HAMPSHIRE COUNTY COUNCIL

Decision Report

Decision Maker:	Cabinet		
Date:	7 December 2021		
Title:	Annual Safeguarding Report – Adults' Health and Care 2020-21		
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 statutory duty to safeguard vulnerable adults.

Recommendations

2. It is recommended that Cabinet:

   - Notes the positive progress and strong performance of the Department to keep adults at risk safe from abuse and/or neglect, whilst acknowledging ongoing risks to fulfilling statutory safeguarding duties.
   - Notes the commitment of a wide range of Adults' Health and Care staff, and wider partner agencies, to delivering robust safeguarding arrangements in Hampshire.
   - 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.

Executive Summary

3. This report provides an overview of the actions undertaken by Adults' Health and Care and multi-agency partners in **safeguarding adults at risk of abuse and/or neglect** in Hampshire.

4. Over the last year, the Department has seen an **increase in the volume and complexity of safeguarding concerns**, leading to higher numbers of safeguarding enquires. This is largely due to the impact of the Covid-19 pandemic, particularly national lockdown and social distancing measures. In the face of these challenges, the Department **continued to ensure robust governance arrangements and the continuous improvement** of services and safeguarding responses.

5. The **Hampshire Safeguarding Adults Board** continued to play an important role in overseeing safeguarding across the county and four local authority area, including through the development of safeguarding policy. Achievements include the production of **local Multi-agency Safeguarding Adults Policy and Guidance** and introduction of a **new Quality Assurance Framework**.
6. The Board continued to fulfil its statutory duty to arrange **Safeguarding Adults Reviews** (SARs), seeing an increase in referrals compared to the previous year. A **new system improvement framework** is being piloted across the four Local Safeguarding Adults Board area to ensure learning from SARs drives improvement. A Hampshire **Partnership Review model** is also planned to accelerate timescales for completing SARs, where appropriate.
7. The report demonstrates how the Department continued to fulfil its duties under the Mental Capacity Act 2005 for **Deprivation of Liberty Safeguards** and drove excellent practice in relation to assessing capacity and promoting service users' rights. Furthermore, it highlights the very positive feedback received following **external validation of the Department's Client Affairs Service** by the Office of the Public Guardian.
8. Information is provided on steps taken to improve the Department's multi-agency response to adults at risk of **domestic abuse** and respond to the Domestic Abuse Act, introduced in April 2021.
9. The PREVENT programme is now covered in a separate report due to the high level of risk and the specialist nature of the areas involved.

Contextual information

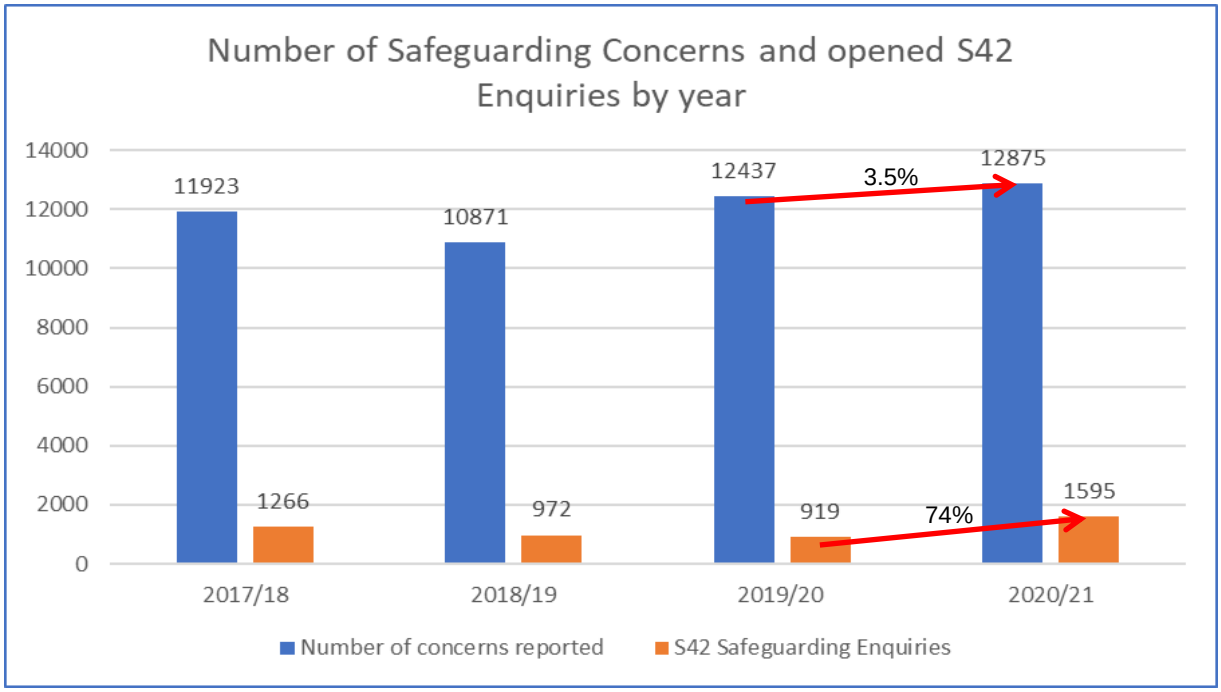
10. Adult safeguarding is a core duty of every local authority. The main statutory responsibilities for local authorities, Police and the NHS are covered by the Care Act 2014 and subsequent statutory guidance. A person with care and support needs living in Hampshire who is at risk of, or experiencing, abuse or neglect, and is unable to protect themselves, can access safeguarding support irrespective of their eligibility for services. A safeguarding concern can be referred by anyone with reason to suspect that someone has care and support needs and is at risk.

Safeguarding activity

11. The majority of safeguarding concerns come through to CART (The Contact and Assessment Resolution Team) and MASH (The Multi Agency Safeguarding Hub) where staff gather information, liaise with other agencies, review the risks presented and consider whether to open a Section 42 safeguarding enquiry.
12. **Data indicates a growth in the volume and complexity of safeguarding concerns, leading to higher numbers of safeguarding enquiries**. This is demonstrated in Table 1 below which shows annual referral numbers for the past four years. This illustrates an increase in adult **safeguarding concerns** of 3.5% (438 additional concerns) in 2020/21 compared to 2019/20. This

reflects the national picture with rates of safeguarding concerns during 2020 being higher overall than in 2019.

13. Of the 12,875 safeguarding concerns received in 2020/21, 1,595 converted into Section 42 safeguarding enquiries – an increase of 74% on the number of enquiries the previous year (919). This increase followed a reduction in Section 42 enquiries seen in March 2020 at the start of the pandemic. This again aligns with national trends, where there was a sharp decline in the rate of safeguarding concerns as lockdowns started followed by increases as lockdowns ended.



14. The increase in volume and complexity can largely be explained by the impact of Covid-19 and long Covid. For example, the sedentary nature of national lockdowns and shielding led to the loss of physical abilities (or decompensation) for some older people and people with disabilities. Social isolation measures impacted mental health whilst also making it more difficult to undertake essential face-to-face visits and progress safeguarding enquiries. Professionals had to adapt to changes in practice in line with new national frameworks and respond to increasing demand pressures on key services, including acute hospitals. Furthermore, the disruption to, and reduction in, social care services caused by restrictions is likely to have caused strain on carers despite the Department continuing to support carers and service users as much as possible.

15. In the face of these challenges, Adults' Health and Care continued to prioritise prevention, excellent practice, professional development, system improvement, audit, and learning from Safeguarding Adults Reviews. This included by:

- Introducing extra resource in key areas in the short term, to protect time for professional development despite growth in demand.
- Planning for the implementation of a new social care recording system, *Care Director,* in 2022 to improve recording of safeguarding data.
- Introducing a new senior social work role, which went live on 1st October 2021. Social workers that meet a required standard of practice will be renumerated for taking on professional lead roles, including Safeguarding Lead to ensure good safeguarding standards in teams.
- Restarting home visits for those who could not be visited during lockdown, with the use home working guidance to equip staff to make use of professional curiosity and effectively support people at risk.
- Delivering an extensive campaign on re-launching Making Safeguarding Personal and introducing new mandatory safeguarding training, alongside an automated training dashboard.

Hampshire Safeguarding Adults Board (HSAB)

16. 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.

HSAB 2020-2021 Annual Report

17. In line with its statutory duty under The Care Act, the HSAB published its 2020-21 Annual Report setting out key areas of progress and achievements against its 2019-20 Business Plan. The Report also set out the Board's revised Strategic Priorities for 2021, which were informed by feedback from a stakeholder survey conducted in April 2021. These are prevention, learning and protection. The Board also published its Business Plan (2021-24) detailing the actions planned to deliver on agreed priorities. The Annual Report is available via https://www.hampshiresab.org.uk/wp-content/uploads/HSAB-Annual-Report-2020-2021.pdf.

Safeguarding Policy and Guidance

18. Responsibility for the policy framework for adult safeguarding is shared between the four local authority areas in Hampshire and the Isle of Wight. In June 2020, the four Local Safeguarding Adults Boards (LSABs) jointly produced a local Multi-agency Safeguarding Adults Policy and Guidance setting out how local agencies will work together. Adults' Health and Care is currently reviewing and updating its policies and practice guidance to ensure these are aligned.
19. Further areas of policy development included work towards a transitional safeguarding framework, guidance on homelessness and safeguarding, a hoarding protocol and the SAMA policy, which provides a process for

managing safeguarding allegations that relate to professionals in positions of trust.

20. A further key development was the introduction of a new Quality Assurance Framework across the 4LSABs to enable partners to monitor safeguarding activity and use this intelligence to understand trends, shape priorities and support flexible partnership responses to meet needs.

Cross boundary working

21. The 4LSABs continued to work together to align and coordinate adult safeguarding activity across the area, as far as practicable. Several 4LSAB working groups (e.g., housing and policy) are in place addressing areas of common interest and this approach has reduced unnecessary duplication, improved consistency, and resulted in effective joint working on policy development.

22. The 4LSABs and Hampshire Safeguarding Children Partnerships (HSCPs) continued to deliver joint multi-agency training events on the Family Approach Protocol and work on Transition Services, to support young adults as they transfer from Children's to Adults' Services.

Safeguarding Adult Reviews

23. In line with its statutory duties under the Care Act, the HSAB continues to arrange Safeguarding Adults Reviews (SAR) as required. 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.

24. 2020-21 saw a significant increase in SAR referrals compared to previous years. One SAR was recently published (the Vicky SAR) and there are currently three reviews underway, due to be signed off by the HSAB in December 2021 and January 2022. Each of the reviews have benefitted from the involvement of frontline practitioners from across partner agencies, and liaison with family members. Taken in combination, the SARs highlight the need for practice improvements to safeguarding people who self-neglect and those experiencing homelessness in particular.

25. One SAR (Sam) explored how services have been delivered across agencies (including Childrens Services) to a young man with mental health issues who sadly killed himself. The second SAR relates to a case of a man (adult G) with learning disabilities who was supported by his mother, who herself had physical and mental health needs and struggled to work in partnership with services. The SAR explored the challenges faced by agencies in knowing how to work effectively together to respond to concerns that adult G was being harmed by his mother's reluctance to work with the professionals.

26. The Vicky SAR referenced above provided insight into the circumstances of Vicky who lived with a difficult combination of challenges, having developed epilepsy when she was eighteen and later facing mental health and substance misuse issues. Vicky also became homeless towards the end of her life and very sadly died on her own, in Bed and Breakfast accommodation.

27. In line with the national picture, there has been a notable increase in safeguarding work with adults who self-neglect which is reflected in SAR activity. The HSAB commissioned a thematic review to analyse six local cases where adults died as a result of self-neglecting behaviours. Emerging learning supports a more proactive use of Section 42 enquiries in cases of self-neglect. Once the report findings and recommendations are finalised, work will commence on multi-agency action planning to progress service improvements in response to the learning.

28. A new system improvement framework is being piloted across the 4LSAB region to cross-reference different sources of data, including local and national learning from SARs. This will support a more streamlined approach and consider how feedback from service users can evidence improvement. In addition, the HSAB plans to pilot a Partnership Review model to enable reviews to be completed to an accelerated timescale where appropriate.

29. The final SAR reports and learning summaries will be published on the HSAB website and progress on improvement work will be reported in the 2022 Annual Board Report.

Gosport War Memorial Inquiry

30. The Gosport War Memorial Hospital (GWMH) Inquiry Report was an in-depth analysis of the Gosport Independent Panel's findings. The report revealed that at Gosport War Memorial Hospital, the lives of a large number of patients were shortened by the prescribing and administering of 'dangerous doses' of a hazardous combination of medication not clinically indicated or justified. An Oversight and Assurance Board was established which included membership of Adults' Health and Care. This Board was time limited with HSAB maintaining a scrutiny role to oversee the response to the Inquiry Report and to gain assurance that lessons are being implemented across the relevant agencies involved. There is an ongoing police investigation led by Essex and Kent Constabularies into the historic issues at GWMH which is yet to conclude.

Learning and development

31. HSAB continued to provide a fully funded multi-agency virtual training programme linked to the Board's strategic priorities to ensure that staff could access training during the pandemic. Modules focused on self-neglect, homelessness, safeguarding concerns, Family Approach, transition and financial abuse.

32. Alongside this offer, staff within Adults' Health and Care can access a comprehensive internal safeguarding training programme. This was reviewed and updated to take account of the new Multi-Agency Safeguarding Adults'

Policy and Guidance and has operated virtually throughout most of the pandemic. Consideration is being given to the potential reintroduction of face-to-face training delivery and a training dashboard is under construction which will facilitate better, more accessible monitoring of training uptake and currency.

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

33. 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 which mean their liberty is deprived to keep them safe. 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.

34. Following a Supreme Court judgement in 2014, the number of people eligible for DoLS was extended considerably resulting in increased demand for the service. Furthermore, during the pandemic, response to DoLS had to be reduced to critical referrals only. Whilst the DoLS service has recovered to a normal level, and demand is being managed, pressures are likely to continue until a new working model is established under the Liberty Protection Safeguards. Whilst this is expected in April 2022, delays in publication of the draft Code of Practice and regulations make a further national postponement likely, which will impact the Hampshire implementation plan.

35. The DoLS service continues to support the wider workforce to deliver good social care practice in relation to assessing capacity and promoting human rights for the people of Hampshire.

Deprivation of Liberty (DoL)

36. For people living in community settings requiring complex support packages there should also be due consideration as to whether the care and support arrangements amount to a deprivation of liberty. In these circumstances, applications are made to the Court of Protection. Delays in the Court process are common while demand continues to increase, making this an area of risk. A reduction in risk will ultimately be achieved upon implementation of the Liberty Protection Safeguards allowing authorisation to be given by Local Authority and the NHS responsible bodies.

Client Affairs Service (CAS)

37. 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.

38. The CAS continued to operate an effective service to its 1000 clients during the pandemic and deliver services on behalf of Southampton City Council (SCC). 'Sold service' activities were further developed through previous agreements with Guernsey and with the Clinical Commissioning Groups (CCGs).

39. The Service Manager for the Deprivation of Liberty Safeguards (DoLS) and Client Affairs service is currently in her fourth year as Chair of the National Association of Public Authority Deputies (APAD). She continues to lead on national APAD training, delivered remotely, liaising with the Court of Protection and Office of the Public Guardian on best deputyship practice for public authorities across England and Wales.

40. The CAS is a well-established service and was inspected by The Office of the Public Guardian (OPG) in January 2021, resulting in very positive feedback. The OPG concluded that the operation was very well organised and managed in accordance with the OPG deputy standards. Staff decision making was found to be 'client centred', record keeping clear and up to date, and document storage and financial management secure.

The Care Market

41. Adults' Health and Care takes a robust data-led and proactive approach to monitoring the quality of the provider market, recognising that the risk of abuse and neglect increases in services where care provision is poor. The Department has a dedicated Quality Team which collates and monitors intelligence on the state of Hampshire's provider market and oversees effective use of the Quality Outcomes and Contract Monitoring (QOCM) framework, which further serves to assess the quality of commissioned services and support required improvement.

42. The Department works closely to triangulate information with that of wider partners and to join up monitoring activity to reduce the burden on providers. Working in partnership with Public Health, the Clinical Commissioning Group and Hampshire Care Association, Adults' Health and Care Commissioning supported the timely re-distribution of central Government funds to providers.

43. Alongside this, the wider Department gives leadership support and workforce development guidance to providers, equipping them to empower and learn from the people they support and continuously improve the quality of services.

44. Recognising the significant pressure on Hampshire's social care workforce and staff shortages, which are mirrored nationally, the Department is leading on a dynamic care recruitment campaign on behalf of the independent sector entitled "Call to Care".

Domestic Abuse for adults at risk

45. During 2020-21, new operational guidance was developed by Public Health, Hampshire Constabulary and Adults' Health and Care to support Multi-agency Risk Assessment Conferences (MARAC). This helped to further strengthen links with the Police, supporting improved the MARAC, High Risk Domestic Abuse meetings (HRDA) and safeguarding processes.

46. A new resource was also introduced to CART to ensure appropriate links through for adults in need of care and support who are victims of domestic violence.

47. The Domestic Abuse Act was introduced in April. The Act defines domestic abuse and places a duty on local authorities to create a new Domestic Abuse Partnership Board, which in Hampshire will build on existing, well-established arrangements. In addition, the Act contains new duties relating to refuges and other safe accommodation and provides for all eligible homeless victims of domestic abuse to automatically have 'priority need' for homelessness assistance. This requires the County Council to publish and implement an effective strategy to deliver this, developed in consultation with key stakeholders, which will include a coordinated community response.

48. Looking ahead, as well as responding to the requirements of the Act, the Department plans to undertake a review of the Domestic Abuse training strategy in early 2022, which will be informed by a survey of frontline staff.

Climate Change Impact Assessment

49. Hampshire County Council utilises two decision-making tools to assess the carbon emissions and resilience impacts of its projects and decisions. These tools provide a clear, robust, and transparent way of assessing how projects, policies and initiatives contribute towards the County Council's climate change targets of being carbon neutral and resilient to the impacts of a 2℃ temperature rise by 2050. This process ensures that climate change considerations are built into everything the Authority does.

50. 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.

51. At a more strategic level, reduced travel and a greater reliance on virtual meetings has helped to reduce the Department's carbon footprint during the pandemic. This is likely to continue in some key areas where the wider benefits are clear – for example, virtual meetings with service user and carer representatives for the purpose of co-production have made it easier for external participants to engage with the County Council. Similarly, many teams continue to work effectively from home for most of the week, thereby keeping unnecessary travel to a minimum.

52. There are, however, areas of the Department's business where virtual working is not as effective. This is evidenced in the above report where data indicates an increase in safeguarding referrals which may be, in part, the result of fewer in-person safeguarding visits. The Department recognises the importance of physical meetings to safeguarding vulnerable adults and believes the benefit of these outweighs the climate change impact of greater car travel. To contribute to balancing this, the Department uses several electric vehicles – for example, to deliver public facing engagement relating to its online care and support directory, Connect to Support Hampshire.

Conclusion

53. Despite the challenges presented by the Covid-19 pandemic, Adults' Health and Care continued to fulfil its safeguard remit and continuously improved safeguarding practice during 2020-21, working effectively with partner agencies. The HSAB also made notable progress at both a strategic and operational level, setting updated priorities for the next three years and responding effectively to an increase in Safeguarding Adults Reviews. These served to highlight the need to improve practice to safeguarding those who self-neglect and those experiencing homelessness. It will remain a priority of Adults' Health and Care, alongside multi agency partners, to learn and make system changes in response to all Hampshire SARs.

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**

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.

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.