HAMPSHIRE COUNTY COUNCIL

Decision Report

Decision Maker:	Health and Adult Social Care Select Committee
Date:	22 October 2020
Title:	Adult Safeguarding
Report From:	Director of Adults' Health and Care

Contact name: Sue Lee, Strategic Safeguarding Partnership Manager, Adults' Health and Care

Tel: 01962 845943 **Email:** susan.lee@hants.gov.uk

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. That the Health and Adult Social Care Select Committee receives this annual update report related to adult safeguarding and notes it will be received by Cabinet on 24 November 2020.
3. That the Health and Adult Social Care Select Committee note the positive progress with regards to safeguarding adults in Hampshire and the commitment of a wide range of Adult Services officers in achieving this level of performance.
4. That the Health and Adult Social Care Select Committee note the developments and risks in relation to the remit of our local authority statutory duty to safeguard and keep vulnerable adults safe from abuse and/or neglect
5. That the Health and Adult Social Care Select Committee note the contribution of the Hampshire Safeguarding Adults Board in leading the development of policy across the four local authority areas of Hampshire, Portsmouth, Southampton and the Isle of Wight, including the Hampshire Safeguarding Adults Board Annual Report for 2019/20.
6. That the Health and Adult Social Care Select Committee receive a further update on adult safeguarding in 12 months' time.

Executive Summary

7. Adult safeguarding is a core duty of every local authority and the term is used to describe all activity undertaken to prevent the abuse and neglect of adults with care and support needs, as well as the response to abuse or neglect

when it does occur. It therefore covers a spectrum of responses by a range of partners ranging from the prevention of abuse and/ or neglect through to criminal prosecution.

8. This report provides an overview of developments and actions undertaken by Adults' Health and Care and a range of partners in safeguarding the wellbeing and safety of vulnerable adults in Hampshire.
9. Of significant note is the introduction of a COVID 19 Assurance Framework to enable Hampshire Safeguarding Adults Board (HSAB) and safeguarding partners to closely monitor safeguarding activity and use this intelligence to support flexible partnership responses to meet needs. Data will be reviewed to understand safeguarding trends locally and re-prioritise the strategic plan accordingly in order to support services to respond to any changes in the nature and pattern of local safeguarding activity. Another important development is HSAB's lead role of in respect of safeguarding policy development across Hampshire, Southampton, Portsmouth and Isle of Wight.

Contextual information

10. There are several pieces of legislation covering adult safeguarding with the main statutory responsibilities for local authorities, Police and the NHS covered by the Care Act 2014 and subsequent statutory guidance.
11. Resources have recently been refocused to ensure dedicated leadership and the necessary expertise is applied to these specialist areas, distinct from the adult safeguarding responsibilities.
12. Although previously covered in this generic annual safeguarding report, PREVENT and domestic violence are now covered in separate reports due to the high level of risk and the specialist nature of the areas involved.

Hampshire Safeguarding Adults Board (HSAB)

13. The HSAB continues to be a well-established successful strategic board whose membership includes all key multi-agency partners. This year, the Board has agreed a different approach regarding chairing arrangements. The Director of Adults' Health and Care now chairs the Board. However, an Independent Scrutineer has recently been appointed to work alongside the Board and its member organisations to provide critical challenge and support. This role will commence in early October following the successful appointment of Jane Lawson – who has acted as a Safeguarding Board Chair to three different areas and led work on adult safeguarding nationally through a range of roles, including for the Local Government Association. The Independent Scrutineer will provide scrutiny and challenge to the HSAB and act as constructive critical friend ensuring that the Board continues to fulfil its core statutory responsibilities. The focus will be on gaining assurance around the Board's key strategic priorities and objectives. including:

- Partner agencies working together effectively and collaboratively to prevent abuse and neglect where possible.

- Implementation of effective local safeguarding arrangements with agencies and individuals making timely and proportionate responses.
- Safeguarding practice is person centred and outcome-focused and it improves and enhances the quality of life of the adult.
- Safeguarding practice is continuously improving and reflective practice and learning from serious cases drives continuous improvement.

Safeguarding responsibilities and COVID 19

14. Duties and responsibilities relating to safeguarding adults have remained a statutory duty and Sections 42-45 of the Care Act 2014 that relate to safeguarding adults have not changed or been 'eased'. The local authority and HSAB have been required during the pandemic to offer the same level of safeguarding oversight but with an emphasis on proportionate responses and consideration given to the operational pressures providers and others are likely to be under.
15. The Care Act Easements guidance 2020 clarified that local authorities must continue to offer the same oversight and application of Care Act 2014 Section 42 duties as before, but that responses should be proportionate and mindful of pressures on social care providers.
16. Safeguarding concerns and risks have increased during the pandemic and so HSAB and partners across health and social care and other sectors are needing to continue to work to prevent and reduce the risk of harm to people with care and support needs, including those affected by COVID-19.
17. HSAB has introduced a COVID 19 Assurance Framework to enable the Board and partner agencies to closely monitor safeguarding activity and use this intelligence to support flexible partnership responses to meet needs. HSAB will be reviewing data to understand safeguarding trends locally and re-prioritise its strategic plan accordingly in order to continue to support services to respond to any changes in the nature and pattern of local safeguarding activity.
18. HSAB has continued to offer the same level of safeguarding oversight whilst recognising the increased operational pressures partner agencies have been responding to. Going forward, the focus will be to continue work to prevent and reduce the risk of harm to people with care and support needs.
19. A key priority for the Board will be to gain assurance from partner agencies about how any impact of COVID-19 on local safeguarding arrangements is being managed. The HSAB COVID 19 Assurance Framework will enable us to closely monitor the extent to which COVID 19 is impacting on people with needs for care and support and specifically, on the effectiveness of local safeguarding arrangements. This Framework is under constant review and regularly updated to take account of new and emerging challenges and issues.
20. During COVID 19, the HSAB has maintained 'business as usual' as far as possible during the pandemic but with a focus on working differently and flexibly in order to take account of the need to protect the wellbeing of staff and partners. The Board's business continuity plan included making a number of

adjustments to working arrangements to ensure effective partnership working and to maintain progress. Furthermore, the HSAB has commissioned a cross-Hampshire review into excess deaths and harms as a result of Covid-19. This a complex undertaking and will be reported in due course.

HSAB Annual Report

21. The Care Act sets out a duty for Safeguarding Adults Boards (SABs) to publish an Annual Report on their activities. These should be published as soon as feasible after the end of the financial year. The report should include information on the findings of Safeguarding Adults Reviews (SARs) completed during the financial year, and information about those which are ongoing at the year end. Given the pandemic and the significant increase in operational pressures faced by partner agencies it was agreed to defer publication of the annual report until September

22. The 2019-2020 Annual Report has been produced outlining the Board's progress and achievements against the published Strategic Plan. These priorities focus on the themes of awareness and engagement; prevention and early intervention; workforce development; quality assurance; learning and review and service user involvement including Making Safeguarding Personal. The annual report highlights the key themes the Board will be focusing on over the coming year under the strategic priorities described above as well as a continued focus on joint working and coordination. As can be seen significant progress has been made in spite of the unprecedented challenges facing partner agencies during the COVID-19 pandemic. The report also highlights the key areas the board will be focusing on during 2020/21. A copy of the report can be viewed here **HSAB Annual Report 2019-20** .

Safeguarding Policy and Guidance

23. Responsibility for the policy framework for adult safeguarding is shared between the four local authority areas in Hampshire and the Isle of Wight. The Hampshire Safeguarding Adults Board continues to lead the policy development work on behalf of neighbouring Local Safeguarding Adults Boards (LSABs). The new 4LSAB Multi-Agency Safeguarding Adults Policy and Guidance was been published in July 2020 and is available on the HSAB website. Partner organisations have been requested to review their current standard operating procedures and training programmes to ensure these are in line with the new 4LSAB Multi-Agency Safeguarding Policy and Guidance.

24. Another key area of adult safeguarding guidance that has been developed is the new 4LSAB Safeguarding Concerns Guidance which is based on the national guidance published by ADASS and the Local Government Association (LGA) in June 2020. This provides a tool to support partner agency decision-making about what should be referred under formal safeguarding arrangements and clarifies alternative risk referral pathways where statutory safeguarding criteria are not met. It is anticipated that as the Guidance embeds in day to day practice this will help to reduce inappropriate safeguarding referrals.

25. Adults' Health and Care is currently reviewing and updating internal adult safeguarding policies and practice guidance to ensure these are in line with the new multi-agency Adult Safeguarding Policy and Guidance.

Cross boundary working

26. The 4LSABs continue to work together in order to align and coordinate as far as practicable adult safeguarding work across the area. A number of 4LSAB working groups are in place addressing areas of common interest and this approach has reduced unnecessary duplication and improved consistency of approach.
27. There has been effective joint working on policy development between the 4 local authorities in Hampshire and the Isle of Wight particularly where the guidance relates specifically relates to local authority decision making about whether or not statutory safeguarding duties are engaged. This approach has enabled key policy and guidance to be completed in an effective and timely fashion.
28. Joint work between the 4LSABs and the 4 Local Safeguarding Children Partnerships (4LSCPs) has rolled-out the joint Family Approach Protocol in 2018. This protocol was developed in response to findings from a range of reviews, HSAB and Hampshire Safeguarding Children Partnerships (HSCPs) have continued to deliver joint multi-agency training events on the Family Approach Protocol. A further area of common interest between HSAB and HSCP is the development of a joint 'Safeguarding in Transition Protocol' in response to learning from a recent Safeguarding Adult Review.

Safeguarding Adult Reviews

29. Under the Care Act 2014, the local safeguarding adults' board must arrange a Safeguarding Adults Review (SAR) when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult. SABs must also arrange a SAR if an adult in its area has not died, but the LSAB knows or suspects that the adult has experienced serious abuse or neglect. Duties and responsibilities to safeguarding adults remains a statutory duty and Section 44 of the Care Act 2014 relates to the need to conduct Safeguarding Adults Reviews have not changed or been 'eased'. Consequently, the Board has maintained activity regarding SARs, though new ways of conducting these have been adopted as a result of COVID-19.
30. The HSAB Learning and Review Subgroup will review all referrals and will determine whether the circumstances of the case engage SAR criteria and if yes, what type of 'review process will promote the most effective learning and improvement action to prevent future deaths or serious harm occurring again. This may be where a case can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults.
31. SAR referrals are decided upon against agreed criteria which include:

- the concerns relate to a person with needs of care and support – whether or

not in receipt of services at the time of death or injury

- there is information to indicate causal link between the death and abuse, neglect or acts of omission.
- There is concern about the way partners worked together to safeguard the adult.
- The concerns relate to systemic failings relating to multiple organisations and there is potential to identify learning to improve the local safeguarding system, multi-agency practice and partnership working.

32. The purpose of the SAR is to establish whether there are any lessons to be learnt from the circumstances of a particular case and 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 and provides a detailed overview of the interfaces involved in the case, in order to make recommendations for improving future practice, where this is necessary.

33. Over the past year, HSAB has received 15 referrals for a SAR representing a 50% increase in referrals, compared to the previous year and of these 3 cases progressed to a review (2 of which have been completed and 1 is in progress). The issues raised in the referrals include concerns about self-neglect and hoarding, self-harm, substance misuse, homelessness, mental health in transition, financial, sexual and physical abuse, poor care and treatment including medication errors, misdiagnosis, unsafe hospital discharge. Since April 2020 to date, HSAB has received a total of 7 SAR referrals which means despite the significant challenges presented by COVID-19 and heightened operational pressures experienced by partners, the SAR referral rate remains stable and in line with expected volume. The majority of referrals do not progress to a review because they do not meet the criteria outlined in paragraph 31. However, in such cases other learning exercises, either at an individual organisational or multi-agency level are undertaken.

34. During the period covered by this report the HSAB has also competed and published 2 reviews commissioned the previous year (Ms D and Ms E). In January 2019, the HSAB commissioned a SAR to review the circumstances of Ms D's case and her support and during transition from Children's to Adults' Health and Care. A further SAR was undertaken during 2019/20 regarding Ms E who died in hospital following a poor end of life experience in the months prior to her death. Both SARs were undertaken with the full involvement of the families involved. The final report and learning summary for both reviews have been published on the HSAB website and a multi-agency action plan for each review addressing the learning highlighted have now been implemented.

35. Given the current challenges presented by COVID-19, the Board is exploring alternative approaches for conducting reviews to ensure it is able to fulfil its statutory responsibilities in this regard but that these are carried out in a proportionate yet effective way. In 2020/21, the Board will be piloting the SCIE 'Rapid Time SAR' approach which enables reviews to be completed in a very

short timescale. It will also be adding virtual 'learning into practice' events to its training offer.

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Learning and development

36. HSAB has continued to provide a fully funded multi-agency training programme of which the content is linked to our strategic priorities. These training events continue to be very popular with all multi-agency partners and has involved nearly 700 professionals representing a wide cross section of agencies and sectors. Over the past year, 16 half day training workshops have been held linked to the Board's strategic priorities.

37. Due to the restrictions arising from COVID 19, HSAB has been unable to implement a training programme in the first two quarters of 2020. However, a virtual training strategy has been developed to enable the training programme to resume from October 2020 onwards. This will focus on the roll out of the new 4LSAB Safeguarding Adults' Policy (2020) and the 4LSAB Safeguarding Concerns Guidance (2020) as well as well other topics linked to HSAB priorities including, Family Approach, Making Safeguarding Personal, Multi-Agency Risk Management Framework and Financial Abuse, Fraud and Scams. Virtual training packages (departmental and HSAB) will need to be developed to ensure that staff are able to access training during social distancing and periods of lockdown.

38. Adults' Health and Care Learning and Development Team offers a comprehensive safeguarding training programme. This has been reviewed and updated to take account of the new Multi-Agency Safeguarding Adults' Policy and Guidance. The Adults' Health and Care training programme was suspended during the peak of the pandemic however, this resumed at the beginning of September delivered on a virtual basis.

Safeguarding Activity

39. Over the last few years Adults' Health and Care have continued to make improvements to the capture and reporting of safeguarding information supported by the introduction of a Safeguarding Dashboard. As a result of these changes it is not possible to directly compare activity between years.

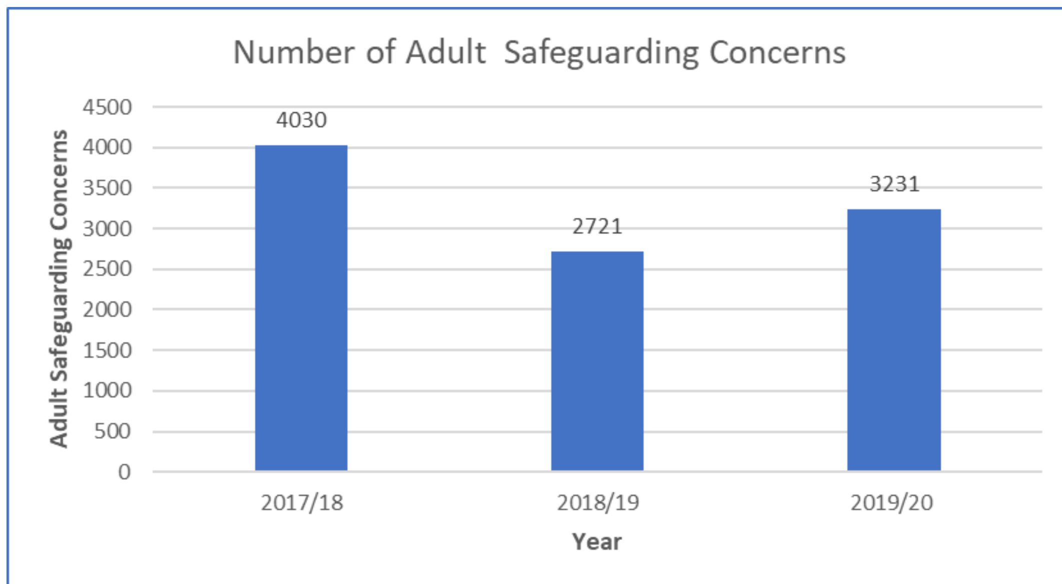
40. The vast majority of safeguarding concerns are now directed to the Adult Multi-Agency Safeguarding Hub (MASH) where staff review them in relation to the action required, consider multi-agency information sharing and proportionality. This enables the services to ensure that concerns that require a different response, for example a review of the care arrangements, are dealt with by the social work teams and not through safeguarding arrangements.

41. The nature of concerns reported to Adults' Health and Care are often on a continuum of poor-quality care through to extremely serious abuse. Information gathering is required before a decision can be reached to establish if abuse or neglect has taken place.

42. MASH screen all safeguarding concerns for cases which are not allocated to a community team or keyworker and advise on appropriate action.

43. An overview of recent annual referral numbers is shown in Table 1 below.

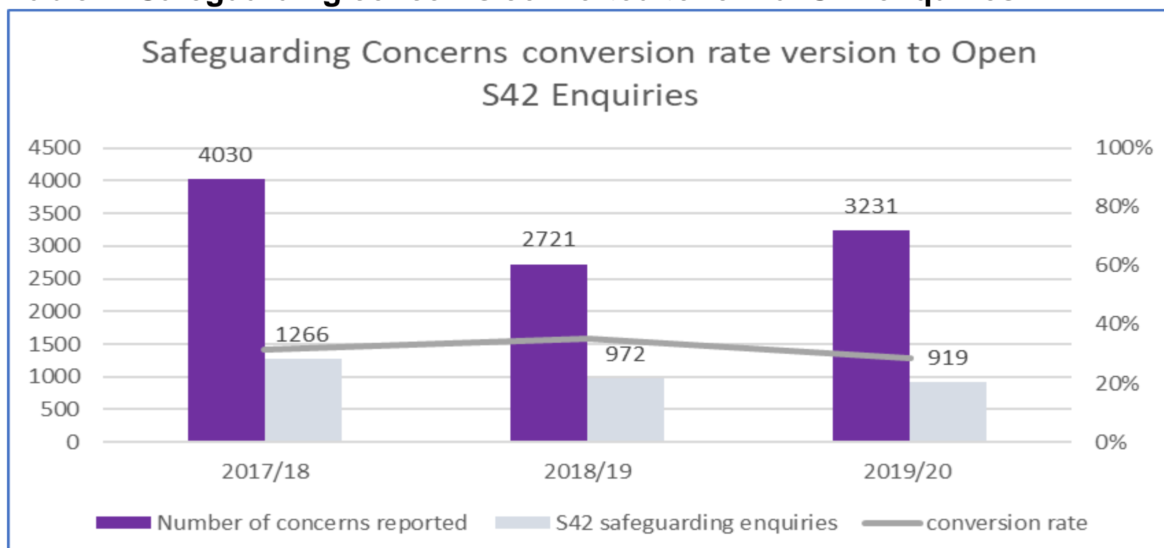
Table 1: Annual safeguarding concerns raised



44. As can be seen in **Table 1** was there was an increase of adult safeguarding concerns of 19% (510 additional concerns) recorded in 2019/20 across the whole year compared to the previous reporting period. There was not a significant increase in concerns during February and March as the impacts of the pandemic began to be felt. However, a significant increase in open concerns has occurred during the first half of the current year. This reflects a variety of factors including the changes to the way in which providers are monitored on the quality of their provision, the more pro-active approach being undertaken in safeguarding adults' and the work to support partner agencies with regard to determining a safeguarding concern.

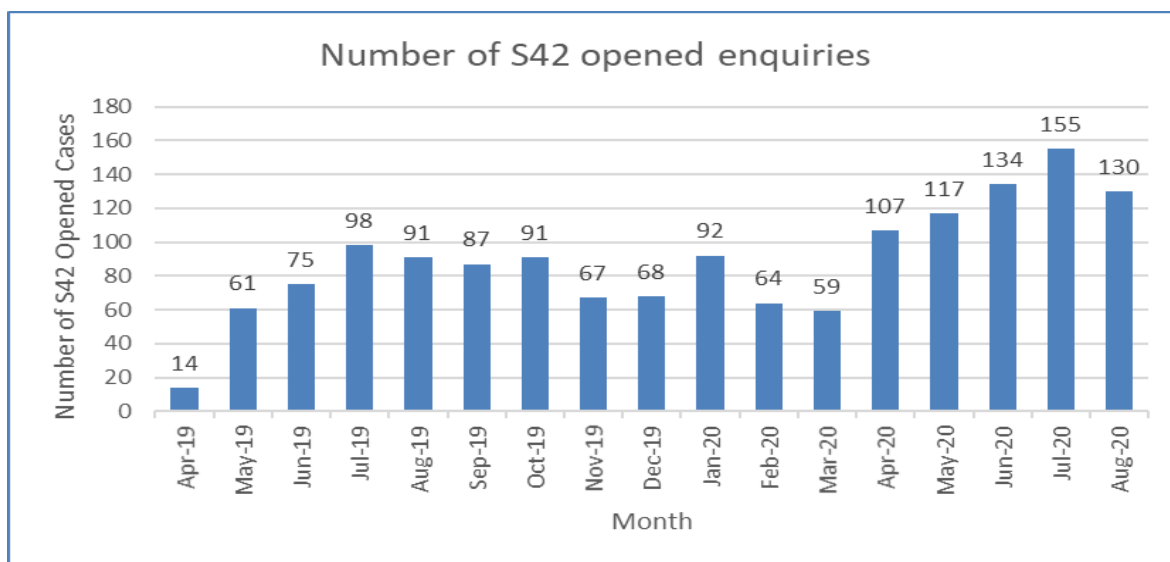
45. As shown on **Table 2,** there were 28% (919) safeguarding concerns in 2019/20 which converted to become formal safeguarding enquiries. This showed a slight decrease compared to the previous year which was 35% (972) in 2018/19.

Table 2: Safeguarding concerns converted to formal S42 enquiries



46. Table 3, below, shows the month on month number of open S42 enquiries over a 17 month period. As can be seen a significant increase has been experienced since April 2020, in comparison to April 2019. This inevitably relates to concerns during the period when Covid-19 began to be significantly experienced.

Table 3: Number of Section 42 opened enquiries



Client Affairs Service

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

48. This is a growing area for the County Council as the contract to provide the service for Southampton City Council was extended to include all their deputyship, not just the higher value cases. This 'sold' service has developed further due to previous agreements with Guernsey and with the Clinical Commissioning Groups (CCGs).

49. During the pandemic, CAS have been able to continue paying their 1000 clients bills, purchasing them the items they require, and ensuring their financial wellbeing, with all CAS staff now working from home 80% of their time.

50. The Service Manager for the Deprivation of Liberty Safeguards (DoLS) and Client Affairs service is currently in her third year as Chair of the National Association of Public Authority Deputies (APAD). In this role she has lead on ensuring the national APAD training can be delivered remotely, assisted with developing webinars and APAD website, liaised with the Court of Protection and Office of the Public Guardian on best deputyship practice for public authorities across England and Wales.

51. A recent audit of the Client Affairs Service identified positive controls regarding safeguarding of clients' assets and good management processes, positive fraud awareness, with security of transactions reinforcing the overall view of this as a safe service.

Key Priorities

52. A focus on COVID-19 assurance, recovery and learning is a key priority. As part of its assurance role, the HSAB will be actively monitoring the volume of safeguarding concerns raised in order to identify patterns and trends in the nature of these. There will be a focus on gaining understanding of key vulnerability factors and risks being experienced during the pandemic impacting on wellbeing and safety of individuals including:

- Presentation of more complex care and support needs and/or safeguarding concerns requiring a higher level of support or intervention due to delays in seeking help.
- In terms of criminal activity, the pandemic has been seen as an opportunity by some criminals to exploit vulnerable people. Financial scams have increased and there has been a noted increase in scams relating to the pandemic. In response, HSAB has established a multi-agency working group bringing together professionals from a wide of agencies to develop joint guidance about protecting oneself from fraud, cybercrime and scams.
- Isolation both for people living in care homes and in their own homes which can increase the risk of abuse occurring and reduce the likelihood it will be reported and dealt with.
- Reduced contact with adults with care and support needs as a result of services such as day services or lunch clubs, closing to protect people from transmission of the virus and also to focus resources where they are most needed. These service disruptions may be unsettling and confusing due to changes in routine and to be more socially isolated with fewer daily contacts.
- Additional pressures on carers or family members as supports such as day services, respite services and lunch clubs are closed. Carers and family members may find themselves having to spend longer periods providing support without adequate breaks and assistance. This can cause stress and tensions that put additional strain on the caring relationship.
- Further work around COVID-19 related deaths will be undertaken by Adults' Health and Care to understand the progression of the virus across all our care settings. Regarding learning disability specifically, the national Learning Disability Deaths Review Programme (LeDeR) has been incorporated into the work programme of the HSAB Learning and Review Subgroup in order to maintain clear oversight of deaths relating to adults with a learning disability. Review activity around safe hospital discharge during the pandemic will also be undertaken.
- Nationally, there has been a significant increase in deaths involving adults with a learning disability. From 10 April to 15 May, the Care Quality Commission received notifications of the deaths of 386 people Figures also

show that people with learning disabilities were dying from COVID-19 at a much younger age than the wider population. While 89% of people to have died from suspected Covid-19 up to May 22 this year were aged 65 or over, deaths from the disease were highest among people with learning disabilities aged 55-64, who accounted for a third of COVID-19 deaths in the Care Quality Commission (CQC) figures.

- Ensuring access routes to services are accessible given the current emphasis on digital access and the potential barriers this may pose to some sections of the population including older people, those with sensory loss, dementia or other vulnerabilities.

53. Another key priority is to manage the demand as effectively as possible and address the opportunity for closer joint working system wide. This includes further developing responses between Children's Services and Adults' Health and Care regarding common areas, such as through embedding the Family Approach Protocol and the 4LSAB Safeguarding Concerns Guidance.
54. There will need to be an increased focus on prevention and early intervention. A key aim in this regard has been to integrate safeguarding and the prevention and intervention agenda across the continuum from the procurement of services through to delivery. This agenda is both promoted and supported by the 4LSAB Multi-Agency Risk Management Framework (MARM) and a key area of focus is to work to embed this approach across a range of activity including high intensity service users, complex hospital discharge, homelessness, safeguarding in transition, etc.
55. In 2021, Adults' Health and Care will make the transition to a new client record system called Care Director to replace AIS. The safeguarding module is currently is the design phase and once implemented, the new module will enhance reporting and analysis of safeguarding activity.
56. The HSAB Strategic Plan is due to be reviewed and refreshed in Q1 of 2021. This process will be informed by a Stakeholder Survey and feedback from stakeholder events across the county.
57. There are a number of partnership areas of safeguarding work where review activity will take place including domestic abuse MARAC arrangements, safeguarding people experiencing homelessness and safeguarding during transition.

Risk Issues

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

58. 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 in order 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 as a result of care arrangements in place. These arrangements are

necessary to ensure that no-one is deprived of their liberty without independent scrutiny.

59. As has been reported previously, as a result of a Supreme Court judgement in 2014 the number of people eligible for DoLS was extended considerably.

60. Now that the Department for Health and Social Care (DHSC) have confirmed Liberty Protection Safeguards are postponed until April 2022, the pan Hampshire implementation plan is delayed.

61. Through the global pandemic, the response to DoLS had to be reduced to critical (March through to July 2020), although referral rates only reduced by about 20%. The DoLS qualified staff have adjusted to undertaking remote assessments in accordance with advice shared by the Court of Protection and DHSC, and the central DOLS team are back up to speed, assessing and authorising DoLS where identified.

62. The DoLS service is developing and leading the broader workforce with best social care practice in relation to assessing capacity and promoting human rights for the people of Hampshire.

Deprivation of Liberty (DoL)

63. 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. The greatest area of risk is our learning disability services and considerable delays are being experienced currently with applications referred to the Court of Protection subject to further delays due to the pandemic and increased demand.

Making Safeguarding Personal

64. All practice should evidence a Making Safeguarding Personal approach to ensure the wishes and views of individuals are reflected in all decisions. A recording tool has been developed to capture a service user's experience of Making Safeguarding Personal during the safeguarding process. HSAB has Making Safeguarding Personal as one of its strategic priorities and this area is under Board scrutiny, as well as the application of the Mental Capacity Act 2005.

Gosport War Memorial Inquiry

65. 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 a time limited Board 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. Going forward, the lead coordinating responsibility will rest with the STP Quality Board. There is an on-going police investigation led by Essex and Kent Constabularies into the historic issues at GWMH of which we are awaiting the outcome.

Finance

66. Adult safeguarding is core work for our front door services and for every team. It is therefore embedded in all service provision as a core duty of the department and as a result it is not possible to provide a total cost for carrying out safeguarding work within the Department.
67. The DoLS budget has been increased to £1.3million in order to support the demands being made upon the service. The department will continue to successfully operate within this budget. However, it is important to underline that we are continuing to use a risk-based approach to manage this area of activity, despite the increases in the budget made available the size of the demand in this area is being actively managed, rather than reduced.
68. In line with a national formula the HSAB budget is made up of agency contributions as follows - Adult Services 63%, Clinical Commissioning Groups 26% and the Police 11%. The total HSAB budget in 2019/20 was £137,750.
69. The HSAB executive group has highlighted a concern that current funding arrangements only cover essential running costs and so there is minimal capacity to fund a wider programme of activities to help drive forward the Board's strategic priorities and business plan. The executive group has highlighted the need for work to be undertaken to consider resources to support the future coordination and delivery of the Board's work programme.. A particular pressure in the last year has been the significant increase in SAR referrals and activity. As an interim measure it has been agreed to use existing, available resources to recruit interim capacity to relieve current pressures. A review will be undertaken to consider organisational contributions to the HSAB funding in order to develop a longer term, sustainable solution.

Future Direction

70. The focus of the work over the coming months will be to:

- Activities relating to COVID-19 assurance, recovery and learning.
- Implementation of the new 4LSAB Safeguarding Policy Framework.
- Ensuring Making Safeguarding Personal practice continues to improve
- Review and refresh the HSAB Strategic Plan.
- Increased focus on prevention and early intervention and develop use of the multi-agency risk management process across a range of services.

Conclusion

71. The approach to adult safeguarding in Hampshire continues to be well understood and co-ordinated via strong partnership arrangements across the 4 local authority areas and with all partners.

72. Within Adults' Health and Care the work is overseen by a senior officer reporting to the Principal Social Worker to provide assurance safeguarding responsibilities are being met. The Independent Scrutineer role will provide an opportunity to strengthen scrutiny and assurance around the effectiveness of local safeguarding adults' arrangements.

73. Further develop the collaborative arrangements across the wider safeguarding partnership and it is hoped will result in a strengthened executive arrangement across Hampshire and Isle of Wight.

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 has its own equality impact assessment. The local authority approach to safeguarding is applicable across all communities. This is an annual report, so no individual Equalities Impact Assessment has been undertaken.