HAMPSHIRE COUNTY COUNCIL

Report

Committee:	Health and Adult Social Care Select Committee
Date:	26 November 2024
Title:	Annual Safeguarding and Quality Report – Adults' Health and Care 2023-24
Report From:	Director of Adults' Health and Care
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Purpose of this report

1. The purpose of this report is to provide an annual update in respect of the local authority responsibilities to monitor the social care market and its safeguarding vulnerable adults.

Recommendations

It is recommended that the Health and Adult Social Care Select Committee:

2. Notes the positive progress and strong performance of the Directorate to keep adults at risk safe from abuse and/or neglect, whilst acknowledging ongoing risks to fulfilling statutory safeguarding duties in the context of increased numbers of safeguarding concerns being reported.
3. Notes the commitment of a wide range of Adults' Health and Care staff, and wider partner agencies, to delivering robust safeguarding arrangements in Hampshire.
4. Notes the contribution of the Hampshire Safeguarding Adults Board (HSAB) to safeguarding strategy, assurance, and the development of policy across the four local authority areas of Hampshire, Portsmouth, Southampton, and the Isle of Wight.
5. Notes the work of the Provider Quality Team and the associated Quality Outcomes and Contract Monitoring Framework (QOCM) to provide market oversight data and intelligence, support quality improvement in the independent market and to undertake due diligence activities for newly commissioned Adults' Health and Care contract frameworks.

Executive Summary

6. This report provides an update on the work of the Adults' Health and Care Directorate, and of the Hampshire Safeguarding Adults' Board respectively, to

safeguard vulnerable adults and to monitor the quality of provision across the social care market.

7. The Directorate has seen high volumes of reported safeguarding concerns, which is a trend seen elsewhere nationally. An extensive programme of safeguarding practice improvement has served to ensure section 42 enquiries are undertaken and recorded to confirm that risks are managed, and people are kept safe. Hampshire's section 42 enquiry rates are now within similar parameters of comparator local authority areas. Safeguarding practice has also been further strengthened through an enhanced training offer, continued development of the Senior Social Worker role, continued use of a safeguarding practice audit tool (Quality Assessment Framework) and a safeguarding activity dashboard to enable trends to be identified and highlighting opportunities for further development.

8. Improvement actions are implemented in response to key learning from Safeguarding Adult Reviews and serious incidents. In the past year this has included:

    a. Increased delivery of direct practice support from the Strategic Safeguarding Team to identified community teams.

    b. Further development of the Risk Assessment and Escalation Framework.

    c. Unique design of new safeguarding recording format in CareDirector to support good practice.

9. Market Oversight is undertaken in accordance with the QOCM framework and associated guidance. This framework was refreshed and republished in April 2024, following consultation with colleagues from commissioning, safeguarding, operations and brokerage internally, as well as Integrated Commissioning Board (ICB) safeguarding and quality colleagues externally. The framework combines policy and guidance in respect of how Adults' Health and Care works with social care providers, regulated and non-regulated, to support improvements, monitor contract performance, and sustain good quality services. The framework outlines the requirements to ensure both quality of service, and monitor performance against contractual obligations, and how these two elements combine to form an overarching view of a provider.

10. The Directorate has continued to work with wider partners to undertake Large Scale Safeguarding Enquiries, with three opened by the Directorate in the 12 months to September 2024.

11. The government has announced an indefinite delay to implementation of the Liberty Protection Safeguards (2019). Local partnerships have shifted focus to streamlining and strengthening the current safeguards. In the absence of new safeguards, a large waiting list is likely to remain; this is in keeping with other local authorities of a similar size and demographic.

12. The Client Affairs Service continues to operate an effective service to its 800 clients, including delivering services on behalf of Southampton City Council.

13. In keeping with the County Council's Modern Slavery Statement, the Directorate has continued to progress actions to raise awareness of modern slavery, including through the delivery of training and guidance for staff.

14. There is a continued focus on Domestic Abuse, with new guidance published and training commissioned.

15. In line with its statutory duty under the Care Act, the Hampshire Safeguarding Adults Board (HSAB) published its 2023-24 Annual Report setting out key areas of progress and achievements against its 2022 – 2025 Strategic Priorities. The Board developed an Operational Plan to support delivery of the strategic priorities. The Annual Report covers the second-year delivery of this plan. The HSAB also responded to further growth in the number of Safeguarding Adult Review referrals and commissions.

16. As part of its assurance and oversight of adult safeguarding activity, HSAB continues to review and update its Risk Register. The Board continues to scrutinise and seek assurance regarding emerging risks in relation to safeguarding as well as continuing to have oversight of the performance of the South-Central Ambulance Service (SCAS) following Care Quality Commission (CQC) inspection of the service's Emergency Operations Centre.

17. The Provider Quality team is a small team that works across all care groups and with providers that are registered with CQC and those that are not. This report will include information regarding the work of the team and aims to provide intelligence and insights regarding the variety of work undertaken.

Contextual information

18. This report provides an update on the work of the Adults' Health and Care Directorate, and of the Hampshire Safeguarding Adults Board respectively, to safeguard vulnerable adults.

19. The main statutory safeguarding responsibilities for local authorities, Police and the NHS are covered by the Care Act 2014 and subsequent statutory guidance. The Care Act 2014 Statutory Guidance defines safeguarding as 'protecting an adult's right to live in safety, free from abuse and neglect'. A person with care and support needs living in Hampshire who is at risk of, or experiencing, abuse or neglect, and is unable to protect themselves, can access safeguarding support irrespective of their eligibility for services. A safeguarding concern is raised where there is reasonable cause to suspect that an adult who has, or may have, needs for care and support is at risk of, or experiencing, abuse or neglect (Care Act 2014, Section 42 (1) (a) and (b)).

20. Statutory responsibility for oversight of Hampshire's local system safeguarding arrangements rests with the HSAB. The main objective of the HSAB is to assure itself that local safeguarding arrangements and partners act to help and protect adults in its area who meet safeguarding criteria. The HSAB achieves this by working closely with wider Adults' and Children's Safeguarding Partnerships.

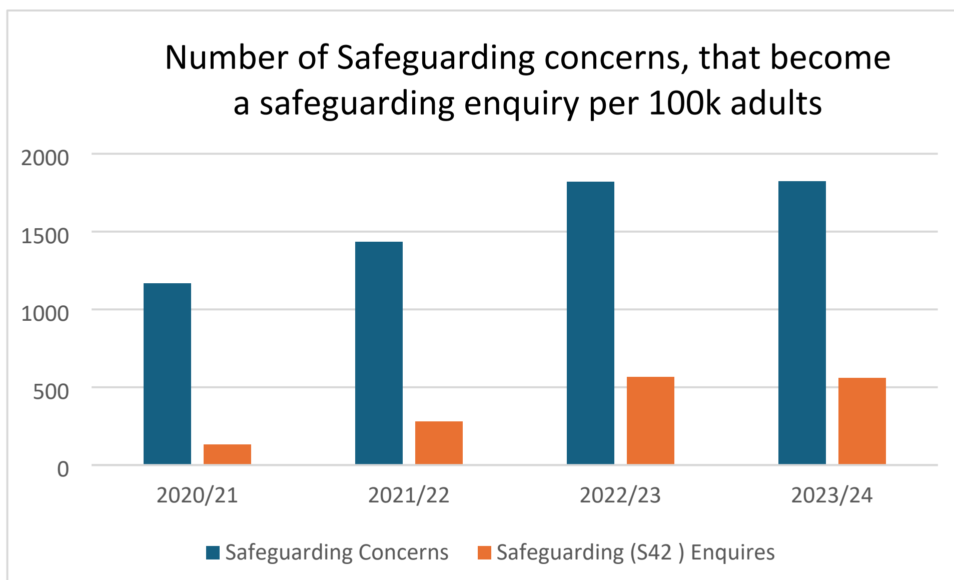
21. The Provider Quality Team responsibilities are in accordance with the following Local Authority duties from the Care Act 2014:

- Section 2 requires local authorities to ensure provision of preventative services.
- Section 5 the duty to promote the efficient and effective operation of the market of services for meeting care and support needs in the local area.
- Section 48 if a regulated provider in the Local Authority area fails the Local Authority has a temporary duty under section 48 of the Care Act to; Provide alternative care and support services.

Safeguarding Improvement

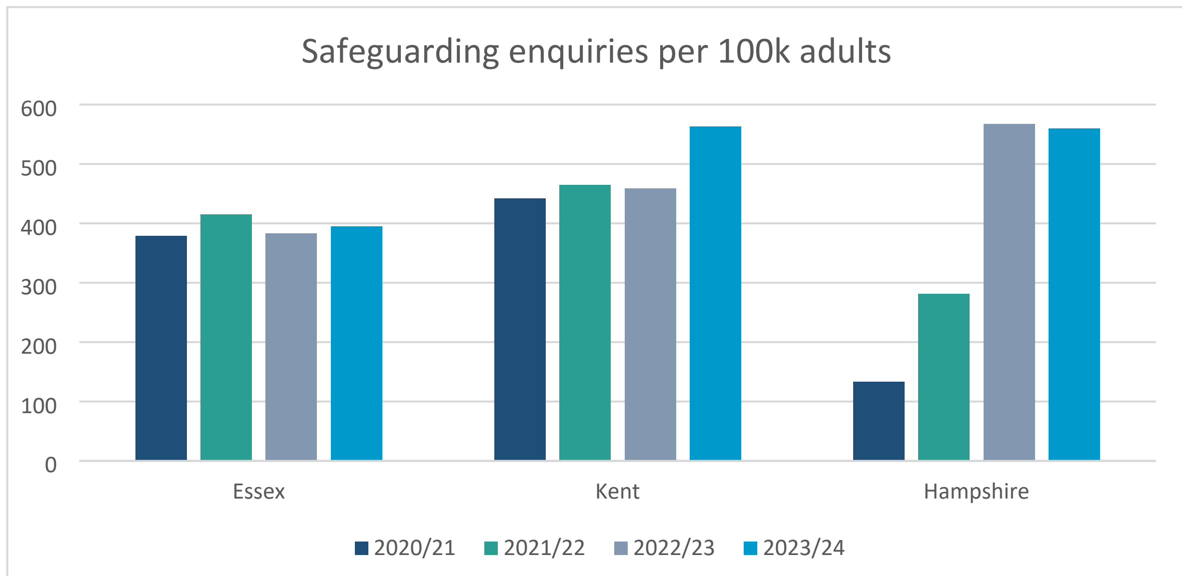
22. Throughout the year 2023/24, the number of safeguarding concerns per 100,000 adults received by the Directorate has remained consistent with the previous year. Comparator local authorities have reported receiving increased numbers of safeguarding concerns. Hampshire continues to receive slightly higher numbers of safeguarding referrals per 100,000 adults than comparator local authorities. Safeguarding concerns are most often received by the Multi-Agency Safeguarding Hub (MASH) but some also come directly to hospital and community teams.

23. Of the safeguarding concerns that are received by the Directorate, around 30% meet the statutory criteria for a safeguarding enquiry to be undertaken. Given the volume of concerns received that do not progress to an enquiry, work is being undertaken with partners who frequently refer safeguarding concerns to ensure referral criteria are clearly understood and consistently applied. This appears to have contributed to safeguarding referral rates levelling off, compared with 2022/23.



24. Under the leadership of the Principal Social Worker, a cycle of continuous safeguarding practice improvement has continued through 2023/24, prioritising proportionate and robust application of safeguarding duties. Following work in preceding years to ensure safeguarding risks were appropriately managed through increasing use of formalised enquiries,

enquiry rates per 100,000 adults in 2023/24 have been broadly consistent with 2022/23. This positions us at a rate of safeguarding enquiries that is consistent with comparator local authorities.



25. Safeguarding training pathways have been reviewed in 2023/24. 80% of staff have either completed or are currently undertaking their mandatory safeguarding training. An additional 19% of staff have training booked in. A new safeguarding refresher training day has been developed to streamline the process of operational staff maintaining current knowledge in safeguarding practice. A training dashboard enables managers to see clearly which staff have attended individual training courses.

26. Safeguarding Adult Review (SAR) learning highlights that working with acute or complex risk can be one of the most challenging areas of practice. A Risk Assessment and Escalation Framework introduced in September 2022 ensures that practitioners are supported with shared decision-making for the most complex risks, drawing on relevant expertise as needed across the Directorate. The most complex risks are reviewed at Risk Escalation Panel, with representation from senior managers within the Directorate. Since its introduction, risks for 27 adults have been discussed at Risk Escalation Panel and 14 have been discussed on multiple occasions due to severity and complexity of risk. Complex considerations relating to mental capacity, hoarding and environmental risks, domestic abuse, self-harm, malnutrition, non-engagement with services and substance misuse have been recurring themes in risks escalated to panel.

27. The Strategic Safeguarding Team provides expert guidance and support to practitioners and managers across a broad range of safeguarding practice matters and provide on-site support in area offices. They also advise on the development and implementation of safeguarding guidance. Four new safeguarding-related guidance topics have been published on the Social Care Practice Manual over the past year, eight safeguarding-related guidance

topics have been reviewed, and the team have supported the development of nine guidance documents within the 4 Local Safeguarding Adults Boards (LSAB) (Hampshire, Southampton, Portsmouth and Isle of Wight) area.

28. There are currently 28 Senior Social Workers with a safeguarding specialism, who provide associated practice advice and guidance for their teams. Bi-monthly sessions for the safeguarding lead Senior Social Workers are facilitated by the safeguarding consultants to support the development of safeguarding practice, create and share resources, and for expertise and insights to be shared across teams.

29. The introduction of the CareDirector client records system in November 2023 incorporates recording formats that more closely reflect statutory safeguarding process and enable further development of associated data collection and reporting. One example has been to introduce the ability to report on how many safeguarding referrals meet the definition of a safeguarding concern. The new safeguarding recording format also supports practice that focuses on the individual's needs and wishes, known as 'Making Safeguarding Personal'. Oversight of the quality of safeguarding practice is supported through a Quality Assurance Framework online questionnaire designed to recognise good practice and identify opportunities for improvement. A revised Quality Assurance Framework is in development, to reflect current practice priorities and CareDirector recording in relation to safeguarding.

30. Improvement actions are identified and implemented in response to key system learning from SARs. Adults' Health and Care take a systematic approach to learning from SARs through an action plan that tracks implementation in practice, systems and processes. Notification of SARs publications are circulated to teams across the Directorate and published SARs are available to practitioners via the Social Care Practice Manual. SAR learning is considered with operational colleagues as part of new Practice Analysis Meetings, led by the Quality Team. Quarterly SAR action plan reports are shared with the Hampshire Safeguarding Adults Board to update on implementation of actions identified.

31. In November 2023, the CQC assessment framework for local authority assurance was introduced. CQC intend to assess all local authorities in England within two years of the introduction. The assurance framework includes a specific quality statement relating to safeguarding adults. Work has been undertaken to prepare related information that is required by CQC and to ensure practice improvement activity is aligned with the quality measures CQC will be assessing against.

32. A survey has been introduced for people to feedback on their experiences of Adults' Health and Care, including people who have been the subject of a safeguarding enquiry. The feedback form questions are based on CQC measures that people with lived experience have identified as what matters most to them in their experience of social care.

Provider Quality Team Activity 2024

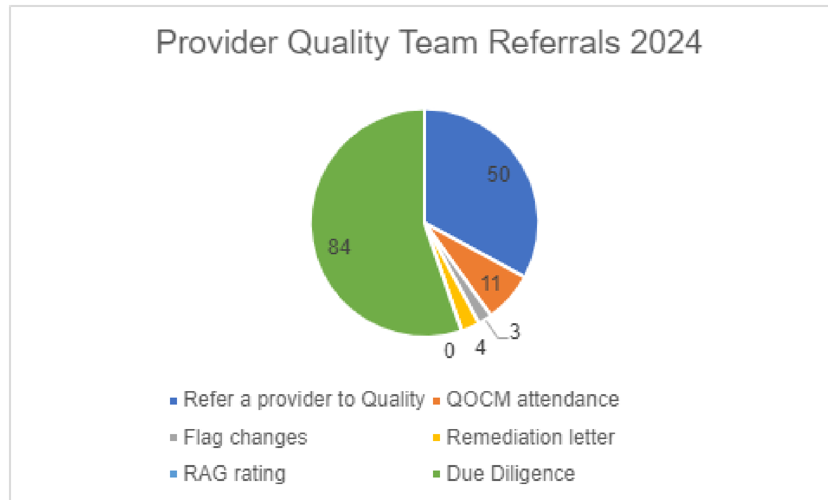
33. The Provider Quality Team consists of **one full time team manager and admin officer and 3.45 FTE Quality Officers**. It is a small team covering all care groups and working with services that are registered as well as non-registered support services. A **key performance indicator** for the team is to undertake an assessment of providers' quality using the internal Adults' Health and Care Red Amber Green (RAG) tool. This evaluates providers using a RAG toolkit. The toolkit consists of eight quality indicators:
    1. Care Quality Commission (CQC) rating,
    2. QOCM
    3. Large Scale S42 Safeguarding Enquiry status,
    4. Hampshire County Council purchasing status,
    5. CQC enforcement action,
    6. Leadership of service,
    7. Quality teams and Health involvement
    8. Operational intelligence.
34. This is to ensure a breadth of information is used to determine any pro-active, or responsive action required by the team.
35. The team have undertaken 760 RAG ratings so far in 2024. These **exceeds** the key performance indicator target required by end of September 2024 of 540.
36. An internal Adults' Health and Care assessment of quality of providers services is especially important at the moment, because the **CQC are experiencing delays in registering, inspecting and reinspecting providers**. This means that Adults' Health and Care cannot depend on a CQC rating alone, to make a judgment of the standard of care delivery and quality of service. The current Hampshire Providers market oversight data shows ratings and commissioned services as follows: Market Oversight

	CQC INADEQUATE	CQC REQUIRES IMPROVEMENT	CQC GOOD	CQC OUTSTANDING	CQC NOT YET RATED	TOTALS
Total number of Hampshire services	3	111	552	45	134	845
Number of services AHC commission from	3	77	455	33	33	601
Number of people supported	5	1366	8447	212	1072	11102

37. Compared to the previous quarter Adults' Health and Care commission with:
    - two less Inadequate rated providers,
    - 28 more Requires Improvement rated providers.

- 95 less Good rated providers,
- 8 less Outstanding rated providers
- 9 less Not Yet Rated providers.
- The directorate commission **277** less packages than June 2024.

38. **Operational teams refer** to the team to request a visit to a provider service or for the team to support at a QOCM meeting, purchasing restriction etc. So far this year the team have received **152 referrals** to undertake some work in respect of provider services, as follows:

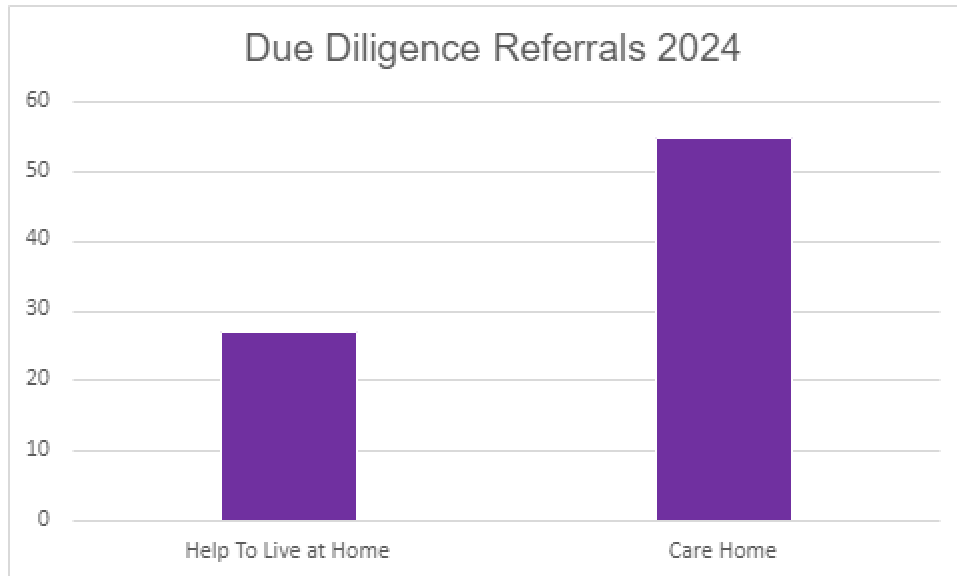


39. The team **work with providers to support improvements and to assist the organisation to respond to regulatory activity**, such as a CQC rating change or a UK Visas and Immigration (UKVI) enforcement activity. The work can be carried out in person with a visit to the service, or remotely via telephone or video link. Where possible visits to a service are limited to three for each referral. In 2024 so far, the four officers have undertaken 84 visits to 56 different services. This averages 1.5 visits per provider, though some will have more, and others would only require the one visit or support remotely.

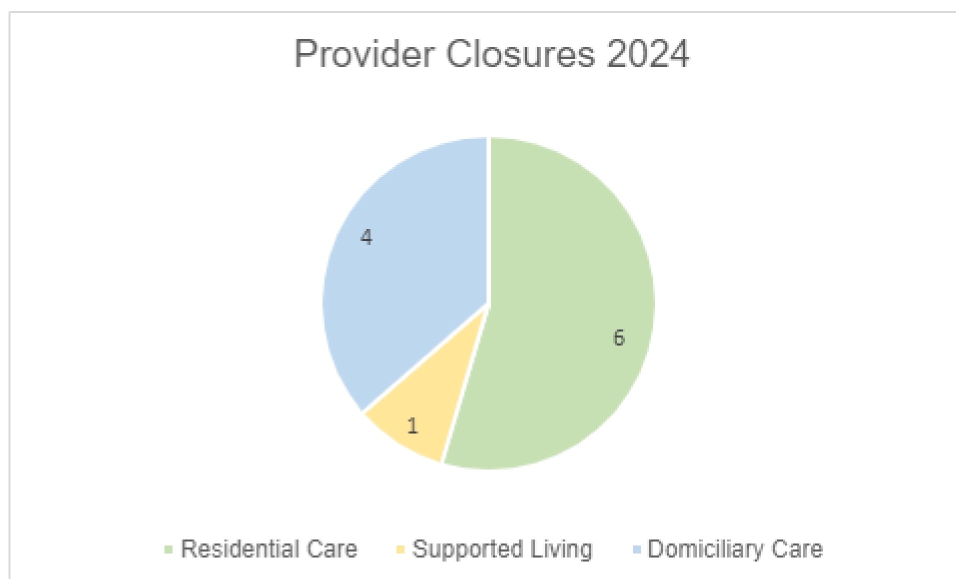
40. The Provider Quality Team has been supporting the existing **Care at Home and new Care Home frameworks** by undertaking **due diligence, or quality evaluations**, of providers referred by the relevant commissioning teams. In 2024, the team received **82** referrals for either existing providers wishing to add additional zones to their existing areas of operation, or care homes joining the new framework, all of which are complete. There have been no new referrals due to the domiciliary care framework closing in June 2023. A decision was made to close applications to add zones in August 2024, though some providers who applied before this have been referred through to the team.

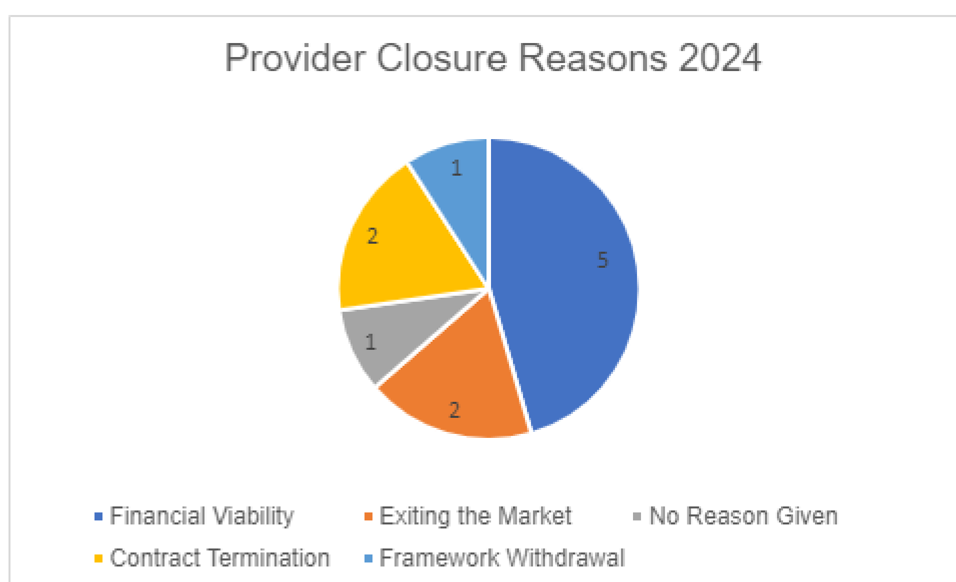
41. Work is well underway for the launch of the new Help to Live at Home framework in October 2024, with applications for the call off contract going live in November 2024. The Provider Quality Team have reviewed their due diligence form to mirror that of the care home framework form and have contributed to the new process for evaluating the quality of providers wishing to join. The referrals to the team will be much more robust, leading to focused

areas of discussion with the providers. Each due diligence will involve a face-to-face visit to the service, rather than a virtual meeting as they have previously been.

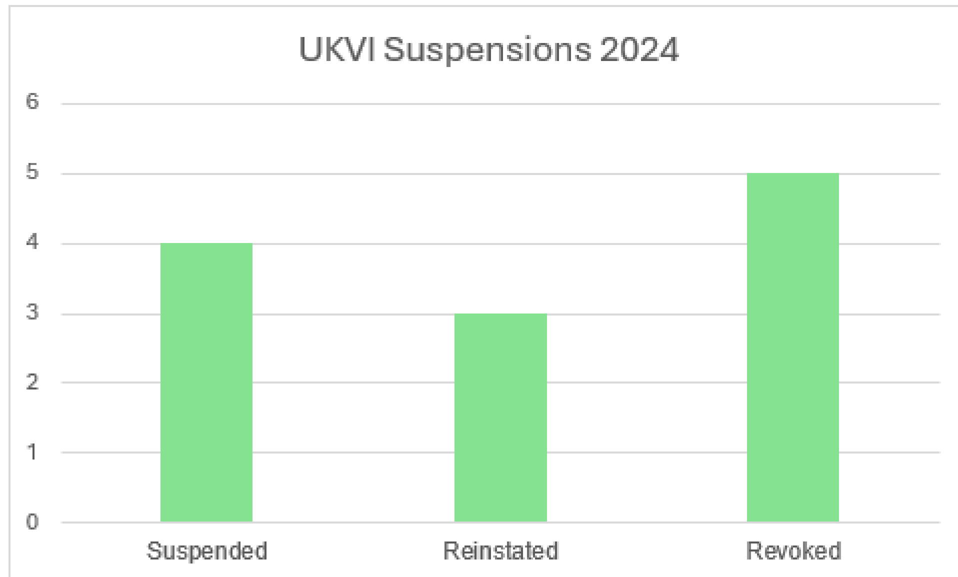


42. An important area of the teams work is to coordinate any **closures or interruptions to provider services** that might arise. This work is in accordance with the published AHC guidance. The guidance aims to provide Adults' Health and Care staff with the information and tools that they need to respond if a service provider is unable to continue providing a service either temporarily or permanently. The tools have been developed to enable a response both in an emergency situation and those where Adults' Health and Care have notice regarding a service interruption or closure. There have been 11 closures so far in 2024: six care home closures, one supported living closure, (6 were Learning Disabilities and 1 Older Adults) impacting 30 people. Four domiciliary care agencies exited the market, this included Adults' Health and Care termination two of the contracts, one service withdraw from the framework voluntarily and one agency went into liquidation. Overall, this impacted 100 people in receipt of a service, where alternative care was found.





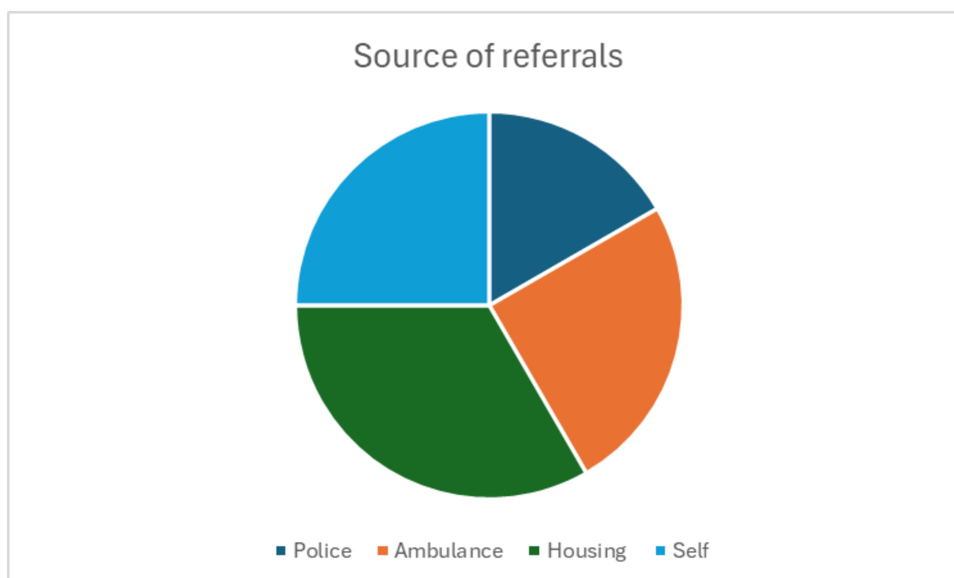
43. A particular busy part of the teams work over the last year has been responding to UK Visas and Immigration (UKVI) enforcement action. This specifically relates to providers that sponsor staff from overseas. Many of these services have found to be in breach of their sponsorship licence requirements and this has resulted in enforcement action of suspension or revocation of their licence. In some instances, if the provider has a high percentage of its staff team sponsored this can lead to business continuity issues and put the care and delivery to the people the organisation is supporting at risk. Twelve providers had UKVI enforcement action since January 2024. AHC re-commissioned care for three providers, two had their contract terminated and one withdrew from the framework. This meant re-commissioning for 100 people.



Enhanced Support Work project

44. Adults' Health and Care Enhanced Support Workers continue to engage with individuals where there are safeguarding concerns primarily in relation to self-neglect (which may include hoarding), or the person is at risk of experiencing home loss. These individuals may present with recurring multiple co-morbidities, including Mental Health issues, Autism, other disabilities, undiagnosed health needs, substance misuse, or chaotic social circumstances and limited social support networks. People referred to the service are often classified as 'hard to reach'. The service addresses learning from a thematic self-neglect Safeguarding Adults Review published in 2022, subsequent gap analysis published in 2023, and escalating numbers of people supported by Adults' Health and Care due to self-neglect.

45. Due to the success of the Enhanced Support Work project in achieving positive outcomes for individuals, continuation of the 2022 project was secured until March 2025. Referrals to Enhanced Support Workers were originally via the MASH from external partners. The service has now expanded to accept referrals from the community teams. The complexity of this work presents a challenge for community teams due to the time-intensive nature of interventions required to successfully address the issues present. The availability of the Enhanced Support Work project provides practical support to help ensure these complex needs continue to be addressed. Referrals to the project are received through a range of channels:



Transformation of the Adults Multi-Agency Safeguarding Hub (MASH)

46. The Directorate continues to develop improved ways of working in MASH, with the aim of being a centre of excellence for safeguarding practice, retaining a particular focus in supporting residents with the most complex risks, such as hoarding and self-neglect. Previously, all safeguarding contacts were passed by the social care contact centre on to two separate teams in MASH. This has since changed to a whole MASH team approach, where all contacts are now channelled through to Adults MASH. The Adults MASH team is made up of experienced caseworkers, senior case workers, social workers, senior social workers and two nurses. The responsibility of this team is to manage all safeguarding contacts that are received through multiple channels to ensure detailed and relevant information is gathered.

47. The MASH team manage all complex cases, complete enquiries and work in partnership with internal and external partners to manage safeguarding risks. The model aims to deliver high quality and timely safeguarding interventions at the front door, a consistent approach to managing safeguarding concerns, increased and consistent feedback to referrers and vulnerable adults from MASH and an upskilled workforce to manage safeguarding concerns through training.

48. Due to the level of demand that MASH is currently experiencing, resolution timeframes are not always in line with expected standards. In the context of increasing safeguarding referrals being made to Adults' Health and Care, work is being undertaken to help ensure referrals received are appropriate and actioned in a timely way. This includes focused work with key stakeholders to build on mutual understanding of referral criteria. Furthermore, HSAB and MASH are working in partnership to further develop Hampshire's online safeguarding referral form. The impact of the Directorate's continuous practice improvement is monitored via a monthly safeguarding dashboard that generates insights into safeguarding activity, trends and potential areas for development. This is used by both operational and strategic staff to influence practice and improvement activity. The development

of a new client records system (CareDirector) for the Directorate has provided opportunities to improve on the existing safeguarding recording format and the measures it generates for governance and assurance. Continued development aims to include more refined reporting on safeguarding concerns received and rationale for decision-making on actions to be taken in response. This will inform improved reporting of safeguarding activity both internally and for national reporting requirements.

49. The Front Door Transformation Programme includes a dedicated MASH Development project, focused on understanding opportunities for improvements and implementing solutions that will benefit our staff, customers and partners. This includes:

- Working with Subject Matter Experts (SMEs) to develop a safeguarding communications plan for key stakeholders to build on mutual understanding of referral criteria, manage expectations around our services, and outline the challenges we are experiencing in managing demand, in order to identify solutions.
- Working in partnership with MASH to further develop Hampshire's online safeguarding referral form. This include; providing a clear explanation of what safeguarding is to prevent unnecessary or inappropriate submissions, reducing free-text fields, and routing individual to correct form type. These changes are due to be implemented in Autumn 24.
- Exploring solutions to automate time-consuming manual tasks to match referrals with existing contacts, which may involve utilising AI, enhancing existing system functionality and other digital developments. Analysis shows that this may save around 1 FTE.
- Undertaking a 'week in the life of' (WILO) exercise to identify opportunities for process and practice improvements. This includes changes to dashboard triaging, and High Risk Domestic Abuse (HRDA) / Multi-Agency Risk Assessment Conference (MARAC) processes, which will have significant time saving benefits for staff in MASH.

Large Scale Section 42 Safeguarding Enquiries

50. Large Scale Section 42 Safeguarding Enquiries (LSSE) are a co-ordinated multi-agency response to protect adults with care and support needs from organisational abuse. LSSE is part of the continuum of potential responses to safeguarding concerns in a provider setting. An LSSE may be triggered where there are safeguarding concerns about more than one adult, there is a place or network that facilitates abuse, or there is a provider who fails to protect adults from abuse. LSSEs are often complex, requiring significant resource from multiple partners. Over the course of the last year, three LSSEs were opened to the Directorate, with work on a fourth continuing into this period.

Deprivation of Liberty Safeguards (DoLS)/Liberty Protection Safeguards (LPS)

51. The Local Authority acts as the ‘supervisory body’ under the Mental Capacity Act 2005 for Deprivation of Liberty Safeguards (DoLS). DoLS is the legal framework applied when someone has care and support needs and for their own safety and welfare their liberty is deprived. Care homes and hospitals (‘managing authority’) must make an application to the local authority if they believe someone in their care, who lacks mental capacity, is deprived of their liberty because of care arrangements in place. These arrangements are necessary to ensure that no-one is deprived of their liberty without independent scrutiny and outside of the appropriate legal framework.

52. The Government had planned to replace DoLS with the Liberty Protection Safeguards, which were introduced through the Mental Capacity (Amendment) Act 2019[1] and originally due to come into force in October 2020. This was delayed to April 2022 due to the Covid-19 pandemic. In April 2023 the Government announce the safeguards would not be implemented within the lifetime of this parliament. This has left some doubt as to whether they will be implemented at all.

53. As part of the strengthening and streamlining of assessments, and to support the management of increasing demand, the DoLS Service has implemented the use of Form 3B and the equivalent assessment pathway. The shortened assessment supports the move to legal minimum service level practice, saving time both for the assessor and the authoriser.

54. The equivalent assessment pathway has been improved with an increase in the number of renewal assessments being completed earlier, reducing the need for an additional medical assessment, therefore improving efficiency and reducing cost.

55. These measures, alongside other process improvements have resulted in a net decrease in the number of individuals awaiting assessment of 607 between April 24 – September 24.

Client Affairs Service (CAS)

56. The Client Affairs Service (CAS) operates to manage the property and financial affairs of people who lack the mental capacity to do this for themselves. People supported by the service have no family willing or deemed suitable to do this on their behalf.

57. The CAS continued to operate an effective service to approximately 800 clients and deliver services on behalf of Southampton City Council. ‘Sold Service’ activities were further developed through previous agreements with Guernsey and with the ICB. A review of the contract with Southampton City

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[1] Mental Capacity (Amendment) Act 2019 (legislation.gov.uk); Mental Capacity (Amendment) Act 2019 (legislation.gov.uk)

Council will be progressing to ensure a robust position both operationally and financially

58. The service is continuing to undertake a systematic review of its processes and practices. This is to ensure that it remains a high performing team that is fit for the future and can manage the increase in demand that is being see. The review is focused on ensuring that full advantage is made of online and digital solutions.

Modern Slavery

59. Adults' Health and Care continue to progress actions to deliver on the County Council's commitment to preventing slavery and human trafficking across its business activities and supply chains. Key developments include:
    - The Directorate remains involved with the Hampshire Modern Slavery Partnership and is currently inputting into a Rapid Read to Modern Slavery, a step-by-step guide to managing modern slavery and a Toolkit for Modern Slavery.
    - The Directorate continues to promote the Hampshire Modern Slavery Partnership eLearning training to key cohorts of Adults' Health and Care staff.
    - The Social Care Practice Manual Page on Modern Slavery has been updated with an increased focus on Adults' Health and Care's responsibility as a First Responder.
    - The Directorate is undertaking a qualitative review of s42 enquiries related to Modern Slavery.

Domestic Abuse

60. The Hampshire Domestic Abuse Partnership is formed by a variety of statutory and voluntary sector agencies working together to tackle the issues of domestic abuse. The Partnership includes the Hampshire Domestic Abuse Partnership Board which operates through several sub-groups that Adults' Health and Care participate in.

61. Operational Teams have access to guidance and resources about Domestic Abuse on the Social Care Practice Manual pages. The safeguarding consultants support practitioners and teams with the identification and response to domestic abuse throughout their practice.

62. Domestic Abuse training has been delivered to 94 practitioners to date, and a further 39 practitioners have this training booked. Domestic abuse has been and will continue to be covered in the safeguarding lead Senior Social Work forums, supporting dissemination of current learning to teams. Training offered by the Hampshire Safeguarding Children's Partnership is also promoted to practitioners and managers in Adults' Health and Care, with recent training offered focusing on understanding domestic abuse in diverse communities. The Strategic safeguarding team have provided input into the 4LSAB Domestic Abuse guidance to support and inform practice.

Hampshire Safeguarding Adults Board (HSAB)

63. The HSAB continues to be a well-established, strategic board whose membership includes all key multi-agency partners. The Board is chaired by the Director of Adults' Health and Care, and an Independent Scrutineer provides critical challenge and support to ensure the Board fulfils its core statutory responsibilities. Additionally, a new post of SAR co-ordinator has been recruited to the Board team, supporting the increased number of SAR referrals received.

64. In line with its statutory duty under The Care Act, the HSAB published its 2023- 24 Annual Report setting out key areas of progress and achievements against its 2022-25 Strategic Plan. Highlights of year two include:

    - A very significant rise in SAR) referrals to the HSAB. As a result, there has been 10 SARs commissioned including two thematic reviews.
    - A Board Membership review and production of a HSAB Constitution, with memorandum of understanding for signup by Board members.
    - In 2023-24 the HSAB delivered 19 multi-agency training events, with bookings totalling 1,898.
    - Collaborating with Safeguarding Adults Boards for Portsmouth, Southampton, and the Isle of Wight to produce joined-up guidance on, 4LSAB Adults who Disclose Non-recent (4LSAB) Sexual Abuse, 4LSAB MARM framework, 4LSAB Escalation Protocol and 4LSAB Prevention and Early Intervention.
    - The Board continues to work through several sub-groups across the 4LSAB areas to reduce duplication and maximise its effectiveness.
    - Raised awareness of abuse and neglect during National Safeguarding Week, reaching a total of 5,957 people across Hampshire.
    - The Board has completed a number of surveys as well as commissioned a Safeguarding Research Project in order to hear the service users voice in addition to the board representation in place.
    - The Board along with the other three SABs in the county completed our biennial self-audit, enabling partners to reflect on their safeguarding practice and provide assurance back into the SABs.

65. The Board continued to deliver on it's 2022-25 Strategic Priorities , which form the basis of the HSAB forward operational work programme. These priorities are to:

    - 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's 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.

Safeguarding Adult Reviews

66. A key statutory duty of the HSAB is to conduct SARs as appropriate under Section 44 of the Care Act. The purpose of a SAR is to learn from events to drive whole system improvement, leading to better outcomes for adults at risk of abuse and /or neglect.
67. Referrals are considered by the HSAB Learning and Review sub-group which determines whether the circumstances of the case fit the requirements for a SAR and if so, what type of review process would promote the most effective learning and improvement action to reduce the likelihood of future deaths or serious harm occurring. The SAR collates and analyses findings from multi-agency records and frontline practitioners and managers involved with the case. It provides a detailed overview of the interfaces involved and, where necessary, makes recommendations for practice improvement.
68. In 2023/24, the HSAB received 49 SAR referrals, which is an increase from the 29 received in 2022/23. Five SARS were published during 2023/24: ‘Helen’ SAR, ‘Alex’ SAR, ‘George’ SAR, ‘Gillian’ SAR and a thematic Self-Neglect Gap Analysis.

Key areas of risk and system oversight

69. Pressure is caused by high volumes of safeguarding referrals (**56% increase since 2020/21**), and section 42 safeguarding enquiries (**322% increase since 2021/21**) within both the MASH and community teams. This pressure is due to high demand of safeguarding concerns raised in terms of volume and complexity, and numbers of safeguarding enquiries required in response. This presents a risk to managing demand while ensuring safeguarding concerns are addressed in an effective, person-centred and timely way.
70. The South Central Ambulance Service (SCAS) are the largest single referrer of safeguarding concerns to Adults’ Health and Care via the Multi-Agency Safeguarding Hub. SCAS are subject to an ‘Inadequate’ rating from CQC, with their latest assessment completed in May 2022. SCAS safeguarding referrals are frequently found not to reflect multi-agency criteria for what constitutes a safeguarding concern contained within the 4LSAB Concerns Framework. This places additional pressure on capacity in MASH. Work is continuing with SCAS to improve the quality of safeguarding referrals to help ensure MASH resource is focused on referrals that meet the definition of a safeguarding concern.
71. An increasing number of SAR referrals and the complex nature of the work involved is putting pressure on agencies’ ability to commission and complete reviews within statutory timescales. In mitigation, the SAR co-ordinator works closely with Adults’ Health and Care and partner agencies to monitor referrals and progress of reviews, and to ensure completion of reviews.

Looking ahead

72. Over the next twelve months, the Directorate will prioritise the following to strengthen further its approach to safeguarding adults:

- To work in conjunction with operational managers to make improvements to the safeguarding recording form in CareDirector.
- Further develop monitoring and reporting of safeguarding activity, maximising the benefits of the new CareDirector system, to help inform strategic priorities.
- To embed action planning from learning identified in cuckooing thematic SAR, to embed learning through the cuckooing Social Care Practice Manual page which is already in place
- Develop improved safeguarding online referral form to support the quality and consistency of incoming safeguarding referrals and efficiency of work in the MASH.
- Continued work to reduce the volume of inappropriate referrals received from partners, specifically with SCAS. Within the aim to reduce the demand seen at the front door, to allow focus to be given to those greater at risk.
- To embed the service user and carer feedback form to ensure the experiences of people subject to safeguarding enquiries are understood and used to inform further practice improvements.
- Further development of Practice Analysis Meetings to ensure learning from serious incidents is used to inform practice change in a streamlined and timely way.
- To continue with the development of the successful mandatory policy and guidance updates to ensure staff are briefed on essential local and national developments within safeguarding and wider social care.
- Continued development of safeguarding practice guidance to include new topics on:
    - Self-harm
    - Falls and Safeguarding
    - Pressure ulcers and Safeguarding
    - MAPPA (Multi Agency Public Protection Arrangements)
- Continue to respond effectively to the sustained, high levels of SAR referrals and commissions, and seek to evidence the impact of improvement actions.
- Collaborate with its HSAB partners to implement the operational plan and deliver on the HSAB Strategic Priorities.
- To further develop responses and actions to the HSAB national safeguarding week survey and safeguarding research project.
- To further develop the Risk Escalation Process by inviting health colleagues to contribute to the panel, to provide more effective multi-agency guidance.

- To launch and embed the new QAF process, to allow for effective quality assurance within safeguarding as an integral element of practice.

Climate change impact assessment

73. This annual report references a wide range of services and activities which serve to fulfil the County Council's statutory duty with respect to safeguarding adults from abuse and/or neglect. Specific projects and initiatives, and the climate impacts of these, are overseen by internal governance arrangements and are not covered in this overarching report.
74. In the main, strategic safeguarding roles require limited travel and are predominantly home based. However, the Directorate also recognises the importance of in-person, physical meetings to safeguarding vulnerable adults and believes the benefit of these outweighs the climate change impact of car travel. To contribute to balancing this, the Directorate is exploring an expansion of its use of electric vehicles.

Conclusion

75. This report demonstrates that the Directorate continues to fulfil its safeguarding remit and continues to seek to improve safeguarding practice, working effectively with partner agencies. The HSAB also delivered on its statutory duties to oversee the local safeguarding system.

REQUIRED CORPORATE AND LEGAL INFORMATION:

Links to the Strategic Plan

Hampshire maintains strong and sustainable economic growth and prosperity:	No
People in Hampshire live safe, healthy and independent lives:	Yes
People in Hampshire enjoy a rich and diverse environment:	No
People in Hampshire enjoy being part of strong, inclusive communities:	Yes

Other Significant Links

Links to previous Member decisions:	
Title	Date

Direct links to specific legislation or Government Directives	
Title	Date
Care Act	2014

Section 100 D - Local Government Act 1972 - background documents

The following documents discuss facts or matters on which this report, or an important part of it, is based and have been relied upon to a material extent in the preparation of this report. (NB: the list excludes published works and any documents which disclose exempt or confidential information as defined in the Act.)

Document	Location
None	

EQUALITIES IMPACT ASSESSMENT:

1. Equality Duty

1.1 The County Council has a duty under Section 149 of the Equality Act 2010 ('the Act') to have due regard in the exercise of its functions to the need to:

- Eliminate discrimination, harassment and victimisation and any other conduct prohibited by or under the Act with regard to the protected characteristics as set out in section 4 of the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation);
- Advance equality of opportunity between persons who share a relevant protected characteristic within section 149(7) of the Act (age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation) and those who do not share it;
- Foster good relations between persons who share a relevant protected characteristic within section 149(7) of the Act (see above) and persons who do not share it.

1.2 Due regard in this context involves having due regard in particular to:

- The need to remove or minimise disadvantages suffered by persons sharing a relevant protected characteristic that are connected to that characteristic;
- Take steps to meet the needs of persons sharing a relevant protected characteristic that are different from the needs of persons who do not share it;
- Encourage persons sharing a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionally low.

2. Equalities Impact Assessment:

The Multi-Agency Policy, Guidance and Toolkit referenced in the main body of the report has its own Equality Impact Assessment. The local authority approach to safeguarding is applicable across all communities. As this is an annual overview report, no individual Equalities Impact Assessment has been undertaken.