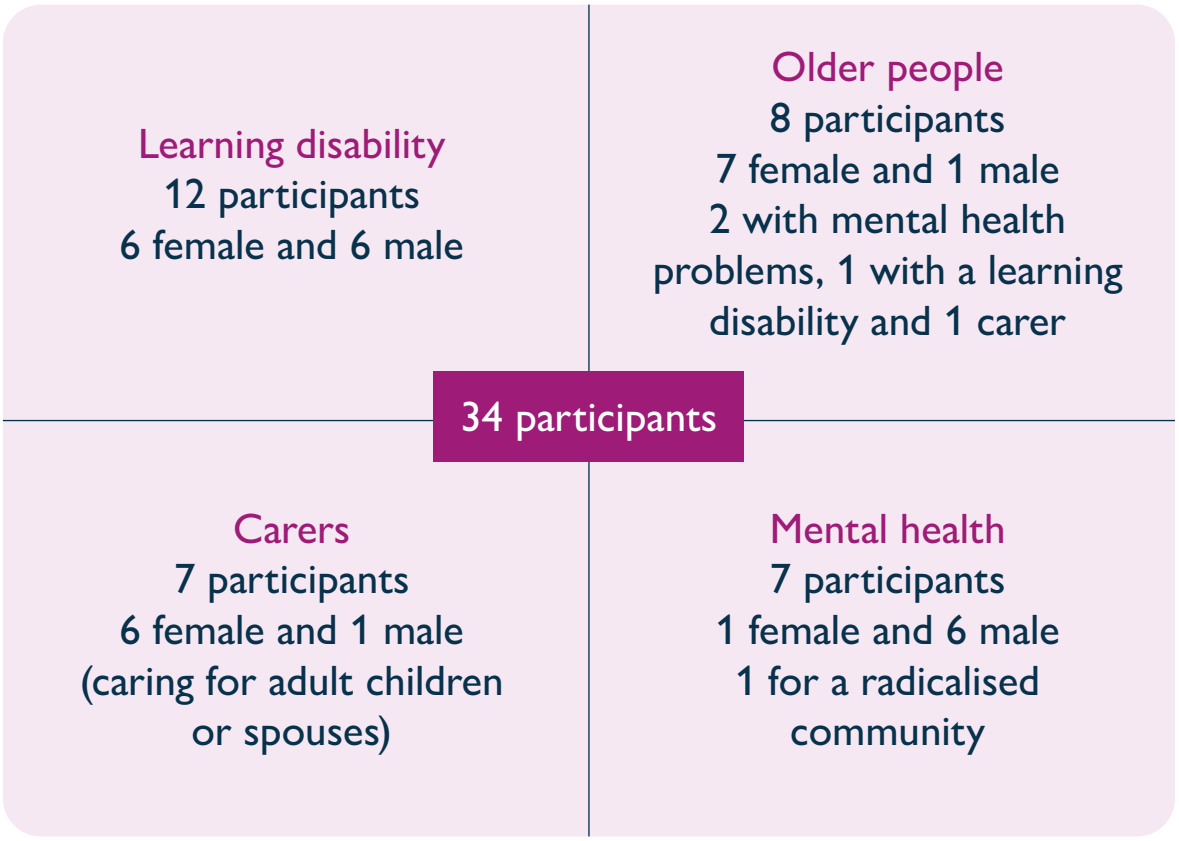
The HSAB commissioned the safeguarding adults research project to hear some of the lived experiences of adults in Hampshire and to focus on two of the HSAB's Strategic Priorities.

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

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

The project aimed to seek to understand a range of people's understanding of safeguarding situations.

The researchers met with four different groups to enable open and honest discussion about their experiences in relation to safeguarding, to gain insight into their understanding of what safeguarding is, how to report concerns and some of the barriers to reporting. The groups were made up as below:



Some key messages from the listening groups:

- service users and carers want to stay safe and generally know what could prevent abuse, but do not necessarily know about routes to safeguarding or understand the term safeguarding
- service users and carers are aware of or had experienced many different types of abuse and neglect
- organisational abuse and neglect are of concern, particularly that in closed settings such as hospitals or residential care homes
- service users and carers who experience abuse or neglect need support to talk about and process their experiences
- trust is a major factor in abuse disclosure and help seeking
- trusted local voluntary sector support groups or advocacy organisations are vital for safeguarding
- cases of abuse are most likely to be reported to the police, however multiple routes are used to report safeguarding concerns
- authorities are often unresponsive and slow when abuse is reported, resulting in frustration, loss of trust and further risk
- carers, neighbours or friends are likely to be the first to notice signs of abuse or neglect
- fear, self-esteem, lack of confidence and self-blame can stop people from reporting abuse or neglect
- the focus groups reflected that services users and carers have low levels of trust in health and social care services and staff
- lack of trust in or negative experiences of authorities and services can prevent people from raising safeguarding concerns
- lack of knowledge about who to contact and how is a barrier to accessing safeguarding

Service users made recommendations to the reviews on changes they would like to see, a summary of these is listed below:

- investment in and engagement with local voluntary and community sector support organisations and groups
- improved awareness and shared understanding of safeguarding
- clear, accessible signposting and routes of access to safeguarding support
- trusted, known and responsive social workers
- ongoing specialist safeguarding training for all health and social care staff in all settings, including those working in provider services and especially in closed environments
- well-funded, good quality person-centred care for prevention
- offer training in trauma informed approaches to safeguarding teams
- trauma informed safeguarding that supports a person-centred, strengths-based approach, which seeks to understand and respond to the impact of trauma on people's lives
- create a safeguarding demystification and awareness campaign co-produced with service users and carers, engaging with local voluntary and community sector support organisations and groups to do so
- reach into closed environments (i.e., hospitals, residential care homes), where perpetrators of abuse and neglect might include staff, and engage with advocacy services to do so
- work closely with the police and voluntary sector support workers, ensuring effective communication channels for reporting safeguarding concerns

The full report has been presented to the Board and we are currently working on a 'you said, we did' piece of work. This will go towards a greater assurance piece in relation to the points raised with the final outcomes being presented at a future Board meeting. It is important to consider these in context of the high numbers of those who are offered support or care via organisations that have a positive experience. We have work to do, and we are committed to continuing improvement and getting the basics right and this research will support this ongoing work in Hampshire.

Advocacy in safeguarding adult reviews (SARs)

The Board will endeavour to ensure the adults voice is present in all safeguarding adult reviews, to better understand the adults' experience. If the adult requires advocacy support to be involved with the review, the Board will ensure this is in place. Where an adult has died, often family members will represent the views and wishes of the adult. Where there is no known family representative a decision to engage advocacy may be taken. A SAR currently in progress includes advocacy support to represent the voice of all three adults subject of the review.

HSAB Subgroup activity

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

See page 25 to see how these groups work with the Board.

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.

1 HSAB Quality Assurance Subgroup

Key achievements

- Increased membership of the subgroup continues to enable rich discussion between partners.
- Refreshed Terms of Reference supporting clear understanding of the groups purpose.
- Welcomed a new subgroup Chair, Sue Corley from Southern Health.
- Increase in data around Advocacy, providing evidence for ongoing work.
- Continues to provide a space that encourages respectful and honest discussion, of the data provided by each organisation. Supporting the better understanding of the narrative around what the data is telling us about the systems responses, pressures and challenges to safeguarding within Hampshire.
- All partners are committed to working within their organisations to try and improve and expand the availability and quality of the data they provide.

Challenges

- Ongoing operational and administrative pressures within partner organisations, coupled with changes in partner representatives, have at times had an impact on attendance.
- Changes in some organisations digital systems have had a significant impact on their ability to be able to provide timely data, assurance has been provided that this will continue to improve.

Future plans for 24/25

- To develop closer working with the other HSAB/4LSAB subgroups to help identify any themes or trends that require further exploration across partner organisations.
- To consider the use of case audits to elicit some of the more quantitative information which is not always readily available via the scorecard. Although this approach would allow a better understanding of some of the challenges faced in the day to day application of safeguarding, the governance around the sharing of information would require support from our Information Governance colleagues.

2 HSAB Stakeholder Subgroup

Key achievements

- Members of the stakeholder subgroup attended and input into the Development day in June 23 to share their expertise and knowledge.
- Widely shared lunch and learn sessions that have received positive feedback from the charitable and third sector.
- Stakeholder survey in Nov 23 comes under the group remit and was supported by the HSAB team.
- Attended several carer engagement events to promote the work of HSAB.
- Through contacts provided attendees for the experiences focus groups project.
- Reviewed Terms Of Reference.
- Work has commenced on two areas that are assigned to the group around PA safeguarding information and myth busting and increasing awareness.

Challenges

- To work within the new group structure of meeting less frequently and working smarter by committing to respond when required. Everyone in the group has risen well to the challenge (respond by email in a timely manner).
- To ensure we have a wide variety of members.

Future focus

- Produce information for service users and carers around safeguarding and employing Personal Assistants (PA's) as well as for PA's and safeguarding whilst they are in the role especially around who to take concerns to and what will happen next.
- Work with other HSAB groups to reduce myths and increase awareness. Including a targeted message for unpaid carers – especially following the November survey where carers said they were likely to report safeguarding issues, but unpaid carers were more reluctant to (around neglect/abuse).
- To continue to increase service user involvement in the development of policies and task and finish groups supporting workstreams on the HSAB operational plan.
- Engagement of unpaid carers.

3 HSAB Learning and Review Subgroup (LRS)

Key achievements

- Managing to coordinate an approach to a high number of historically agreed reviews that had been 'on hold'.
- The confidence of LRS reps generates helpful discussion and learning is identified quickly: gaining a regular housing rep, Inclusion (substance misuse service) rep and Domestic Abuse rep at LRS following themes/areas featuring in referrals.
- Implementing learning events for practitioners to share learning from SARs.
- Referrals for SAR consideration are being received from all agencies. This evidences a shared understanding amongst agencies of the criteria needed for a review and the benefit of undertaking a review.

Challenges

- Considerable number of SAR referrals, far more than any previous year.
- Extensive amount of time for LRS reps undertake and review scoping information.
- Ever increasing financial pressures requiring consideration and flexibility of methodology type.

Future focus

- Continue to explore and promote efficient ways to conduct learning reviews in order to share learning quickly and ensure the time taken in undertaking and reviewing scoping is valuable.
- Increased number of joint Domestic Homicide Reviews and SARs, considering how the processes link and most efficient way to gain learning.

4 4LSAB Policy Sub Group

Key achievements

Publication of the following new/revised policy documents:

- 4LSAB Safer Recruitment
- 4LSAB Adults who Disclose Non-recent Sexual Abuse
- 4LSAB MARM framework
- 4LSAB Safeguarding Adults Multi-Agency Policy, Process and Guidance
- 4LSAB Escalation Protocol
- 4LSAB Prevention and Early Intervention

Find all the **4LSAB Multi-Agency Safeguarding Adults Policy and Guidance on the HSAB website.**

Challenges

The main challenge for the subgroup is the volume of work to deliver within the time constraints - however, we acknowledge and thank the commitment of partners to the work of the group.

Future focus

The key pieces of work for the following year on the 4LSAB Policy workplan include, publishing a revised Family Approach toolkit, Modern Slavery Guidance, Self Neglect Guidance, and Guidance on Multi Agency Safeguarding Roles and Responsibilities. We plan to consult with staff on how they have used the Safeguarding Concerns Guidance and will incorporate their feedback into a revised version. We are also in the process of developing new guidance on Adult Sexual Exploitation and will begin work on some new Domestic Abuse guidance for staff.

5 4LSAB Housing Subgroup

Key achievements

- Reviewing SAR's, sharing best practice and learning from providers to help prevent further similar issues from occurring. Ensuring understanding of how and when to raise a safeguarding concern.
- Housing colleagues raised an increase in calls relating to suicide, arranged for Public Health to talk to the subgroup, providing information on services and training available.
- Following new policy updates the group has asked partners for assurance on how these will be embedded within their own organisations. This has generated meaningful discussion and examples.

Challenges

Ensuring attendance at meetings from relevant partners due to busy work schedules and ensuring that the meetings provide value to their organisations and the housing sector.

Future focus

Ensuring relevant speakers attend the housing subgroup and asking for feedback as to how their presentations have been considered or implemented by providers. Areas that have been highlighted have included: housing adults out of area/temporary placements, update on HIOW Fire and Rescue priorities, access to mental health services.

6 4LSAB Fire Safety Development Group

This summary contains both organisational updates from Hampshire and Isle of Wight Fire and Rescue Service as well as from the Fire Safety Development Group.

Key achievements

- Review of current practices to ensure alignment to new guidance developed by the National Fire Chiefs Council regarding:
  1. levels of DBS checks for Fire Service Personnel and volunteers
  2. Safeguarding Allegations
  3. training matrixes and requirements

- Continued to chair the 4LSAB Fire Safety Development Group to ensure fire incidents resulting in serious injury and death are reviewed and learning is identified and shared across the partnership.

- FSDG reviewed 11 fire incidents which resulted in serious injury or fatality, 7 of the 11 were within the Hampshire LA area.

- Developed and published an emollient fire risk campaign for members of the public, in partnership with the ICB and South-Central Community Pharmacy.

Full compliance to the National Fire Standard for Safeguarding, with all criteria points rated as substantial.

- Continuing to review and develop our delivery of Safe and Well visits to ensure effective partnership working and risk mitigation to individuals and families.

- Developed and embedded quality assurance and evaluation activity for our Safe and Well visits.

- Reviewed and updated our training offer for partner agencies regarding fire risk and vulnerabilities.

Challenges

- Continued focus on the initiation of MARM meetings type.

Future focus

- Plan to complete internal audit activity regarding the quality of safeguarding concerns reported by HIWFRS personnel – to identify areas of best practice and development areas for training and learning.

7 4LSAB Health Subgroup

Key achievements

The 4LSAB subgroup has continued to successfully progress and complete health related priorities as identified by the 4LSAB and health partners. These include:

- Writing the health information for the "adults who disclose historic sexual abuse" which was subsequently updated by safeguarding partners so that social care and police responsibilities were detailed. This policy has now been ratified by the 8 safeguarding boards and partnerships.
- Scoping has been completed to clarify how health organisations raise safeguarding concerns with adult social care. The scoping illustrated that appropriate processes are in place. Further work is scheduled for the next financial year to review if a multi-agency audit on the quality of referrals is required.
- Clarity on how safeguarding processes are integrated across the system with the introduction of the new Patient Safety incident response Framework (PSIRF) has been gained and demonstrates that safeguarding is an integral part of PSIRF. This priority will continue into the next financial year to review the effectiveness of the systems to identify further areas of development.

Challenges

- Challenges have been minimal but workforce capacity to meet the high work demand limits partners ability to take actions forwards. This is mitigated by group discussions at the subgroup to ensure that priorities are achievable, realistic and will have an impact on service provision.

Future focus

- Three key thematic areas for the System Improvement Learning Forum (SILF) will be reviewed by the subgroup to identify potential areas for improvement by health providers as a system.
- Oversight and scrutiny of current processes within health to review deaths to identify any gaps and inform any required service improvement to share learning.
- Learning from Domestic abuse related Death reviews is shared with the subgroup to facilitated joint learning and system improvement.
- Review of the Pressure Ulcer Guidance document.

Partner feedback

Partners shared examples of good news stories within their sector that were linked to policies/guidance or SARs published by the Board.

The SAR's this year have been a focal point for all stakeholder group members to focus on outcomes and action plans and take back to their networks. The message being 'we can all learn'. They have been discussed at the Hampshire Leadership Forum as well.
– Stakeholder Subgroup

The Gillian SAR raised a learning point for how we can recognise unofficial or reluctant carers. Police LRS rep raised this with the Head of Public Protection who agreed to amend the Public Protection Notice (PPN) by creating a bespoke question asking "do you have anyone else that helps or supports you (friend, family, neighbour etc)" to capture those who may not recognise themselves as carers and those who are unwilling/reluctant/unaccepting.

The Alex SAR raised learning about risk assessment and planning ahead to safeguard an adult when working with the court of protection. It is also identified the need to recognise and respond to the needs of all adults within a home environment, adopting a whole family approach. Adults' Health and Care applied this learning in a similar situation and were able to safeguard the individual and ensure robust support was in place for their carer. The team involved fed back that the learning from the Alex SAR directly impacted the approach taken and achieving a positive outcome.
– Learning and Review Subgroup (LRS)

Following a referral into LRS relating to a death where there was single agency learning for housing identified, a presentation was given to the housing subgroup regarding the concerns around no-access, a learning briefing was provided. Colleagues were asked to feedback assurance to the group that organisations have reviewed their own procedures regarding no access. Several partners reported back that this was an area that required improvement within their business as they had identified that there was no specific procedure relating to this, but that access was part of a wider procedure regarding compliance.

This has resulted in positive feedback that several members now have a stand-alone procedure for no-access being implemented by their organisation, as well as directing people to consider safeguarding. There was acknowledgement that in such circumstances where the organisation is aware of an adult with care and support needs that it is a priority to communicate with the adult in person.
– 4LSAB Housing Subgroup

In partnership with the Hampshire and IOW Integrated Care Board and South Central Community Pharmacy, Hampshire and Isle of Wights Fire and Rescue Services (HIWFRS) delivered a public awareness campaign on the fire risks of emollient products - utilising over 300 pharmacies, 200 GP surgeries, 500 Domiciliary Care providers and a variety of online platforms to share safety messages and raise awareness.

– 4LSAB Fire Safety Development Group

4LSAB Biennial Self-Audit

The Safeguarding Adults Boards in Hampshire, Isle of Wight, Portsmouth and Southampton (4LSAB) developed a shared Safeguarding Self-Audit Tool which was designed to enable respective Boards to fulfil their remit of ensuring local safeguarding arrangements are both effective and also deliver the outcomes that people want.

Local agencies were asked to undertake the Self-Audit to help them evaluate the effectiveness of their internal safeguarding arrangements and to identify and prioritise any areas needing further development. The Self-Audit is completed on a biennial basis and this approach supports the 4LSAB in its governance and remit of holding local agencies to account for their safeguarding work. The HSAB was assured by the high number of returns that identified similar areas of good practice, namely in relation to: clear management, responsibilities regarding safeguarding and recruitment, the ability to recognise indicators of abuse and raise the appropriate concerns. There were also good examples of service user engagement. This is a facilitative process to support continuous improvement and the data that is collected is shared with the boards and each areas annual report. Areas of shared learning that require review and further consideration by our partners, have been identified and are listed below. These areas will be used to inform the HSAB's strategic development plan.

Theme	Response from HSAB
Staff supervision	All staff involved in safeguarding should have access to regular supervision and have opportunities to reflect and debrief. Supervision is important for learning and development and to support wellbeing and resilience. The 4LSAB are in the process of updating the Multi-Agency Guidance on Safeguarding Roles and Responsibilities to clarify responsibilities in relation to staff supervision.
Organisational abuse	Agency safeguarding policies should include reference to organisational abuse which is one of the types of abuse set out in the **Care And Support statutory guidance**. Organisational Abuse is one of the workstreams on the HSAB operational plan.
MARM and when to use it	The **MARM framework and toolkit** was extensively revised and relaunched in 2023. Recordings of the three MARM webinars are available on the **HSAB website**. Each LSAB will continue to work on promoting the MARM in their area

Unpaid carers	The Local Government Association has a briefing on **carers and safeguarding**. Empowering and informing people and those who help support them is a further area of work on the HSAB operational plan. New information is also being added to **Connect to Support Hampshire** on unpaid carers.
Managing risk moving into adulthood	Agencies should be aware of the **4LSAB Multi Agency Framework for managing risk and safeguarding people moving into adulthood**. There is work ongoing in relation to transition into adulthood by the HSAB team and multi-agency partners.
Alcohol/self neglect	Alcohol and self-neglect are often factors in safeguarding adults' reviews. Hampshire have alcohol dependency as a workstream on the operational plan. We are completing some focused work with Alcohol Change UK.
Mental Capacity Act	Partners are encouraged to read the **7-minute guide on Mental Capacity**. Hampshire have 'create a clear understanding of when and how to engage the Court of Protection in safeguarding' on our operational plan, we have three training sessions on areas associated with Mental Capacity
Advocacy	The 4LSAB has a **one minute guide to Advocacy**. There is also a video from Voiceability on our website and can be found **on the HSAB website**. Hampshire have Advocacy engagement and referrals on our operational plan and three **training** sessions to support this.
Feedback	It is an expectation on agencies that they will seek feedback from adults supported through safeguarding and use this information to improve processes and practice, as part of their governance. HSAB will look to gain assurance from our partners in relation to this via our Quality Assurance Subgroup.

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. During the period 1 April 2022 to the 31 March 2023, the home page of the Website was the most popular with 1,875 views. Following this it was 'Report Concerns' with 1,020 views.

Work has been completed on streamlining the HSAB website, as well as planning the new pages for the refreshed website. A strict tendering process has been followed and the HSAB is pleased that the tender for the new website has been awarded Phew, whom we look forward to working closely with.

National Safeguarding Week (20 – 26 November 2023)

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

During the week, HSAB social media reached a total of

5,957 people

2,190 on Facebook and
3,767 via X (formally Twitter)

Event attendance

The HSAB resource stand was taken to various events in different areas of the county. These included conferences networks, forums and seminars, reaching 1,898 attendees.

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

In 2023-24 the HSAB delivered 19 multi-agency training events, with **bookings totalling 1,898.**

Delegate feedback examples 2023-24

> The presentation was actually brilliant, informative with the right amount of data shared to be relevant and not dull. The presenter was very engaging and presented at a good speed.

> It was simple, easy to follow, and the presenters instilled a confidence about the subject which I think patients will find extremely reassuring.

> The workshop was really informative and well presented. There were some lovely positive outcomes for the cases discussed.

> The way the information was presented was really engaging and the knowledge the trainer had and how they made it easy to follow and understand was great. There was useful signposting to services, information and guidance available and the aim and purpose of what was trying to be achieved was really clear. I learnt a lot and will be applying and taking this information into my work going forwards.

> Case studies are always for me the most helpful way of learning and you had some great examples.

Breakdown of attendees by sector for courses run in 2023-24

Attendance from Fire Services, Police and Education have been amalgamated into Other.

Sector	Number of Delegates
Local Authority	386
NHS	411
District and Borough Councils	146
Care	276
Housing	205
Charity	325
Other/Not Specified (inc. Fire Services, Police and Education)	149
Total	**1,898**

Looking ahead

Having completed the second year of the Strategic Plan we now look towards 2024/25 and the completion of our 2023/25 operational plan.

We will build on the good progress made, and insights gained, during year two and keep focused on our foundational blocks, ensuring these continue to support delivery.

Key priorities for the coming year include:

- co-producing the new strategic priorities for 2025/28
- welcoming the new HSAB Chair
- managing the volume of SAR referrals coming into HSAB
- ensuring that learning from SARs or Single agencies is acted on and embedded within practice and assurance from our partners received by HSAB
- continuing to work closely with our sub-groups and create a structure to support constructive challenge and multiagency working
- delivering key training to partners through a comprehensive and relevant HSAB training offer
- launching a new HSAB website to better connect with people and communities, ensuring accessibility for all
- engaging in future Care Quality Commission assurance of Local Authority social care and Integrated Care System delivery
- concluding the workstreams within our 23/25 Operational Plan with our partners and providing outcomes to HSAB
- ongoing support of Policy/guidance delivery via 4LSAB Policy Subgroup
- distributing the HSAB Constitution to all Board members to ensure a baseline of understanding of their roles and responsibilities in relation to the HSAB
- responding to the learning identified from our survey, safeguarding experiences project and self-audit
- respond to the Recommendations for Safeguarding Adults Board Regarding Individuals Rough Sleeping received from the Department of Levelling up and Communities and the Department of Health and Social Care

We continue to remain focused, despite the wider system challenges faced by all our partners across Hampshire, to assure ourselves that local safeguarding arrangements are in place to help and safeguard adults with care and support needs. As a Board we remain focused on our commitment to gain assurance, challenge and support our partners in the ongoing delivery of safeguarding adults in Hampshire.

HSAB Financial Summary 2023-24

The Board continues to work efficiently delivering value for money, looking internally for partnership opportunities as well as collaboration with neighbouring Safeguarding Adults Boards where appropriate. The Board successfully sought contributions from partners although the 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 2021-22	Amount (Rounded, £)
Hampshire County Council	191,000
Hampshire and Isle of Wight Integrated Care Board	68,250
Hampshire Constabulary	31,000
Wider Partners	20,530
Total	**£310,780**

Published July 2024