Hampshire Safeguarding Adults Board

Annual Report

2017-2018

Hampshire Safeguarding Adults Board Annual Report 2017/18

Forward from the Independent Chair

I am pleased to be able to introduce the Hampshire Safeguarding Adults Board's Annual Report for 2017/18. As a Board, our aim is to provide strategic leadership to ensure adults with care and support needs, who are at risk of abuse or neglect are effectively safeguarded. Prevention and early intervention is critical to this vision as is the need to identify and apply learning when people experience poor outcomes. We place equal focus on developing a safeguarding culture that focuses on the personalised outcomes desired by those people who may have been abused and who wish to access support.

We are being encouraged from a national perspective to work with the following key themes in relation to Adult Safeguarding:

- Prevention
- Making Safeguarding Personal
- Quality

These themes are reflected within our Business plan for the coming year. In particular I wanted to highlight that there are now resources available from the Association of Directors of Adult Social and the Local Government Association to describe what 'good' might look like in Making Safeguarding Personal and promotes ownership of this agenda within and across all organisations.

The recent publication of the Independent Inquiry into deaths at Gosport War Memorial Hospital (and also other similar events such as Mazars) means that going forward HSAB will be placing a specific focus on gaining assurance from partner agencies of their processes to follow up unexpected deaths.

Given the context of increased pressures within all sectors, I am keen that the Board continues to identify opportunities for increased joint working and coordination across Hampshire's wider strategic partnership.

Significant progress has been achieved in undertaking joint work with our neighbouring local safeguarding adult boards as well as the Hampshire Children's Safeguarding Board. This approach has led to the introduction of new 4LSAB work groups addressing areas of common interest. We continue to maximise opportunities for joint working with the Hampshire Childrens Safeguarding Board leading to the development of a Whole Family Protocol and building on our successful joint conference in 2017, planning is underway for another conference in early 2019.

Robert Templeton

Independent Chair, Hampshire Safeguarding Adults Board

About us

The Hampshire Safeguarding Adults Board (HSAB) is a statutory, multi-organisation partnership coordinated by the local authority, which oversees and leads adult safeguarding across the Hampshire County Council (HCC) area. HSAB's main objective is to gain assurance that safeguarding arrangements locally, and its partner organisations work effectively individually and together, to support and safeguard adults in its area who are at risk of abuse and neglect.

The HSAB also has an interest in a range of matters that contribute to the prevention of abuse and neglect including the safety of patients in its local health services, quality of local care and support services, effectiveness of prisons and approved premises in safeguarding offenders and awareness and responsiveness of further education services.

Our purpose

HSAB's remit is to set priorities, agree objectives and to co-ordinate the strategic development of adult safeguarding across the HCC area. It is the key mechanism for agreeing how local agencies will work together effectively to safeguard and promote the safety and wellbeing of adults with care and support needs who are at and/or are in vulnerable situations.

Under the Care Act 2014, HSAB is required to publish a strategic plan (developed in consultation with local communities) and an Annual Report. The HSAB also acts as an important source of advice and assistance, for example in helping others to improve their safeguarding arrangements.

Our membership

The Board has an independent chair that is responsible for ensuring that all organisations contribute effectively to the work of the Board. The Chair provides accountability for the work undertaken by the HSAB by way of reports to relevant strategic committees and boards.

The HSAB is made up of wide range of statutory, community and voluntary organisations which includes representatives from Hampshire County Council, Police, Clinical Commissioning groups, NHS providers, Emergency services, District and Borough Councils, Independent Care Providers, Housing, Advocacy, Service users and Carers, etc.

Our vision

The HSAB works to promote a zero tolerance culture of abuse and neglect of adults who are vulnerable and its work is underpinned by the following ethos and principles:

- Living a life free from harm and abuse is a fundamental human right of every person;
- Safeguarding adults at risk and their carers is everyone's business and responsibility;
- All organisations and local communities have a responsibility to ensure that they foster a culture which takes all concerns seriously, and enables transparency, reporting of concerns and whistleblowing;
- All staff and volunteers in whatever the setting have a key role in preventing abuse or neglect occurring and in taking prompt action when concerns arise;
- Adults at risk and their families, carers or representatives must have access to information regarding the standards, quality and treatment they can expect to receive from any individuals (paid or unpaid), services or organisations involved in their lives;
- A 'Making Safeguarding Personal' approach is essential in order to ensure that any support offered or provided is person centred and tailored around the needs, wishes and the outcomes identified by the adult. The person at risk at the centre of any safeguarding process must stay as much in control of decision making as possible'.
- Personalised support is for everyone but some people will need more support than others to make choices and manage risks. Making risks clear and understood is crucial to empowering and safeguarding adults.
- All organisations must have processes aimed at preventing abuse from occurring in the first instance and to enable support to be offered at an early stage.
- When abuse does take place, it must be identified early and dealt with swiftly and effectively, and in ways that are the least intrusive and most proportionate.
- People supporting adults with care and support needs and/or their carers must have the appropriate level of skills, knowledge and training to safeguard adults from abuse.
- It is vital that clear processes are in place to identify learning from serious cases so that lessons can be used to improve partnership working.

Our Priorities

HSAB's vision and principles have been published in our Strategic Plan. A number of factors have influenced these including:

- The Board's recognition of the need to adopt a more coordinated, joined up approach to avoid overlap and duplication across the wider strategic partnership..

- Response to national and local events which highlight the need for learning from deaths and gaining assurance that lessons learned lead to sustained improvements. These include the independent inquiry into Gosport War Memorial Hospital, Mazars Review, LeDeR programme and learning from the safeguarding adult reviews we have carried out.

- The need to focus on developing a safeguarding culture that focuses on the personalised outcomes desired by those people who may have been abused and who wish to access support. The Making Safeguarding Personal approach needs to be embedded across all organisations. Our priorities are:

- Wide awareness of adult abuse and neglect and neglect and its impact and engaging local communities.

- Prevention and early intervention – promoting well being and safety and acting before harm occurs.

- Well equipped workforces across all sectors.

- Safeguarding services improved and shaped by the views of service users, carers and other stakeholders.

- Clear, effective governance processes in place within and across organisations, and

- Learning from experience - mechanisms to gain learning from serious cases and promote service and practice improvement.

We deliver these priorities via a number of themes and sector based multi-agency work groups who coordinate and manage all the work necessary to achieve the objectives stated in our business plan.

Joint Working

Over the past year, we have made significant progress to ensure we are working in a joined up and coordinated way with our Safeguarding Adult Board colleagues in the neighbouring local authority areas. This approach recognises the fact that the membership and priorities of our respective Safeguarding Adults Boards are often overlapping.

We have therefore, established joined working groups for Policy and Guidance, Workforce Development and Quality Assurance and have agreed a shared vision and common objectives for these areas. We recognise however, the importance of flexibility to enable each individual Board to address specific priorities and objectives relevant to their Board and/or locality.

This joined approach has enabled us to not only reduce duplication but has also led to greater effectiveness and impact in a number of important areas including:

- Availability of consistent multi-agency policy and guidance.
- Sharing of expertise and best practice.
- Improved delivery of training and development.
- Wider application of learning from serious cases.
- Better use of time and resources for the Boards and partners.

HSAB and the Hampshire Safeguarding Childrens' Board (HSCB) have continued to identify and maximise opportunities for greater joint working across the two boards on themes that cross over both children and adult services.

Building on the success of the joint 'Think Family – Domestic Abuse' Conference held in September 2017, we co-commissioned a series of multi-agency training workshops on a Think Family Approach to Domestic Abuse. A further joint conference focusing on Think Family – Transition' is being held in January 2019.

We are working with HSCB and the other Safeguarding Children and Adults Boards in the neighbouring local authority areas to develop a joint 'Whole Family' Protocol. This outlines a set of principles including a commitment to joint training, awareness raising within respective workforces, development of joint policies and guidance, awareness of the Mental Capacity Act 2015 and shared Learning into Practice activities. It is anticipated that this protocol will be formally launched at the January 2019 joint conference.

The following Table outlines the HSAB's work programme:

Priority	Key actions			Lead
Board governance	Alignment/coordination with other partnerships	Review of Board membership	Stakeholder events, survey & annual report	**HSAB Business subgroup**
Prevention, early intervention	Risk Framework and Risk Assessment Tools	Mental Capacity Act guidance, self audit, competency framework	Guidance on raising a safeguarding concern, Escalation protocol	**4LSAB Policy Group**
Assurance and accountability	Develop a 4LSAB integrated scorecard	Annual MSP themed audits and MSP feedback pilot. Mr C SAR post review audit	Process for effective monitoring/evaluation of SARs – outcome focus	**4LSAB Quality Assurance Group**
Well equipped workforce	Training programme linked to priorities (awareness Risk, MSP, S42, self neglect, financial abuse)	NHSE training programme – primary care professionals	Learning into Practice Workshops. Joint events with LSABs and HSCB	**4LSAB Workforce Group**
Awareness and engagement	Refresh of publicity material & social media. Animated scribe	Joint themed conferences/campaigns with LSABs/HSCB	Joint annual calendar of events	**HSAB Stakeholder Group**
User voice	Service user representation on HSAB	Links with harder to reach groups	Tools for participation and co-production	**HSAB Stakeholder Group**

What we have accomplished

Over the past year, this is what we have done:

Priority	What we said we'd do	What we've done	Focus for 2018/19
Wide awareness of adult abuse and neglect and its impact and engaging local communities	a) Review HSAB's communication plan and publicity material to reflect the issues highlighted in the 2016 Survey. b) Undertake theme based awareness campaigns to develop community awareness and engagement of adult abuse and neglect and its impact. c) Establish a calendar of events and reboot the 4LSAB communication network. d) Build networks and engage with community level organisations – Neighbourhood Watch, Citizens Advice. e) Focus on breaking down barriers to reporting, personal responsibilities to speak out, 'building confidence' to report concerns and that the 'system' will respond. f) Development of the 'Safeguarding Adult Lead' Network and targeted work in the independent care provider, housing.	• New communication plan written and published on HSAB website. • A financial abuse materials and themed campaign was undertaken in 2017 launching newly developed publicity materials – available on the HSAB Website. • Self neglect materials and themed campaign undertaken in 2018. • Stakeholder subgroup membership widened to include Citizens Advice, victim support and sensory services. • HSAB publicity materials on adult abuse and neglect have been reviewed and updated. • A housing subgroup has been established. • Safeguarding Adult Lead (SAL) Network events held twice per year. • A Community Engagement Forum for Hampshire has been established with links to HSAB.	• Development of a social media strategy and plan to increase visibility to a wider audience. • Themed campaign on tackling loneliness and social isolation. • Publication of a 4LSAB animated scribe awareness raising resource. Joint workshop to be held. • Engage the further and higher education sectors on the Board. • HSAB to engage with the Community Engagement Forum for Hampshire. • Stakeholder Group to review membership and develop links with user forums including the Personalisation Expert Panel. • Develop 4LSAB multi-agency guidance on raising a safeguarding concern.

Priority	What we said we'd do	What we've done	Focus for 2018/19
Prevention and early intervention – promoting well being and safety and acting before harm occurs	a) Board activity aligned with wider initiatives aimed at promoting well being, prevention and early intervention b) Promote initiatives aimed at addressing social isolation and loneliness. c) Joint work with partner agencies to embed the 4LSAB multi-agency risk management framework. d) Alignment of Board activities with the broader health and well-being agenda and to deliver accountability to the wider local strategic partnership - Health & Wellbeing Board. Healthwatch. e) Partners to audit against the Prevention Strategy to explore further opportunities to promote wellbeing, prevention and safety within business as usual activity.	• Links are been established between HSAB and the Health and Wellbeing Board and other strategic partnerships ensuring initiatives are shared. • Roll out of multi-agency risk management workshops with guidance is published on the HSAB website. • LGA/Age UK guidance on tackling loneliness and isolation adopted. • Joined up working with neighbouring LSABs and also the HSCB. 4LSAB work groups on quality assurance, workforce development and policy development. .	• Include loneliness and social isolation theme in the HSAB training programme. • Joint work with HSCB to develop use of the risk framework within children's services. • Joint work with health trusts to develop use of the risk framework in acute hospital settings and ambulance service. • Joint themed campaign with on the use of the MCA to safeguard against abuse and neglect. Links to be added to the HSAB Website. • Joint work with the further and higher education sector to address student mental health.
Well equipped workforce across all sectors	a) Implement the HSAB Learning and Development Strategy. b) Build networks and partnerships with the safeguarding and workforce leads in partner organisations. c) Joint work with partners to develop a multi-agency safeguarding training programme.	• A 4LSAB workforce group has been established. • SAL Network membership has increased to 140 organisations. Regular events have been held for the Network. • HSAB training programme implemented linked to strategic priorities.	• Targeted training for primary care professionals. . • Development of a 4LSAB risk assessment tool &templates. • Joint Learning into Practice events to share learning from the Thematic Review of SARs re learning disability and physical health.

Priority	What we said we'd do	What we've done	Focus for 2018/19
	d) Develop training web pages on HSAB website to support single agency training. e) Source/develop training materials, resources and innovative delivery methods f) Develop a system of HSAB training endorsement. g) Establish a sustainable model for multi-agency training 2017/18 onwards. h) Policy Group to formulate new policy and guidance in response new legislation and national/local developments. i) Learning gained from serious cases is shared within and across organisations and this is used to inform and improve practice.	• Programme includes Safeguarding Awareness, Risk, Making Safeguarding Personal, S42 Enquiries, Self Neglect, Financial Abuse, Think Family and Domestic Abuse. • Good engagement and attendance from partners on this programme. A total of 420 partners attended our training events last year. • Training website set up providing access to HSAB learning zone and resources. • Publication of the 4LSAB Multi-Agency Risk Management Framework and Escalation Protocol published. • A joint HSAB/HSCB conference on a 'Family Approach to Domestic Abuse' held in 2017. • Family Approach Domestic Abuse training commissioned with HSCB. • Review of the HSAB website – Professionals section set up as a web based resource. • Usage figures show the website has been viewed 96, 615 times by 31,871 users, with our Professional pages being the most popular.	• Refresh and implementation of the Hampshire MCA Toolkit. • MCA Organisational Self Audit in November 2018. • 4LSAB guidance on raising a safeguarding concern and launch. • Publication of 4LSAB multi-agency guidance on Hoarding. • Publication of a joint LSAB/LSCB Whole Family Protocol. • Joint work with the Serious and Organised Crime Partnership to develop a multi-agency strategy on Vulnerability and Exploitation.

Priority	What we said we'd do	What we've done	Focus for 2018/19
Safeguarding services improved and shaped by the views of service users, carers and other stakeholders	a) Introduce the Making Safeguarding Personal (MSP) approach across all agencies. b) Design and implement a pilot of an independently facilitated user feedback process on a sample of people who have received support through the safeguarding process. c) Develop a sustainable model for the MSP reviews going forward including the sourcing of funding to support this. d) Explore a range of approaches to achieve meaningful involvement of service users and other stakeholders on the Board and work groups to ensure Board activities are informed by the voice of stakeholders.	• MSP workshops included in the HSAB training programme. • A MSP feedback tool has been developed. • Development of a Community Engagement Forum • A Community Engagement Plan has been developed.	• Board Development Day on MSP in December 2018. • 4LSAB work programme on MSP. • Pilot an independently facilitated user feedback process. .
Clear, effective governance processes are in place within and across organisations	a) Formally adopt the HSAB Assurance and Accountability Framework (AAF). b) Review the Quality Assurance Framework against the HSAB AAF. c) Undertake an annual themed audit. d) Reboot the Integrated Scorecard approach to gain a holistic overview of safeguarding risks across the 'system'.	• A 4LSAB Quality Assurance work Group has been established. • A 4LSAB Organisational Self Audit Tool has been published. • A 4LSAB MCA Organisational Self Audit Tool has been published. • A MSP feedback tool has been developed. • Mr C SAR and Thematic Review Action Plan have been implemented.	• Establish a 4LSAB Quality Assurance work programme. • Review and refresh the Quality Assurance Framework. • Undertake the Organisational Self Audit in Nov 2018. • Undertake the MCA Self Audit in Nov 2018. • Develop a 4LSAB Integrated Scorecard for adult safeguarding.

Priority	What we said we'd do	What we've done	Focus for 2018/19
	e) Benchmark local data against the HSAB AAF, government 6 safeguarding principles and national comparator information.		• Develop and implement a local peer review programme. • Develop a multi-agency themed audit programme linked to learning from serious cases. • Partner agencies to adopt the Hampshire MCA Toolkit. • Partner agencies to introduce an executive strategic lead for MCA. • Partner agencies to introduce MCA champions in all service delivery areas. • Partner agencies to adopt the national MCA competency framework. • Health Group to set up a task and finish group to address the health related actions in the SAR action plan.
Learning from experience - mechanisms to gain learning from serious cases and promote service and practice improvement.	a) Formally adopt the HSAB Assurance and Accountability Framework (AAF). b) Align single agency governance processes as far as possible to avoid duplication and provide an holistic and multi agency	• Development of a new approach has been developed for undertaking multi-agency partnership reviews for cases not meeting SAR criteria. • Learning from Experience Database has been updated. Going forward this will provide a link to the newly	• Partner organisational leads to review training to ensure learning form serious cases is addressed on staff training and development activities. • Develop a memorandum of understanding to ensure

Priority	What we said we'd do	What we've done	Focus for 2018/19
	perspective to learning. c) Undertake activities to ensure lessons from serious cases are shared and applied d) Establish mechanisms to evidence that services have improved as a result of lessons gained from investigations reviews and these have led to better outcomes for service users.	established national SAR repository managed by RiPfA. • An analysis of fire deaths has been undertaken with HFRS. This highlights a significant level of risk between vulnerability and fire death as well as common risk factors.	effective communication and joint responses to critical events. • Joint work with HFRS to address findings from the fire death analysis including publication of hoarding guidance. • HSAB to gain assurance from partners about their response to the Gosport War Memorial Inquiry. • Establish a 4LSAB Learning from Deaths Forum to enable the SAB's to gain assurance from partners about the response to critical events and inquiries. This will include Gosport WMH, Mazars, LeDeR and local SARs. • Joint annual learning event covering lessons from local and national SARs, DHR's, LeDeR, SCRs, etc.

Learning and Development

Safeguarding Adult Lead Network

During this period, HSAB has hosted two Safeguarding Lead Network (SAL) events bringing together representatives from a wide range of community, voluntary and statutory agencies. Attended by 112 partners, these events provide local and national Safeguarding updates to support organisations to promote safe environments for adults at risk. The events were very well received by participants.

HSAB Training Programme

The Board has introduced a multi-agency training programme, the content of which links to HSAB strategic priorities. Over the past year, training workshops have been held on:

- Safeguarding awareness
- Undertaking section enquiries
- Multi-Agency Risk Management Framework
- Making Safeguarding Personal
- Self neglect
- Think Family and Domestic Abuse

The HSAB training events have been very well attended with over 420 attendees representing a wide cross section of agencies and sectors. The events were positively received as the feedback overleaf indicates.

Primary Care Training

The National Health Service (England) has funded HSAB to develop and deliver an adult safeguarding training programme for primary care practitioners in Hampshire. The programme has been designed and it is planned to be delivered between January and the end of 2018

Joint HSAB and HSCB Conference

In September 2017, HSAB and HSCB held our first ever joint conference on the theme of Domestic Abuse – A Family Approach. The conference was co-chaired by the safeguarding board chairs. The event was very well received and attended by over 200 professionals from a wide range of sectors including: Adult Social Care, Childrens Social care, NHS Foundation Trust, Hampshire Fire and Rescue, District and Borough Councils, National Probation Service, Education Services, charity and voluntary services.

A further joint conference has been planned for January 2019 on the theme of a 'Think Family Approach – working together to achieve better outcomes'. This conference will be used as an opportunity to launch the joint Think Family Protocol currently in development.

HSAB Training Programme – Feedback

Learning and Review

Under the Care Act 2014, local safeguarding adults boards (LSAB) have a statutory duty to carry out a Safeguarding Adults Review (SAR) when an adult with care and support in its area dies; and the Board knows, or suspects the death was as a result of abuse or neglect and there is concern about how the SAB, its members or organisations worked together to safeguard the adult.

The SAR process is designed to establish whether there are any lessons to be learnt from the circumstances of a particular case, about the way in which local professionals and agencies worked together to safeguard the adult at risk. The SAR brings together and analyses findings from investigations carried out by individual agencies involved in the case, in order to make recommendations for improving future practice where this is necessary.

Over the past year, the HSAB has received ten referrals for a SAR. The issues raised in the referrals include concerns about neglect and self neglect, substance misuse, mental health, poor care and serious injury or death from fire. One of these referrals was forwarded to a different SAB as it had lead responsibility. Of the remaining referrals, whilst none met the criteria for a statutory review, the following action was taken:

- 1 case resulted in a multi-agency partnership review.
- 2 cases were referred for a CCG led review as both had similar issues relating to feeding tube care.
- 1 case relating to a fire death was reviewed as part of wider fire death analysis.
- 4 cases were referred back to partner agencies to undertake an investigation.
- 1 case is currently under consideration.

The multi-agency partnership review was carried out in relation to an adult with a history of depression and attempted suicide that sadly died. The adult also had a diagnosis of a mild learning disability and possible autism. At the time of their death the adult was of no fixed abode. A number of safeguarding concerns made in respect of alleged abuse. Despite initial engagement, the adult ceased to be involved in the safeguarding process and subsequently refused to engage with offers of support. The review focused on the multi-agency response to the concerns raised and how the disengagement was managed. The partnership review identified the following learning:

The need for improvements in support for individuals when transitioning between services; increased knowledge and use of the HSAB Multi Agency Risk Management Framework; guidance for services in relation to safeguarding concerns and thresholds for an enquiry under S42 (Care Act 2014) and an increasing demand for support services relating to people who are street homelessness.

Response to the Mr C SAR and Thematic Review of SARs relating to People with a Learning Disability

In December 2016, HSAB commissioned a SAR to review the circumstances of Mr C's case to draw out specific learning relating to his support, care and treatment. As part of the SAR process, a multi-agency reflective workshop was held with the practitioners and operational managers involved in Mr C's care and support. This event focussed on Mr C's journey through the system and enabled reflection and shared learning in order to identify opportunities for improved working within and between agencies in the future.
Mr C was the third case since 2012 which involved the death of an adult with a learning disability highlighting concerns about the way deteriorating physical health needs of people with complex needs and behaviours are managed (Mr A 2012 and Ms B 2015). HSAB commissioned an independent thematic review and analysis of the issues and root causes across the three cases. The Thematic Review identified that there has been considerable improvement since the first of the three SARs and therefore there should be recognition of this.

There is, however, still more that can be done to improve the experiences of those people with a learning disability who require admission to an acute hospital for diagnosis, care and/or treatment. People with learning disability often have a range of family, carers and health and social care professionals involved in their care. This makes coordination of that care when there is a change, especially complex for people for whom change can be particularly difficult. Common issues identified across all three cases include:

- Understanding and application of the Mental Capacity Act.
- Access to advocacy.
- Effective management of transitions in placements and transfer to and from acute hospital care.
- Involving family in treatment decisions.
- Availability and access to the Learning Disability Liaison Nursing Service.
- Use of the Hospital passport.
- Effective hospital discharge planning.

- Continued use of the Care Programme Approach during hospital admission.
- Escalation and challenge

The HSAB has developed a multi-agency action plan to respond to the themes and recommendations identified in the reviews. This reflects 3 distinct work streams which the Board and partners will be progressing over the coming year as follows:

1. Understanding and application of the Mental Capacity Act (MCA) 2005:

   Partner agencies will:

   - Adopt the national MCA Competency Framework and review their training plans and programmes against this.
   - Adopt the refreshed Hampshire MCA toolkit as the one tool for use across Hampshire.
   - Introduce Agency Executive Strategic MCA Leads and to introduce MCA champions in all service delivery areas.
   - Ensure managers use supervision to support and assess competency and confidence of staff in application of MCA.
   - Ensure staff can access guidance on eligibility and entitlement to advocacy support.
   - Develop and support a culture of professional curiosity which enables professionals to explore and understand what is happening within an environment rather than making assumptions or accepting things at face value.

2. Health Service Delivery:

   Health partners to:

   - Agree a joint protocol for continuance of Care Programme Approach (CPA)when a person with a Learning Disability is admitted to hospital.

- Adopt the 4LSAB Multi-Agency Risk Management Framework to improve coordination and communication where patients who are admitted to hospital are not subject to CPA.

- Introduce Learning Disability champions within hospital wards and departments.

- Review and develop the hospital passport to address the issues highlighted in the reviews and to include a persons wishes on who they want involved in their care, treatment, environment and discharge.

- Review hospital discharge processes and revise to reflect learning from the reviews.

- Ensure care providers are advised of any change in clinical condition that occurs between the initial assessment and actual discharge date.

3. Transition

   Partners, led by Adults Health and Care to:

   - Produce guidance on transitions/placement moves that sets out responsibilities of commissioners and providers as well as key agencies.

HSAB has collaborated with our neighbouring LSABs to developed a multi-agency Escalation Protocol to professionals to challenge care and treatment decisions when it is felt these are not in the best interests of the service user and where necessary, to escalate concerns to senior managers for resolution.

Learning from serious cases – key messages for practice

A number of themes have emerged for the learning and review activities undertaken by the Board which we will be focusing and addressing in our overall programme of work:

- Use of the 4LSAB Multi-Agency Risk Management Framework to respond to complex situations the circumstances of which fall outside the statutory section 42 safeguarding enquiry process.
- The importance of effective partnership working with adults, families and other professionals.
- Adopting a Making Safeguarding Personal approach to ensure the support offered meets the personalised outcomes desired by those people who may have been abused
- Using safeguarding support as an opportunity to build personal resilience and the prevention of future risk or harm.
- Recognition of the reality of another form of 'Toxic Trio' involving capacity, unwise decision making and disengagement
- The presence of mental capacity is not an excuse to walk away – there may still be a professional duty to protect the adult from foreseeable harm.
- The importance of adopting a relationship based approach to address long term, entrenched behaviours with a focus on building trust and rapport
- Assessment of an adult's mental capacity needs to include consideration of their executive function and whether they understand the limits of their own ability.
- Preparedness on the part of professionals to challenge and escalate concerns when it is felt the decisions/actions of other professionals are not in the best interests of the adult
- Professional curiosity has also been an important theme in the learning that has been gained. This necessitates a proactive mind set and the communication skill to explore and understand what is happening within an environment rather than making assumptions or accepting things at face value.

Gaining assurance and holding agencies to account

As reported last year, a range of processes have been introduced designed to enable the Boards to hold partner agencies to account and for gaining assurance about the quality, effectiveness and outcomes of the safeguarding work undertaken locally. As part of its continued drive to raise standards, the Board has developed a Safeguarding Organisational Self Assessment tool to support organisational development and self improvement relating to adult safeguarding. This audit will be carried out in the autumn and the information gained will help shape the Board's priorities and work programme going forward.

Recent critical events such as the independent inquiry into Gosport War Memorial Hospital and also similar events and programmes such as Mazars, PHT, LeDeR, local SARs, etc. highlight the need for the HSAB to be proactive in gaining assurance that partners agencies both individually and collectively, have adopted robust implementation of learning in order to ensure similar events cannot happen again in the future. HSAB will therefore, be establishing a multi-agency 'Learning from Deaths' Forum to help drive these improvements.

Safeguarding in Practice – Making a Difference

Effective safeguarding is underpinned by a number of important principles which include prevention and early intervention; capacity, consent and control; Making Safeguarding Personal and Advocacy. The following case studies illustrate how these principles when put into practice, lead to better outcomes for the adult being supported.

Capacity, Consent and Control

The CCG Safeguarding Team was asked to provide support for an adult who was presenting signs of self-neglect. The individual had a septic leg wound and had been recommended for amputation by three different clinicians. The health service multi-disciplinary team was concerned that the adult would die as a result of declining self-care. A meeting was held under the multi-agency risk management framework between the local authority, GP and Community Team. The adult was invited to engage in the process and they advised that they would like all communication on the phone and in writing. The multi-agency meeting identified further opportunities to ensure that the adult was able to make an informed decision regarding their care and treatment. As a result, the adult was able to express their wishes about end of life care. In accordance with the wishes expressed, the adult was able to pass away at home rather than being taken to hospital. As a result of the multi-agency risk management process, the adult was supported to make an informed choice regarding care and treatment.

Prevention

In May 2017, concerns were raised by a local housing association that a male service user was the victim of ongoing financial abuse from local known drug users. The ongoing abuse meant that the service user was visiting his local bank and withdrawing large amounts of cash as well as making credit card applications. He had ongoing support services from a multi agency perspective and the following outcomes were achieved: with the service user's permission, a Lifeline was installed and accommodation door locks changed by the police. Support provided in maintaining a good and healthy diet and arrangements made for a weekly cleaning service. Hampshire Trading Standards Safeguarding Team provided support with contacting credit reference agencies, attending a joint visit to the bank with the service user to review transactions, which identified theft. Support provided to cancel multiple credit card applications, and a limit on his bank account. This limited access to the amount of cash that could be taken from his account each week, for a short term basis until the risk of financial abuse had diminished. The service user was supported by a support worker from the local authority to attend his GP for check up and a medication review, and a deep clean arranged at his property. Weekly visits were carried out from a housing support worker to maintain tenancy and complete checks regarding visits by suspected perpetrators. This Service user is now living in his own home environment safe and well, managing his own safety and is more aware of others taking advantage of him, his home and his finances.

Advocacy

S42 enquiries were made after an older adult wanted to revoke her LPA and 'sack' her commissioned care providers and replace with an informal carer that the family had concerns about. The adult's existing Care Act Advocate supported her to attend meetings where she continued to express her wish to change her LPA and use direct payments so her friend could provide her care. The advocate also supported the adult to contact the Office of the Public Guardian who assessed that she had capacity to revoke the LPA and appoint another one. The adult got her wish of a having her friend as her LPA and paid carer. The local authority and family members put measures in place to minimise the risks of possible financial abuse and that care plans met her assessed care needs.

Making Safeguarding Personal

An adult with mental health issues and learning difficulties was supported to take part in S42 meetings relating to concerns about her support staff. The adult was able to understand the process and give her views after an advocate spent time going through notes of previous meetings and recording her views to be shared with the social worker. The adult was happy with the outcome of the investigation and said she feels safer.

Capacity, Consent and Control

An adult with a severe learning disability wasn't able to verbally communicate his views about whether members of staff, who were suspended following allegations of abuse, should return to work with him. He had been assessed as lacking capacity to make decisions about his care and support. Family members, other support staff who knew him well and a Care Act Advocate were all involved in the best interests' decision and the staff did not return. The adult had increased access to the community and people who knew him well reported that his quality of life had improved.

Performance Summary

Hampshire County Council Adults Health and Care are the lead agency who records all the safeguarding information on behalf of the multi-agency partnership and the Hampshire Adults Safeguarding Board. Overall there were 4,030 Safeguarding concerns in 2017/18 which is just 14 more than the previous year 2016/17 (4,016). Of the 4,030 concerns reported, 1,266 resulted in a S42 safeguarding enquiry. Representing a conversion rate of 31% of concerns that were reported were progressed to an enquiry.

The decrease in referrals was an expected consequence of more rigorous application of the 3 part test for S42 enquiries – and so screening of more concerns away from formal safeguarding if the test was not met.

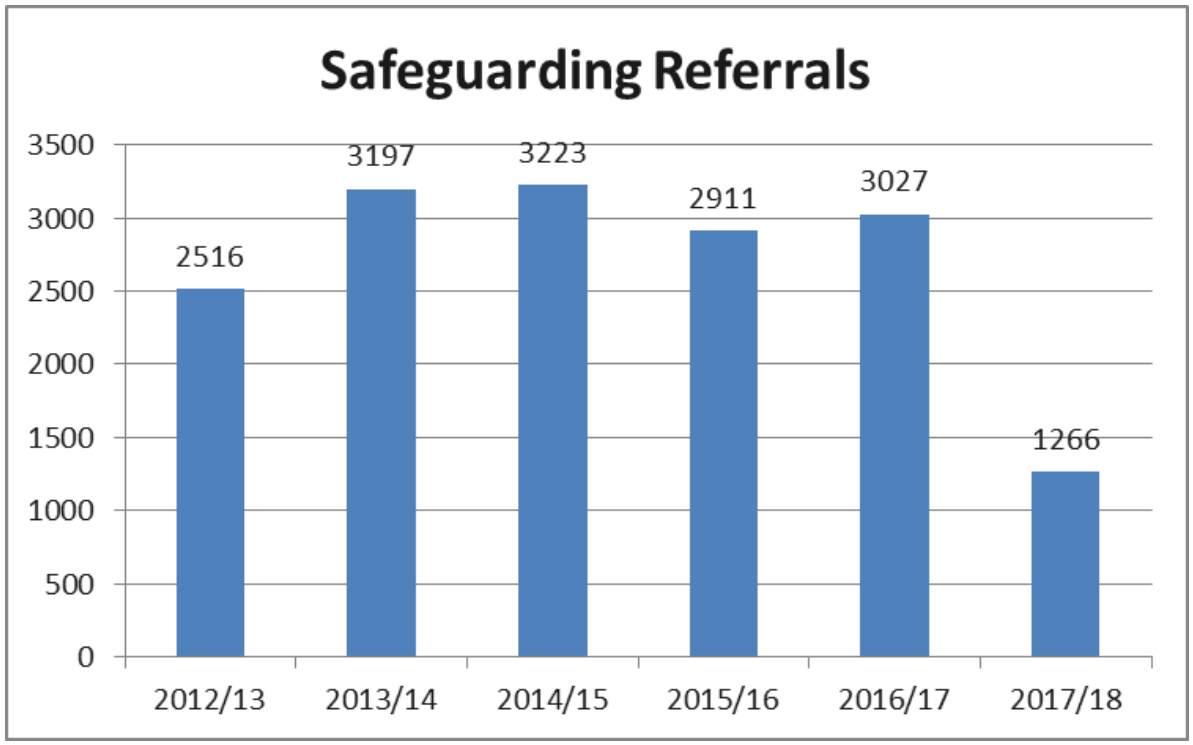
When S42 Enquiries are broken down by client categories as in previous years, S42 Enquiries relating to older people still account for the highest proportion of safeguarding at 64% (63% in 2016/17). Clients aged 65 and under with a Learning Disability where the second most referred group accounting for 15% which is a decrease from last year of 5%. In 2017/18 the number of cases relating to clients aged 65 and under with Mental Health Care and Support needs decreased from 195 to 125. However, this still represented 10% of safeguarding for this year compared to 6% in 2016/17 (see Table 1, Appendix A).

Concerns about neglect or acts of omission as well as physical abuse remain the most common reason for safeguarding (45% and 21% respectively). Reports of Financial and material abuse concerns have reduced from 328 to 167 indicating a continued reduction over the past 4 years. However, for 2017/18 these concerns represent 13%, compared to 11% last year of the overall types of abuse reported.

Further details about safeguarding performance and activity and the figures outlined in this summary can be found in **Appendix A**.

Appendix A - Hampshire Safeguarding Adults Board Annual Statement - Performance and Activity 2017/18

Figure 1 – Safeguarding referrals (2016/17 refers to S42 enquires)



Additional facts and figures

- The Population of Hampshire is forecast to increase from 1,362,700 to 1,473,500 by 2024, an increase of 110, 800 (8.1%).
- Adult Services are contacted approximately 140,000 times by people needing care advice, information and support, and carries out over 35,000 social care assessments.
- Hampshire is in the top ten of the largest counties by land area, covering approximately 1,400 square miles.

Table 1 shows the number of referrals by client group since 2012/13

Table 1 - Number of referrals by client group	2012/13		2013/14		2014/15		2015/16		2016/17		2017/18	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Older People 65+	1,348	54%	1,828	57%	1,890	58%	1,762	61%	1,915	63%	804	64%
Learning Disability 18-64	701	28%	724	23%	570	18%	541	19%	594	20%	186	15%
Mental Health 18-64	248	10%	317	10%	459	14%	290	10%	195	6%	125	10%
Physical Disability 18-64	200	8%	264	8%	290	9%	239	8%	204	7%	117	9%
Substance Misuse 18-64	6	<1%	37	1%	30	1%	10	<1%	4	<1%	0	<1%
Other/Not Known	13	<1%	27	1%	0	0%	69	2%	115	4%	34	3%
Total*	**2,516**	**100%**	**3,197**	**100%**	**3,223**	**100%**	**2,911**	**100%**	**3,027**	**100%**	**1,266**	**100%**

*A person can have more than one referral during the year

Additional facts and figures

- In Hampshire Age Group 16 – 64 is predicted to increase by 44,000 (+5.4%) by 2024.
- In Hampshire Age Group 65 – 84 is predicted to increase by 35,200 (+14.2%) by 2024.
- In Hampshire Age Group 84+ is predicted to increase by 10,500 (+23.8%) by 2024.
- Dementia is a leading cause of disability in people aged over 65.

Table 2 – Type of abuse reported since 2012/13

Table 2 - Types of abuse reported	2012/13		2013/14		2014/15		2015/16		2016/17		2017/18	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Physical	783	30%	851	26%	941	28%	660	22%	629	20%	276	21%
Neglect or Acts of Omission	908	35%	1,278	39%	1,223	37%	1,292	43%	1,583	51%	598	45%
Financial & Material	440	17%	563	17%	541	16%	433	14%	328	11%	167	13%
Psychological	235	9%	327	10%	319	10%	240	8%	219	7%	86	7%
Sexual	138	5%	183	5%	230	7%	160	5%	104	3%	67	5%
Institutional /Organisational	81	3%	55	2%	42	1%	25	1%	7	0%	7	1%
Discriminatory	20	1%	26	1%	15	<1%	10	<1%	2	0%	5	<1%
Domestic Violence /Abuse	Not recorded in these years						116	4%	60	2%	31	2%
Victim of Hate Crime							3	<1%	Not recorded in these years			
Sexual Exploitation							3	<1%				
Modern Slavery							0	<1%	2	0%	3	<1%
Self Neglect							96	3%	141	5%	82	6%
Total*	**2,605**	**100%**	**3,283**	**100%**	**3,311**	**100%**	**3,038**	**100%**	**3,075**	100%	**1,322**	100%

*more than one abuse type per referral can be recorded

Table 3 breakdowns the location of where the abuse is reported to have occurred over the last 5 years

Table 3 - Location of abuse reported	2012/13		2013/14		2014/15		2015/16		2016/17		2017/18	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Own Home	839	33%	1340	42%	1489	46%	1267	44%	1492	49%	507	40%
Residential Care	856	34%	806	25%	677	21%	481	17%	417	14%	243	19%
Nursing Care	308	12%	423	13%	509	16%	398	14%	568	19%	260	21%
Mental Health Inpatient Setting	48	2%	63	2%	79	2%	37	1%	32	1%	9	1%
Alleged Perpetrators Home	68	3%	75	2%	55	2%	40	1%	22	1%	14	1%
Acute Hospital	66	3%	118	4%	121	4%	61	2%	40	1%	32	3%
Public Place	57	2%	90	3%	83	3%	53	2%	56	2%	7	1%
Community Hospital	38	2%	27	1%	15	1%	59	2%	77	3%	10	1%
Day Centre/Service	48	2%	21	1%	48	1%	11	<1%	25	1%	7	1%
Other Health Setting	17	1%	16	<1%	14	0%	5	<1%	16	1%	9	1%
Education/Training/Workplace Establishment	9	<1%	17	<1%	3	0%	5	<1%	3	<1%	2	0%
Supported Accommodation	56	2%	38	1%	72	2%	63	2%	29	1%	34	3%
Other/Not Known	106	4%	163	5%	58	2%	431	15%	250	8%	132	10%
Grand Total*	**2516**	**100%**	**3197**	**100%**	**3223**	**100%**	**2911**	**100%**	**3,027**	**100%**	**1,266**	**100%**

Table 4 - Response to the safe and secure questions over the last 4 years, and compared to the average score for 16 local authorities within Hampshire's comparator group; 2014/15 is the most recent comparator information available.

Description	2014/15	2015/16	2016/17	2017/18	England 2016/17
Proportion of people who use services who have control over their daily life	80%	80%	79%	81%	77%
Proportion of people who use services who feel safe	74%	76%	70%	74%	70%
Proportion of people who use services who say that those services have made them feel safe and secure	90%	91%	90%	92%	86%

Nationally local authorities are required to undertake a user satisfaction survey every year which asks clients receiving social care support a range of questions on how the services they receive help to improve their quality of life. Including two questions asking people to rate how safe and secure they feel.

Appendix B Glossary of Terms

This section explains the meaning of terms commonly used in the context of adult safeguarding:

4LSAB: Four Local Safeguarding Adults Boards covering Southampton, Hampshire, Isle of Wight and Portsmouth.

Abuse: includes physical, sexual, emotional, psychological, financial, material, neglect, acts of omission, discriminatory and organisational abuse.

Advocacy: support to help people say what they want, secure their rights, represent their interests and obtain services they need. Under the Care Act, the Local Authority must arrange for an independent advocate to represent and support a person who is the subject of a safeguarding enquiry or a safeguarding adult review if they need help to understand and take part in the enquiry or review and to express their views, wishes, or feelings.

Alert: a concern that a person at risk is or may be a victim of abuse, neglect or exploitation. An alert may be a result of a disclosure, an incident, or other signs or indicators.

Alerter: the person who raises a concern that an adult is being, has been, or is at risk of being abused or neglected. This could be the person themselves, a member of their family, a carer, a friend or neighbour or could be a member of staff or a volunteer.

Assessment: a process to identify the needs of the person and how these impact on the wellbeing and outcomes that they wish to achieve in their day to day life.

Best interests decision: a decision made in the best interests of an individual defined by the Act) when they have been assessed as lacking the mental capacity to make a particular decision. The best interest decision must take into consideration anything relevant such the past or present wishes of the person, a lasting power of attorney or advance directive. There is also a duty to consult with relevant people who know the person such as a family member, friend, GP or advocate.

Care Act 2014: came into force in April 2015 and significantly reforms the law relating to care and support for adults and carers. This legislation also introduces a number of provisions about safeguarding adults at risk from abuse or neglect. Clauses 42-45 of the Care Act provide the statutory framework for protecting adults from abuse and neglect.

Care and support needs: the support a person needs to achieve key outcomes in their daily life as relating to well being, quality of life and safety. The Care Act introduces a national eligibility threshold for adults with care and support needs which consists of three criteria, all of which must be met for a person's needs to be eligible.

Carer: unpaid carers such as relatives or friends of the adult. Paid workers, including personal assistants, whose job title may be 'carer', are called 'staff'.

Clinical Commissioning Group (CCG): these were formally established on 1 April 2013 to replace Primary Care Trusts and are responsible for the planning and commissioning of local health services for the local population.

Crown Prosecution Service (CPS): the government department responsible for prosecuting criminal cases investigated by the police in England and Wales.

Care Quality Commission (CQC): the body responsible for the registration and regulation of health and social care in England.

Domestic Abuse, Stalking and Harassment and 'Honour' Based Violence (DASH): a risk identification checklist (RIC) is a tool used to help front-line practitioners identify high risk cases of domestic abuse, stalking and 'honour'-based violence.

Deprivation of Liberty Safeguards (DOLs): measures to protect people who lack the mental capacity to make certain decisions for themselves which came into effect in April 2009 as part of the Mental Capacity Act 2005, and apply to people in care homes or hospitals where they may be deprived of their liberty.

Domestic abuse: any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to psychological, physical, sexual, financial and emotional abuse. Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour. Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim. Family members are defined as mother, father, son, daughter, brother, sister and grandparents, whether directly related, in-laws or step-family (Home Office 2012).

Domestic Homicide Reviews: statutory reviews commissioned in response to deaths caused through domestic violence. They are subject to the guidance issued by the Home Office in 2006 under the *Domestic Violence Crime and Victims Act 2004*. The basis for the domestic homicide review (DHR) process is to ensure agencies are responding appropriately to victims of domestic abuse offering and/or putting in place suitable support mechanisms, procedures, resources and interventions with an aim to avoid future incidents of domestic homicide and violence.

Duty of Candour: a requirement on all health and adult social care providers registered with the Care Quality Commission (CQC) to be open with people when things go wrong. The duty of candour means that providers have to act in an open and transparent way in relation to service user care and treatment.

Enquiry: An enquiry is any action that is taken (or instigated) by a local authority, under Section 42 of the Care Act 2014, in response to indications of abuse or neglect in relation to an adult with care and support needs who is at risk and is unable to protect themselves because of those needs.

Family Group Conferences (FGC): an approach used to try and empower people to work out solutions to their own problems. A trained FGC co-ordinator can support the person at risk and their family or wider support network to reach an agreement about why the harm occurred, what needs to be done to repair the harm and what needs to be put into place to prevent it from happening again.

Harm: involves Ill treatment (including sexual abuse and forms of ill treatment which are not physical), the impairment of, or an avoidable deterioration in, physical or mental health and/or the impairment of physical, intellectual, emotional, social or behavioural development.

Hate Crime: any crime that is perceived by the victim, or any other person, to be racist, homophobic, transphobic or due to a person's religion, belief, gender identity or disability.

HealthWatch: an independent consumer champion created to gather and represent the views of the public. It exists in two distinct forms - local Healthwatch and Healthwatch England at a national level. The aim of local Healthwatch is to give citizens and communities a stronger voice to influence and challenge how health and social care services are provided within their locality. Local Healthwatch has taken on the work of the Local Involvement Networks (LINks).

Human Trafficking: the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation".

Independent Mental Capacity Advocate (IMCA): established by the Mental Capacity Act 2005, IMCAs are a legal safeguard for people who lack the capacity to make specific important decisions, including decisions about where they live and serious medical treatment options. IMCAs are mainly instructed to represent people where there is no one independent of services (such as a family member or friend) who is able to represent the person. However, in the case of safeguarding concerns, IMCAs can be appointed anyway (i.e. irrespective of whether there are friends or family around and irrespective of whether accommodation or serious medical treatment is an issue).

Local Safeguarding Adults Board (LSAB): a statutory, multi-organisation partnership committee, coordinated by the Local Authority, which gives strategic leadership for adult safeguarding, across the Local Authority. A SAB has the remit of agreeing objectives, setting priorities and coordinating the strategic development of adult safeguarding across its area.

Making Safeguarding Personal (MSP): an approach to safeguarding work which aims to move away from safeguarding being process driven and instead, to place the person at risk at the centre of the process and work with them to achieve the outcomes they want.

Mental Capacity refers to whether someone has the mental capacity to make a decision or not on a specific issue.

Multi-Agency Public Protection Arrangements (MAPPA): statutory arrangements for managing sexual and violent offenders.

Multi-Agency Risk Assessment Conference (MARAC): a multi-agency forum of organisations that manage high risk cases of domestic abuse, stalking and 'honour'-based violence.

Multi-Agency Safeguarding Hub (MASH): a joint service made up of Police, Adult Services, NHS and other organisations. Information from different agencies is collated and used to decide what action to take. This helps agencies to act quickly in a co-ordinated and consistent way, ensuring that the person at risk is kept safe.

Mate Crime: a form of exploitation which occurs when a person is harmed or taken advantage of by someone they thought was their friend.

Mental Capacity: refers to whether someone has the mental capacity to make a decision or not. The Mental Capacity Act 2005 and the Code of Practice outlines how agencies should support someone who lacks the capacity to make a decision.

No Delay: the principle that safeguarding responses are made in a timely fashion commensurate with the level of presenting risk. In practice, this means that timescales act as a guide in recognition that these may need to be shorter or longer depending on a range of factors such as risk level or to work in a way that is consistent with the needs and wishes of the adult.

Patient Advice and Liaison Service (PALS): a NHS service created to provide advice and support to NHS patients and their relatives and carers.

Public interest: a decision about what is in the public interest needs to be made by balancing the rights of the individual to privacy with the rights of others to protection.

Office of the Public Guardian (OPG): the administrative arm of the Court of Protection and supports the Public Guardian in registering enduring powers of attorney, lasting powers of attorney and supervising Court of Protection appointed deputies.

PREVENT: Government strategy launched in 2007 aimed at stopping people becoming terrorists or supporting terrorism. It is the preventative strand of the government's counter-terrorism strategy aiming to respond to the ideological challenge of terrorism and the threat from those who promote it; prevent people from being drawn into terrorism and ensure that they are given appropriate advice and support and work with sectors and institutions where there are risks of radicalisation that need to be addressed.

Prevention: describes how the care and support system (and the organisations forming part of this system) work to actively promote the well being and independence of people rather than waiting to respond when people reach a crisis point. The purpose of this approach is to prevent, reduce or delay needs escalating.

Protection of property: the duty on the Local Authority to protect the moveable property of a person with care and support needs who is being cared for away from home in a hospital or in accommodation such as a care home, and who cannot arrange to protect their property themselves. This could include their pets as well as their personal property (e.g. private possessions and furniture).

Radicalisation: involves the exploitation of susceptible people who are drawn into violent extremism by radicalisers often using a persuasive rationale and charismatic individuals to attract people to their cause. The aim is to attract people to their reasoning, inspire new recruits and embed their extreme views and persuade vulnerable individuals of the legitimacy of their cause. The PREVENT Strategy, launched in 2007, seeks to stop people becoming terrorists or supporting terrorism.

Referral: an alert becomes a referral once it has been assessed and it has been determined that the concerns raised fall within the remit of adult safeguarding arrangements.

Safeguarding: activity to protect a person's right to live in safety, free from abuse and neglect. It involves people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that their well being and safety is promoted.

Safeguarding activity: actions undertaken upon receipt of a safeguarding referral. This may include information gathering, holding a safeguarding planning meeting, activities to resolve the risks highlighted, safeguarding review meetings and developing a safeguarding plan with the adult at risk.

Safeguarding support plan: one outcome of the enquiry may be the formulation of agreed actions for the adult which should be recorded on their care plan. This will be the responsibility of the relevant agencies to implement.

Safeguarding planning meeting: a multi-agency meeting (or discussion) involving professionals and the adult if they choose, to agree how best to deal with the situation as determined by the views and wishes of the individual.

Safeguarding work: describes all the work multi-agency partners undertake either on a single agency basis (as part of their core business) or on a multi agency basis within the context of local adult safeguarding arrangements.

Safeguarding Adult Review (SAR): a statutory review commissioned by the Safeguarding Adults Board in response to the death or serious injury of an adult with needs of care and support (regardless of whether or not the person was in receipt of services) and it is believed abuse or neglect was a factor. The process aims to identify learning in order to improve future practice and partnership working.

Safeguarding enquiry: the action taken or instigated by the Local Authority in response to a concern that abuse or neglect may be taking place. An enquiry could range from a conversation with the adult, or if they lack capacity, or have substantial difficulty in understanding the enquiry their representative or advocate, prior to initiating a formal enquiry under section 42 of the Care Act 2014, right through to a much more formal multi-agency plan or course of action. This is sometimes referred to as a section 42 enquiry'.

Self neglect: the inability (intentional or non-intentional) to maintain a socially and culturally accepted standard of self-care with the potential for serious consequences to the health and well being of the self-neglecters and perhaps even to their community.

Serious Incident Requiring Investigation (SIRI): a process used in the NHS to investigate serious incidents resulting in serious harm or unexpected or avoidable death of one or more patients, staff, visitors or members of the public.

Significant harm: the ill treatment (including sexual abuse and forms of ill treatment which are not physical), and impairment of, or an avoidable deterioration in, physical or mental health, and the impairment of physical, intellectual, emotional, social or behavioural development.

Vital interests: a term used in the Data Protection Act 1998 to permit sharing of information where it is critical to prevent serious harm or distress or in life-threatening situations.

Wilful neglect or ill treatment: an intentional, deliberate or reckless omission or failure to carry out an act of care by someone who has care. Abuse includes physical, sexual, emotional, psychological, financial, material, neglect, acts of omission, discriminatory and institutional abuse.