Independent Chair, Hertfordshire Safeguarding Adults Board – Elizabeth Hanlon

It is my pleasure to introduce the 2018/19 annual report for Hertfordshire Safeguarding Adults Board. This report demonstrates our achievements throughout the year. Hertfordshire can take great pride in the strength of its partnership working. The board benefits from excellent engagement by our partner agencies across the statutory and third sector. We have a committed and active membership who work together to make a real difference to the people in Hertfordshire who are most in need of our support.

Hertfordshire is a great place to live and work, and our job as the Safeguarding Adults Board is to help ensure that organisations work together to both prevent and where possible stop the risks of abuse and neglect. At the same time we have to make sure that the wellbeing of vulnerable adults is protected, including having proper regard to their views, wishes, feelings and beliefs in deciding on any action to protect them from harm.

Abuse and neglect can happen to anybody, regardless of individual characteristics, and can occur in any setting, including someone’s own home, public place or a hospital or care home. The person causing the harm may be a stranger, but more often than not they are usually in a position of trust or power, such as a health or care professional, relative or neighbour. Adults at risk of abuse or neglect are often older or have a mental health problem or learning disability.

It is widely accepted that abuse and neglect are under-reported. Academic research has estimated that approximately 10% of older people experience abuse in later life; however, it is likely that this figure is under-estimated due to the reliance on self-reported information from people who are able to participate in research, which excludes certain groups such as patients with dementia.

The population of adults 65 and over in Hertfordshire is predicted to increase by 68% over the next 25 years, which is a higher rate than younger age groups. This is likely to increase demand on all professionals over the next 25 years. Persistent loneliness can considerably increase a person’s risk of physical and mental illness. Approximately 6-13% of older people in the UK report that they are often or always lonely.

We need to be as confident as we can be that the right of every adult, including the most vulnerable, to live in safety, free from abuse and neglect, is promoted and protected as fully as possible.

The Annual Report details how the Hertfordshire Safeguarding Adults Board has delivered on the areas of work identified as priorities for 2018-19. This is important because it shows what the HSAB aimed to achieve and what it has actually delivered as a partnership. The report provides a picture of who is safeguarded in Hertfordshire, in what circumstances and why. This helps us to focus on priorities for the future and our plans for 2019-20 are set out in this report.

As part of its statutory duties, the Hertfordshire Safeguarding Adults Board carried out an independent Safeguarding Adults Review (SAR) and a Partnership Case Review in 2018-19. Significant work has been undertaken by partners to understand how agencies could work better together to safeguard adults at risk in such circumstances. These reviews have been published on our website and have provided us with important learning to take forward in 2019-20.
Introduction

This Annual Report is for the period 1st April 2018 to 31st March 2019 and is produced as part of the Board’s statutory duty under The Care Act 2014 and Chapter 14 of the Care & Support Guidance. It is one of the three core statutory duties of the SAB Chair to publish an annual report in relation to the preceding financial year, on the effectiveness of safeguarding in the local area.

This Annual Report gives details of progress on our priorities and Strategic Plan 2017-20; sets out how effective the HSAB has been over the 2018-19 year; provides detail on the SARs that it has commissioned, and describes how its partners have contributed to the work of the Board to promote effective adult safeguarding.

The report will be submitted to the Local Authority Chief Executive, Leader of the Council, the Police and Crime Commissioner and the Chair of Hertfordshire’s Health and Wellbeing Board.

The report provides an overview of SAB activities and achievements during 2018-19; it summarises the effectiveness of safeguarding activity in Hertfordshire.
The Purpose of the Annual Report

Adult Safeguarding was spelt out for the first time in law, in the Care Act 2014. Local authorities were required to set up multi-agency safeguarding boards to undertake the actions arising from the board’s strategic objectives, from the annual Business Plan and from any Safeguarding Adult Reviews (SAR) and to report on these annually, ensuring the report is available to a wide audience including on the HSAB Web Site.

The overarching purpose of the Hertfordshire Safeguarding Adults Board is to help and safeguard adults with care and support needs and the work of the board is supported by five sub groups and Task & Finish groups for specific short pieces of work.
This is the fifth annual report of the HSAB since the Care Act 2014 and in this report we will consider how the HSAB is:

- assuring itself that local safeguarding arrangements are in place as defined by the Care Act 2014 and statutory guidance;
- assuring itself that safeguarding practice is person-centred and outcome-focused;
- working collaboratively to prevent abuse and neglect where possible;
- ensuring agencies and individuals give timely and proportionate responses when abuse or neglect have occurred;
- assuring itself that safeguarding practice is continuously improving and enhancing the quality of life of adults in Hertfordshire.

Our Business Plan outlines how HSAB will seek to prevent abuse and neglect and how it will help and protect adults at risk. It covers the actions required by HSAB and each of its partner agencies to implement our strategies and will also inform the local community and all interested groups about the work of HSAB. The Business plan is a proposal to support our vision for safeguarding adults in Hertfordshire over the next year.

Both our Business Plan for 2019-2020 and previous Annual Reports can be found here.

The HSAB vision is that all adults at risk live and work, are cared for and supported in an environment free from abuse, harassment, violence or aggression. HSAB’s mission is to work in partnership to ensure that Hertfordshire is a safe place to work and live for all adults at risk and to assure that people who have care & support needs are empowered to speak out and make informed choices, are kept safe from abuse or neglect and that where abuse has taken place, agencies act together, swiftly and competently.

As always, we welcome any comments on the content or format of this report to inform the development of future reports to ensure they are relevant, informative and accessible to the citizens of Hertfordshire as well as the agencies/constituencies directly involved in the day-to-day work of supporting those adults who experience or are at risk of experiencing abuse or neglect.

If you would like this document in large print, Braille, audio formats or require it in languages other than English please contact the Safeguarding Business Unit on 01992 588757.

NB Do not use this number for safeguarding concerns – the contact number is 0300 123 4042. You can keep up to date with HSAB by following us on Twitter @HertsSab

The work of the Board and Sub Groups is underpinned by the six safeguarding principles:

- Empowerment: people being supported and encouraged to make their own decisions and give informed consent;
- Prevention: it is better to take action before harm occurs;
- Proportionality: the least intrusive response appropriate to the risk presented;
- Protection: support and representation for those in greatest need;
- Partnership: local solutions through services working with their communities – communities have a part to play in preventing, detecting and reporting neglect and abuse;
- Accountability and transparency in safeguarding practice.
So What Have We Achieved?

Priority 1

To be assured by partner agencies that there is effective leadership, partnership working and governance for safeguarding adults; holding partners and agencies to account.

The HSAB has during the course of 2018-19 endeavoured to ensure that agencies are held to account with regard to partnership working, including governance and leadership.

The Board have has built on initiatives begun in 2017-18 to develop a more in depth quality assurance function. The performance sub-group have continued to analyses detailed performance information to support the functions of the Board.

Performance management is integral to the work of the HSAB. The Board has a responsibility to ensure the effectiveness of adult safeguarding practices and interagency working.
The HSAB commissioned an intelligence analysis which was presented to the Board in June 2018. This in-depth review provided the Board with some recommendations:

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<th>Recommendation</th>
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<td>To develop a countywide communication strategy to raise awareness of abuse and neglect and ultimately increase reporting, with a particular focus on engaging with elderly residents in their own homes and encouraging reports from BME and LGBTQ communities.</td>
<td>The HSAB are running two significant campaigns. Firstly, linking to World Elder Abuse Awareness Day (15th June). This campaign focusing on elderly people has been developed across three strands: The elderly population in Herts – via various channels – district councils, Crimewatch, health trusts, age concern Herts, Health watch plus voluntary and faith groups. We are targeting clubs and other social outlets. The campaign also is targeting the general public with social media to support this. Finally, professionals are being targeted by partners holding events across the County – stalls and other promotional activities. The Board will be supporting as many external events as possible including events held by Health watch and Age Concern Herts. The HSAB will be running a full campaign on raising awareness of adult abuse and neglect in Hertfordshire. The strategy for this campaign will be inclusive of all Hertfordshire’s communities and will encourage reporting from BME and LGBTQ communities. This campaign will be launched during the Autumn of 2019. A formal communications strategy is available on the HSAB website.</td>
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<td>For local care services, including domiciliary care, to ensure that they have sufficient whistle-blowing procedures and detection strategies in place to increase reporting for individuals that experience abuse in their own home and other care settings.</td>
<td>The HSAB have sought assurances from partners around their whistle blowing procedures and this has been an item that has been discussed at Board level and is reflected in the business plan. The HSAB are currently assured that such procedures are sufficiently embedded.</td>
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<td>Recommendation</td>
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<td>To incorporate hate crime awareness training into the HSAB training framework.</td>
<td>Hate crime awareness training is now part of the HSAB work plan for learning and development. The HSAB Annual conference in 2018 had a performance from the Blue Apple Theatre company on the theme of hate and mate crime. In addition, members of the Learning and Development sub-group are now meeting with colleagues in the constabulary to discuss accessing awareness opportunities that can be shared across the partnership.</td>
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<td>For organisations to ensure that front line adult social care staff are routinely trained on wider aspects of adult safeguarding, including the Mental Capacity Act 2005 (MCA), Deprivation of Liberty Service (DOLS), to increase opportunities for early intervention and prevention.</td>
<td>An online questionnaire is being completed by members of the partnership which asks for assurance around staff training on adults safeguarding. The survey will be analysed, and the findings presented back via the Learning and development group to Board in September. This will provide assurance and an opportunity for challenge by Board members. In addition, a further follow up with partners around wider training assurances including MCA and DOLS training will be run this financial year. The Board although unable to offer training opportunities on these areas will be including a forum event this year on changes to the Mental Capacity Act.</td>
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<td>For organisations to routinely provide follow-up communication to clients after cases have been closed to improve client satisfaction and help victims feel safer.</td>
<td>An online questionnaire is being completed by members of the partnership which asks for assurance around staff training on adults safeguarding. The survey will be analysed, and the findings presented back via the Learning and development group to Board in September. This will provide assurance and an opportunity for challenge by Board members. In addition, a further follow up with partners around wider training assurances including MCA and DOLS training will be run this financial year. The Board although unable to offer training opportunities on these areas will be including a forum event this year on changes to the Mental Capacity Act.</td>
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The performance sub-group has continued to provide the Board with items for discussion and focus during 2018-19. In March 2019 the HSAB joined with HSCP to look at joint reporting on key issues particularly around contextual safeguarding. This included shared information on domestic abuse, modern slavery. Breakdowns by district are now readily available and the interactive dashboard has been developed for partners.

The Board’s focus on Self-Neglect has continued during 18-19. In order to assure that the guidance developed on Self-Neglect has been embedded in organisations, the Board conducted a multi-agency audit. The action plan will be developed and worked on during 2019-20 – below a couple of key findings:

The Hertfordshire Safeguarding Adults Board made the decision in 2017/18 that they would ask members of the board to carry out self-assessment’s within their organisations in relation to the way they are prioritising adults in need of care and support. The process involved each agency filling out a self-assessment questionnaire which was then followed up by a personal visit by the Independent Chair of the HSAB and the safeguarding lead from the CCG’s, to talk them through the assessment. The self-assessment was divided in to six sections:

- **Section A:** Leadership, Strategy and Governance.
- **Section B:** Workforce, Organisational culture and Learning.
- **Section C:** The organisation’s approach to workforce issues reflects a commitment to safeguarding and promoting the wellbeing of adults at risk.
- **Section D:** Effective multi-agency working to safeguard and promote the wellbeing of adults at risk.
- **Section E:** Key Practice Areas (Da, Prevent, Self Neglect, Hoarding)
- **Section F:** The service can demonstrate that people who use services are informed about safeguarding adults and empowered within the organisation’s responses to it.

The self-assessments were carried out by all 10 Districts and all board member partner agencies. A decision was made that Health would not be involved in this process as a similar rigorous process already takes place and is reported annually to the board.
The findings of the assessments were reported back to the agencies, including recommendations for future developments. These recommendations were then turned into action plans which are monitored by the board. Findings this year showed a significant improvement in corporate ownership of adult safeguarding. There was also an increased level of training being offered by agencies, particularly around prevent and general safeguarding awareness.

Areas of good practice through the agencies were also identified with safeguarding both children and adults identified as a priority. Some of the themes arising from these visits include:

- Examples of good practice – clear procedures, DBS checks in place, key staff trained in adult safeguarding, executive leadership cited on safeguarding
- Recommendations include: provision of training on Mental Capacity Act for key staff, monitoring of provider contracts regarding safeguarding policies and embedding HSAB policies and guidance.

To further embed the self-assessment process the HSAB is planning to put together a panel for staff to come and present their work plans arising from the assessment process. This will give the Board further assurance that the recommendations are being taken forward.

Making Safeguarding Personal continues to be a priority for the Board. The findings of the audit conducted in 2017 have been completed.
Recommendations and Actions from.
The Making Safeguarding Personal Audit.

- **Share Survey Findings and Outcomes**
  - An Infographic was distributed in 2017. Findings have also been included in Safeguarding Awareness Multi-agency Training.

- **Incorporate MSP into Multi-Agency Training**
  - MSP has been included in the commissioned Safeguarding Adults Course. Subsequently this has been quality assured by the Board.

- **Develop an ‘Understanding Capacity Fact Sheet’ for relatives, carers and friends**
  - The fact sheet has been created in an easy read format and linked to other materials – it can be found on our website [insert link here].

- **Ensure access to information on ‘Understanding Stronger Protective Networks’ is available across the partnership.**

- **Link with the Domestic Abuse Partnership to ensure Adults with Care and Support Needs are established in their work plan and campaigns.**

- **A link to Connected Lives via website has been shared with practitioners.**

- **The joint partnership learning and development sub-group is now in place which brings together multi-agency training initiatives across Adults and Children and prioritises Domestic Abuse.**
Priority 2

To identify, and monitor the implementation of changes that help to prevent similar abuse or neglect happening to others.

It is a requirement of the Care Act 2014 that the details of any Safeguarding Adults Reviews (SARs) conducted during the year must be in the SAB Annual Report. It is the responsibility of the SAB Chair to decide whether or not a death or serious incident should be the subject of an SAR, which would involve commissioning an independent review and publishing a full report written by an author recruited for the purpose.

**HSAB Learning Bulletin: Case Study**

The subject of this learning review was a young man who died at age 29. At the point of death he was extremely underweight, had a documented alcohol addiction and was self-neglecting. The HSAB felt that although the case didn’t meet the criteria for a safeguarding adult review there was evidence of good practice which could be explored and shared plus the opportunity to identify areas for improvement.

**Pen Picture**

- X was a young man with a learning disability who over a period of years suffered with an alcohol addiction. This resulted in self-neglect to a point where he could no longer go upstairs and slept on a sofa downstairs. There was also previous domestic abuse within the family.
- A Safeguarding concern was raised by the District Nursing team and they liaised closely with the social care worker and chair of the Safeguarding meeting prior to a hospital admission.
- On admission the patient was found to weigh only approx. 35kg, there was evidence of self-neglect, reduced mobility, multiple pressure ulcers and he had been suffering from a flu like illness for previous 3 days.
- A couple of days after admission he was transferred to Intensive Care Unit, where he deteriorated over night and died.
Examples of Good Practice

• There had been a lot of agencies involved in the case and they had all worked really hard to support X.
• The agencies had been talking to each other. The agencies had cooperated with each other to gain access to X.
• Both Social Care and HPFT kept trying to engage with the family over a long period of time and kept cases open to try to encourage engagement.
• There was documented persistence of an Occupational Therapist (HCT) to arrange appointments despite the difficulties in contacting the family. The case had not been closed due to no contact.
• Once the OT (from Hertfordshire Community Trust) had made contact with the family they took other health professionals along with them to ensure access to the family.

Learnings and Resources

• A Multidisciplinary Team meeting could have been held earlier and the family could have been involved in the meeting.
• The larger family dynamics could possibly have been addressed differently.
• Better co-ordination between agencies could have saved time and resources.
• There was no clear lead agency.

What has the HSAB done?

• There is now a HSAB multi-agency complex case guide for professionals, which gives advice and guidance on using multi-agency meetings to manage cases.
• This guide also helps identify a lead professional and gives a clear template for running a multi-agency meeting.
• The HSAB has also issued a comprehensive guide to managing self-neglect cases.
• Both these guides will be reviewed to ensure family dynamics are reviewed by professionals.

A Partnership Case Review

In October 2018, the HSAB published a multi-agency partnership review which arose from the murder of Ms M, a twenty-three year old woman in December 2015 and the subsequent conviction of Mr O, a twenty-six year old male for that murder. Ms M lived with her parents at the family home located within the administrative boundaries of the Epping Forest District Community Safety Partnership (EFCSP). In December 2015, Ms M met Mr O, whom she had met through an Internet dating site, face to face for the first time. They met at a bar in East London, following which they took a taxi to a hotel in Hertfordshire, where he subsequently murdered her.

Given the complexity of the case and that a number of agencies had been in contact with Mr O over an extensive period of time before he committed the murder, the Chief Constable of the Hertfordshire Constabulary, under the auspices of the Memorandum of Understanding, proposed a multi-agency review. However, since the case did not meet the criteria for a Domestic Homicide Review nor the criteria for a Safeguarding Adult Review, the decision was taken to establish a multi-agency partnership review, to include an independent investigation commissioned by NHS England, in order to determine the circumstances leading to the murder of Ms M and identify what lessons, if any, the various agencies might learn, either individually or collectively, from this tragic event.

1. That NHS England remind all NHS Mental Health Services of the importance of information sharing, within the confines of the Caldicott Principles and associated guidelines, when high risk patients move or are transferred between NHS administrative areas.
   - Recommendation discussed and accepted at the National Independent Investigation Governance Committee on the 13 December 2018. The Regional Chief Nurse London Region and Chairman of the committee will write to the Royal College of General Practitioners and NHS England Medical Directors to reinforce the message of the importance of appropriate information sharing when high risk patients move between areas

2. That Hertfordshire Partnership University NHS Foundation Trust and Avon and Wiltshire NHS Trust should review and revise discharge procedures so that when a patient who is considered to present a potential significant physical risk to the public is discharged back into the community, the local police constabulary is informed of that discharge, with the details of the potential risk. Procedures to be shared with NHS England for dissemination of wider learning.
   - Procedures reviewed, updated and disseminated
3. That the National Probation Service provide guidance to all relevant staff in respect of the application of Mental Health Treatment Requirements with particular emphasis on the importance of timely contact with local Mental Health Services following sentencing.

Completed Actions:
- Local Mental Health Treatment Requirements (MHRT) audit tool commissioned in August 2017. Two audits of all current cases with a MHTR completed (October 2017 & January 2018). January audit included mirror analysis from Health professionals of the same cases.
- Hertfordshire Court staff were briefed and issued with MHTR guidance in January 2018 with specific focus on the process for recommending MHTRs
- All Hertfordshire National Probation Service staff issued with Mental Health Facts and Questions local good practice guidance

Ongoing Actions:
- Continuation of MHTR audits, to be completed by operational staff rather than managers.
- Influence the national guidance to ensure that once someone is sentenced to a MHTR in Court they are able to leave with their first appointment with both the OM and the responsible clinician.
- Provide training to all National Probation Service staff responsible for the proposal and delivery of MHTRs. Training will be completed by December 2018 and will be led by the Senior Probation Officer who leads for Mental Health and Criminal Justice and forensic Mental Health Workers from Hertfordshire Forensic Team.

4. That the National Probation Service, in conjunction with local Mental Health Services, develop new or update existing protocols for the implementation of Mental Health Treatment Requirements to include, in particular, clarity around implementation timescales and agency responsibilities.

- Guidance reviewed, updated and disseminated by National Probation Service

5. That Police Constabularies should take steps to ensure that when an individual diagnosed as suffering from mental health issues is released under investigation or bailed to reside in another constabulary area, the receiving constabulary is notified and provided with all appropriate information.

- Extensive training has been undertaken in custody to ensure the pre-release assessment is completed by the officer in the case and signed off by the custody sergeant. This is a mandated process endorsed on the custody record holding officers to account. There is also two tier quality assurance process post release to ensure that this has been complied with.
- NPCC Mental Health Lead has been sent the independent report which has now been disseminated nationally.
6. That HPFT, the Hertfordshire Constabulary and the Probation Service, through the auspices of the Hertfordshire Safeguarding Adults Board, develop and implement a programme of joint training to better inform relevant officers of the complex interactions between mental health services and the criminal justice system.

- Hertfordshire is currently the only County to hold an MDO panel of its kind. Whilst other areas utilise liaison and diversion schemes this is only part of what the Herts MDO Panel do. The Herts MDO panel flags up potential Mental Health needs for all offenders referred and discussed. This is recorded on police, health and probation systems.
- Historically the NHS England/NPS OPD Pathway team has delivered Mental Health training to Hertfordshire Police and this will be repeated to include HPFT and NPS staff via a whole systems approach to managing Mental Health.

7. That in conjunction with the Hertfordshire Clinical Commissioning Group, deliverers of primary care services be informed of the need to share essential patient clinical information with other health service providers, in accordance with the Caldicott Principles and existing information sharing protocols and guidelines.

- Training program with GPs is in place around sharing clinical information where appropriate. Quarterly newsletters go to GPs which cover information sharing. A professional website within CCG which includes information sharing is available.

As at the end of March 2018 there are currently one Safeguarding Adult Review in progress and two partnership case reviews which should all be completed during 2019-20.
Priority 3

To listen to people who have experienced abuse or neglect, and to seek assurance that people are able to be supported in the way that has been identified and agreed with the adult at the centre of the safeguarding process, that they are empowered to make decisions, and can achieve the outcomes they want.

Making Safeguarding Personal sits firmly within the Department of Health (DH) Care and Support Statutory Guidance, as revised in 2017 that supports implementation of the Care Act (2014).

It means safeguarding adults:
- is person-led
- is outcome-focused
- engages the person and enhances involvement, choice and control
- improves quality of life, wellbeing and safety (paragraph 14.15)

Making Safeguarding Personal must not simply be seen in the context of a formal safeguarding enquiry (Care Act, 2014, Section 42 enquiry), but also in the whole spectrum of activity. The HSAB remains fully committed to engagement with service users and other stakeholders so that they are empowered to make decisions.

The Local Government publication ‘Making Safeguarding Personal: Support for safeguarding adults boards’ outlines the expectations on SAB.

- Empower, engage and inform people so that they can resolve and prevent abuse and neglect in their own lives, and build their resilience.
- Maintain a focus on capacity in the voluntary and community sectors where there is significant scope for supporting prevention of abuse and neglect, and early intervention.
- Support partner organisations in making the links between Making Safeguarding Personal and effective prevention, for example, challenging board partners to identify and address issues of social isolation to prevent future risk of harm.

• Engage providers and commissioners in making the relevant links between service quality and prevention and the role of Making Safeguarding Personal within this.
The HSAB have during 2018 linked in with the World Elder Abuse Awareness Campaign on 15th June to highlight to local communities the importance of this issue, how to spot the signs and where to contact for further information and advice or make a referral.

The Board has worked with Carers in Hertfordshire to incorporate some safeguarding questions into their annual questionnaire to carers. The results of the survey can be found on the Caring in Hertfordshire Website [https://www.carersinherts.org.uk/have-your-say/consultation-responses/the-state-of-caring-in-hertfordshire-2018-survey-findings](https://www.carersinherts.org.uk/have-your-say/consultation-responses/the-state-of-caring-in-hertfordshire-2018-survey-findings)

‘Our State of Caring in Hertfordshire Survey showed that some carers did not feel safe in their caring role. Only 56% of the 1,434 carers that responded to the Survey said they had never felt unsafe due to their caring situation. In response to this, carers have been working with us, Hertfordshire County Council and local health services to consider how to make carers feel safer in their caring role. A Keeping Safe Traffic Light has been produced that contains details about the organisations that provide assistance or support, their contact details and when to contact them.

The Traffic Light has a red level for issues requiring immediate action, the amber layer is related to concerns and the green level has actions and contact details for organisations to help prevent a crisis.’

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<th>Scenario</th>
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<tr>
<td>If you or the person you care for feels unsafe now.</td>
<td>Police 999 for an emergency</td>
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<td>Police 101 to report less urgent crime</td>
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<td>0300 123 4042 for Hertfordshire County Council’s Adult Care Services and 0300 123 4043 for Children’s Services</td>
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<tr>
<td>If you are worried, feeling frustrated or feel there will be a safety issue in the future.</td>
<td>Adult Care Services 0300 123 4042</td>
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<td>Carers in Hertfordshire 01992 586969</td>
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<td></td>
<td>Hertfordshire Domestic Abuse Helpline 08 088 088 088</td>
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<td>Samaritans: 116 123</td>
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<td>If you want to build up resilience and find out how to cope with changes to your caring role and relationships.</td>
<td>Carers in Hertfordshire 01992 58 69 69</td>
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<td>HertsHelp: 0300 123 4044</td>
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<td>Relate: 0300 003 2324</td>
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<td>Your GP</td>
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The Board will continue during 2019-20 to be part of the carers group looking at 'Keeping Carers Safe', will link to any identified campaigns and work with Carers in Hertfordshire to share any relevant resources.

The Board has also reviewed publicity materials which can be used by the voluntary and community sector to raise awareness and these are available on the HSAB website. The Chair of the Board also uses opportunities at Board and statutory partners meetings to challenge partners around making links between Marking Safeguarding Personal and prevention. Various discussions have been had at Board level, the policy and procedure group check all new documents to ensure MSP is at the heart of what is being produced by the HSAB.

Learnings from Adult Safeguarding Reviews are shared both within organisations and by the Board. The audit conducted into self-neglect cases also referred to Making Safeguarding Personal within it’s terms of reference, the full report is currently being compiled. A Safeguarding Forum took place in December 2018 which gave partners the opportunity to come together in a multi-agency setting to hear key note speakers on safeguarding in the Gypsy, Roma and Traveller communities. This unique opportunity lead by GATE (Gypsy and Traveller Empowerment - Hertfordshire) gave delegates the chance to learn from case studies and discussions.

The HSAB received positive feedback for the event and will run similar events in the future.

A Participant said:
Attending the course has given me a greater understanding of the issues surrounding GRT group, and will aid in the development of local policy to better support the group.
Priority 4

To promote safeguarding adults among the general public, by raising awareness and promoting well-being with the aim of preventing abuse and neglect.

The Public Engagement sub-group of the Board leads the work around raising awareness of adult safeguarding. The group’s public engagement strategy which outlines the Board’s aims and objectives can be found on the HSAB website.

The group had the following focus during 2018-19:

The further development of literature to support the Board priorities – including an Easy Read Safeguarding Leaflet, Having Difficult Conversations Guide with case studies, Understanding Capacity Guide and the Fire and Rescue – Easy Read Guide.

The review of the content of the app ‘Safeguarding Adults from Abuse’ has recently started and will be completed during 19-20. The app contains sections on: ‘Definitions of Adults at risk; Categories of Abuse; Recognising Abuse; Reporting a Concern and Making Safeguarding Personal. The app was developed for guidance and is in an easy to use format. Work is ongoing on making the ‘App’ available for desk top users.

The group ran a general safeguarding adult’s awareness campaign in October. Awareness raising was done via FaceBook and Press releases were developed. The campaign will run again in 2019-20 with a greater media input.

As mentioned above a targeted piece of work was also undertaken in relation to Carers. The Board wanted to find out whether carers felt safe so in partnership with Carers in Herts a couple of questions were pulled together which were added to the survey run by Carers in Herts. Findings from this questionnaire were generally positive, however the Board had identified that some of the responses indicated that there is some work to be done explaining the purpose of safeguarding to carers and reassuring them that it is a process to help them not something that should worry them.
The traffic light guide developed by Carers in Hertfordshire has been widely dissimilated via their newsletter and the public engagement sub-group will request regularly updates on this work stream during 2019-20.

The public engagement sub-group of the Board has been re-aligned during 2018-19. This was done to ensure a more productive approach to the work of the group. Each significant piece of work will now be overseen by the sub-group with the work being carried out through a task and finish group model. The first campaign which will work in this way will be the World Elder Abuse Awareness Day (in June 2019). The group intend to also run a significant campaign on Raising Awareness of Adult Abuse.

The group will also input into the newly established Joint communications group, currently chaired by the Constabulary and aim to work with other partnerships to share resources and support key campaign indicatives across the County.
Priority 5

To promote effective training and development in Safeguarding Adults, ensuring that there is a quality improvement approach to workforce practice.

Previous to 2017-18 the HSAB had no specific training offer for members of the partnership. A training needs analysis was undertaken by the Chair of the Learning and Development sub-group which identified the need for some key multi-agency training to be developed to meet the needs of the partnership. The Board has agreed funds to support a multidisciplinary training programme for staff working with adults at risk of abuse and initial priorities have been agreed to include a ‘train the trainer’ programme.

The following courses have been delivered during 2018-19:

Safeguarding Adult Awareness (x4): a full day course for partners to come together in a multi-agency environment. The course outcomes include:

- To develop or refresh awareness of what to do when we suspect or know an adult is being abused;
- To identify the different kinds of abuse, signs and symptoms identified in safeguarding adults guidance, including emerging issues such as self-neglect, exploitation and modern slavery;
- To have an understanding of relevant legislation and national and local guidance related to safeguarding adults, with particularly reference to the duties identified in the Care Act 2014 and Making Safeguarding Personal;
- To consider recent developments in learning around specific safeguarding adult issues arising from local and national reviews;
- To understand the processes of assessment, planning and review for vulnerable adults and your agency’s possible involvement;
- To recognise the importance of working together in a multi-agency approach.
Feedback courses has been positive, with practitioners commenting on the usefulness of the multiagency discussions.

“\textbf{This course was fantastic and gave me a greater understanding of identifying risk as well as what action to take at each stage.}”

“\textbf{Learnt lots of valuable information including recommendations coming out of recent reviews such as the Stanley review.}”

“\textbf{The networking opportunities and examples given by colleagues were very informative.}”

“\textbf{This course was thought provoking and made me think more about my practice and how to address different situations.}”

The Board has also run courses on Modern Slavery and Human Trafficking (x4). This was delivered by the Police. The Operation Tropic lite bite is designed to give an overview of Human Trafficking and Modern Slavery with a Hertfordshire focus on cases and the complex investigations that may then follow.

“The course was extremely informative and has enabled me to have confidence to identify signs of modern slavery in my role as a family intervention worker”

“I feel confident to recognise indicators and also to support victims appropriately.”

The final course initially identified was Fire Safety; this is delivered by colleagues in the Fire and Rescue service. The course aims to help participants:

- Identify \& understand the factors that increase the fire risk to vulnerable persons;
- Know how to make referrals to the Fire \& Rescue Service;
- Understand the services the Fire \& Rescue Service can provide to the vulnerable.

“\textbf{Having attended the Fire Safety training, I feel that I now have an increased awareness of the risks that could potentially occur within my workplace, and I now have the confidence to challenge colleagues in regards to these.}”

All HSAB courses are aimed at a multi-agency audience in order to give practitioners the extra learning opportunities that such forums provide.

A train the trainer course was commissioned for 2018-19 which will give those professionals who already train within their own organisations and are subject experts some extra skills in delivering their sessions.

As required by the Care Act, the Learning and Development sub-group have put together a Training and Workforce Development Strategy. This is a document which offers guidance to partner agencies around the type of training that should be undertaken by different job roles. The Aim of the Workforce Training Strategy is to provide guidance on the recommended:

- \textbf{Minimum requirements for safeguarding education and training}
- \textbf{Learning outcomes expected at each level of education and training}
It is the responsibility of each organisation to assess the level of safeguarding adults training required within their organisation, and it is recognised that organisations will have in place a policy which clearly specifies the level of safeguarding education required for all the various roles within their organisation. This guidance document does not address the additional educational requirements required by professionals to maintain their professional registration.

The assessment of competencies should be a mix of direct observation of practice as well as a process of exploration, discussion and questioning in supervision and appraisal meetings to develop analytical and evaluative thinking developing professional judgement. The competencies build upon the knowledge gained in the previous level.

Alongside individual agencies learning and development requirements, the Safeguarding Board may offer additional multi-agency learning and development opportunities that would contribute to annual updates.


The HSAB hosted a Safeguarding Adults conference in June 2018 to coincide with World Elder Abuse Awareness Day with a focus on Making Safeguarding Personal. A wide range of professionals attended from various disciplines, heard speakers and took part in workshop activities around the key priorities. In addition there was a performance from the Blue Apple Theatre. Feedback from the conference was very well received and the HSAB will go on to run another conference in June 2019 on the topic of Safeguarding People with Learning Disabilities.

`Really informative and gave me more confidence to make decisions based on a person centred approach.`

`It reiterated the message of listening and talking to the adult first, take your time with them to understand how they feel with regards to the situation.`

`Better understanding of the impact hate crime has on vulnerable adults and will seek other ways of resolving the issues if no criminal acts involved.`

`I will frame risk taking or risk behaviours against personal choice`

The HSAB also ran two multidisciplinary Safeguarding Adult Forums during 2018-19. The topics this year were: Domestic Abuse – Coercion and Control and Working with the Gypsy, Roma and Traveller Community. These events are smaller than conferences and give participants the opportunity to use case studies to consolidate the learning from speakers. The HSAB will continue to run these events during 2019-20, the first one being on Learnings from Domestic Homicide Reviews.

`It is has deepened my understanding of coercion and controlling behaviours and given me a good understanding of how to manage concerns which may arise both professionally and personally.`

`Able to advise others of what to look for and how to deal with situations in my role as designated safeguarding lead`'
The Board also hosted two significant launch events, firstly on Self-Neglect and Hoarding. This brought together front-line practitioners from across the partnership to hear about the new guidance that had been devised and signed up to by senior leaders. The morning gave an opportunity for participants, to listen to experts in the field and feedback what they could pledge to do within their own organisations around self-neglect and hoarding.

The second big launch was for the ‘See the Adult; See the Child’ guidance. This guide written in conjunction with the children’s Board is to ensure effective and timely referrals between all adult and children’s services, including the transition between children’s and adults’ services and to promote good practice in multi-agency working. This guidance respects an adult at risk’s right to live free from abuse with dignity, autonomy, privacy and equity.

The guide highlights the fact that all agencies that mainly serve adult service users must consider, when deciding if an individual meets their threshold for a service, the possible impact on the individual of any caring responsibilities for children and whether they have the capacity to meet these, and the potential impact on a child who is the carer of an adult receiving services. If a member of staff working with adults has concern that a child may be at risk of or suffering abuse or exploitation, then they should refer to the Children’s Services.

The guide looks at certain groups including:

- Those in transition
- Pregnant women and unborn children
- Young Carers


Work has also started with the Hertfordshire Safeguarding Children’s Partnership and the Domestic Abuse Partnership to develop and deliver shared programmes of learning. The key priorities being developed during 2019-20 are a domestic abuse awareness, hate crime, modern slavery and skills based training.
What’s next?

Learning and Development Plans

The HSAB will continue to develop the Learning and Development offer during 2019-20. This will include:

- Continuing to offer multi-agency face to face courses on Adult Safeguarding Awareness
- Development of learning opportunities around: Self-Neglect, Mental Capacity and Hate Crime
- Develop systems for monitoring longer term outcomes from training
- Running Safeguarding Forums on Key themes throughout the year
- Running a conference in June 2019 on Safeguarding People with Learning Disabilities
- Embedding the Workforce Strategy amongst partner organisations
- Challenging agencies on the training and learning opportunities provided within their organisations

Joint Working with HSCB and other Strategic Partnerships

More than ever there is a need for partners to have a joint approach to many key priorities. The HSAB has identified the following areas where joint approaches will be beneficial to all practitioners:

- Learning Events (hubs): These have been developed by the Children’s Partnership and the HSAB will join with these events over the coming year where the topics are appropriate. The first on Gangs and Knife Crime supporting the Serious and violent crime work stream took place in the final quarter of 2018. The aim of these hubs is to gain insight from the feedback from front line practitioners across Hertfordshire and so the partnerships can feed these into strategic planning. The HSAB will take part in the Learning Hub planned on transitional safeguarding in January 2020. (See Appendix 2 for outcomes infographic)
- Learning and Development sub-group: the joint group is now operational and the work streams are now in place to deliver key joined up events and learning opportunities during 2019-20. As well as the Learning hubs, this will include the development of a specific course on exploitation, so that any cross-over in learning can be shared throughout both partnerships.
- Learnings from Safeguarding Adult Reviews, Serious Case Reviews and Domestic Homicide reviews are being pulled together to produce a coordinated approach to the dissemination of learning from such reviews.
- Campaigns: The HSAB is now a member of a joint communications and campaigns group with the other key strategic boards. This will enable the HSAB to feed into planned campaigns where it is appropriate and avoid duplication. One of the key areas identified is to improve awareness of honour based violence
- Policy: Where appropriate joint policies will be written which cover both Boards agendas e.g. a recent policy on See the Adult See the Child
- Performance Data: Again where appropriate the HSAB and HSCP will identify areas where a ‘deep dive’ into data would benefit both Boards.
New Policies and Guidance

There has been a lot of concentrated work during 2017-18 on policy and guidance initiatives which have been launched during 2018-19.

- As a recommendation from a recent Self-Neglect audit, the HSAB will review the Self-Neglect guide for practitioners; this work will consider in the main the further development of a resources pack which forms part of the guidance. This will be led by the policy and procedure sub-group during 19-20.
- The HSAB supervision guide has been agreed and will be formally disseminated across the partnership during 19-20.
- The Safeguarding Adult Policy will be reviewed and updated as necessary throughout the year.
- The group will look at some particular elements of the policy for significant review; these include, medication errors, pressure ulcer guidance and will contribute to any joint initiatives on documentation relating to serious and violent crime.

Develop Service User Involvement

The HSAB will continue to use wherever possible established service user groups to gain feedback on any new policies / initiatives. The Board is keen to hear the voice of the service user and will be considering the possibility of having lay members on the public engagement group to provide added value to the work of the partnership.

The Board will also seek service user feedback via the Co-Production Board whenever possible.

Serious and Violent Crime

An ongoing work-stream is the multi-agency Serious and Violent Crime Strategy. During 2019-20 the board will continue to work with all the other key partnerships across Hertfordshire to deliver a strategic approach to this emerging issue. The following points outline the HSAB’s focus for the coming year:

- We will commit to the early identification of vulnerable people and types of vulnerabilities of those at risk of involvement in serious violence through a consistent assessment process.
- People identified through a consistent assessment process will receive multi-agency support at the appropriate level.
- All staff in contact with vulnerable adults will be made aware of the impact of Adverse Childhood Experiences (ACE’s) and be able to deliver appropriate interventions.
- Develop a joint learning package on exploitation with the Hertfordshire Safeguarding Children’s Partnership and the Domestic Abuse Board.
Subgroup Reports

HSAB continues to delegate responsibility for developing the responses to its Business Plans to its subgroups which report back at Board meetings. HSAB has five subgroups; the Public Engagement Sub-group, the Performance Subgroup, the Learning and Development Subgroup, the Policy & Procedure sub group and the SARs sub group.

The Public Engagement Subgroup

The Public Engagement sub-group met four times in 2018/19 as a whole group. In addition there were smaller task and finish groups that met throughout the year to undertake specific pieces of work in relation to the key priorities.

Membership

- East and North Herts and Herts Valleys CCGs (Chair)
- Hertfordshire County Council (Communications)
- West Herts Hospital NHS Trust
- Hertsmere District Council (representing all districts)
- Hertfordshire Urgent Care NHS Trust
- Health Watch Hertfordshire
- Hertfordshire Community NHS Trust
- Hertfordshire County Council (Adults Safeguarding)
- POhWER
- Hertfordshire Care Providers Association
- Hertfordshire Constabulary
- Hertfordshire County Council (Adult Care Services)

Achievements

- Successfully publicised world elder abuse day
- Effectively delivered the public engagement strategy
- Increased the number of referrals as a result of effective dissemination of updated awareness raising materials
- Theme based awareness campaigns promoted around self-neglect and domestic abuse, financial abuse and scamming
- Dissemination of awareness raising materials to targeted vulnerable groups within areas of concern and high priority

Challenges

- Maintaining engagement and proactive membership within the group, due to sub group members additional work loads.
- Achieving effective outcomes from campaign planning and having motivated participation within the group

Objectives 2019/2020

- Development of patient/person focused stories to incorporate making safeguarding personal within awareness raising materials and campaigns
- Change the format of the sub group. This will involve a permanent sub group strategic membership whilst inviting other individuals into task and finish groups in order to support focused campaigns that will be planned at the strategic group. This group will meet 3 times throughout the year. This will include world elder abuse day, domestic abuse and Honour based violence.
- Continue to target specific geographical areas to raise awareness
- Continue to promote safeguarding awareness to vulnerable groups including producing easy read materials for patients/groups with learning disabilities.

Bonita Sparkes
Chair of the Public Engagement Sub group
April 2019
The Learning and Development Subgroup

The Learning and Development sub-group has been very active during 2018/19, meeting four times. There were various smaller task and finish groups that met throughout the year to undertake specific pieces of work in relation to the key priorities.

Membership
- Hertfordshire Community NHS Trust (Chair)
- Hertfordshire Constabulary
- East and North Herts NHS Trust
- Hertfordshire Partnership Foundation Trust
- East and North Herts and Herts Valleys CCG (Vice Chair)
- Hertfordshire Care Providers Association
- West Hertfordshire Hospital NHS Trust
- Hertfordshire County Council (Learning and Development Team)
- Hertfordshire County Council (Adult Disability Team)
- Hertsmere District Council (representing all districts)
- National Probation Service
- Hertfordshire Fire and Rescue Service

Achievements
- The HSAB hosted a Safeguarding Adults conference in June 2018 to coincide with World Elder Abuse Awareness Day with a focus on Making Safeguarding Personal.
- Delivery of a multidisciplinary training programme, including some training in conjunction with the Hertfordshire Safeguarding Children Board
- Agreement of standard levels of knowledge about Safeguarding Adults for use by partners in development of their training programmes (Workforce Development)
- An On Line training offer (via The Virtual College)
- Delivery of Safeguarding Forums on Coercion and Control and Working with the Gypsy, Traveller and Roma Communities
- Joining with HSCP and DA partners to form a new approach and sub-group to deliver on learning objectives going forward

Priorities for 2019-2020
- Delivery of agreed face to face learning
- Development of adults focused training opportunities – Self-Neglect, Hoarding, Hate Crime and Mental Capacity
- Working with HSCP to deliver learning hubs with front line practitioners
- Deliver Annual Conference on Learning Disabilities
- Deliver a safeguarding conference for Housing Staff
- Project on delivering and embedding learning from reviews across the three partnerships.

Jane Trundle
Chair of the Learning and Development Subgroup
April 2019
The Performance Subgroup

The Performance sub-group met four times in 2018/19 as a whole group. There were various smaller task and finish groups that met throughout the year to undertake specific pieces of work in relation to the key priorities.

Membership
- Hertfordshire County Council (Adult Safeguarding) Chair
- Hertfordshire Urgent Care NHS Trust
- West Hertfordshire Hospital NHS Trust
- Hertfordshire County Council (Community Safety Unit) Vice Chair
- Hertfordshire Partnership Foundation Trust
- Hertfordshire Constabulary
- POhWER
- Hertfordshire Community NHS Trust

Achievements
- A safeguarding performance report was produced for every HSAB meeting.
- An agreed data set is now in place and any trends or anomalies that the group identified were reported to the HSAB.
- The sub group has provided Safeguarding adult’s board with key highlights and detailed analysis to aide in decision making throughout the year.
- The work of the sub group has allowed Safeguarding Adults board, HCC and its key strategic partners to gain a greater understanding of Hertfordshire’s performance versus its national comparators. It has also supported and driven focused analysis work with the Community Safety Unit to gain a greater understating of Hertfordshire’s socio economic and demographic challenges around safeguarding Adults.
- Hertfordshire have worked closely with our mental health Partners HPFT and ensured their systems are both care act complaint and are able to meet statutory reporting requirements for the safeguarding adult’s collection.

Challenges
- Differences in reporting systems between ACS and HPFT have made it difficult to get a consistent picture across all care groups. This is being addressed and HPFT will be mirroring ACS reporting.
- HCC continue to work with HPFT to enable more in depth analysis of Hertfordshire’s Safeguarding data in addition to the statutory requirements.
- Understanding the National picture - Research In Practice and ADASS are working on ensuring a consistent approach to recording.
- Data from partners other than Hertfordshire County Council still needs to be gathered and incorporated

Priorities for 2019 -2020:
- To fully embed the electronic dashboard and ensure effective analysis of the collected data to inform HSAB’s direction of travel.
- To support any deep dives and audits identified for Safeguarding Adults

Keith Dodd
Chair of the Performance Sub group
April 2019
The Policy & Procedure Subgroup

The Policy and Procedure sub-group met four times in 2018/19 as a whole group. There were various smaller task and finish groups that met throughout the year to undertake specific pieces of work in relation to the key priorities.

Membership
- Hertfordshire Partnership Foundation Trust (Chair)
- West Hertfordshire Hospital NHS Trust
- East and North Herts NHS Trust
- Hertfordshire Care Providers Association
- Hertfordshire County Council (Learning and Development Team)
- Hertfordshire County Council (Adults Safeguarding)
- Hertfordshire Community NHS Trust
- East and North Herts and Herts Valleys CCGs
- Change, Grow, Live (CGL)
- Hertfordshire County Council (Adult Care Services)
- Hertfordshire County Council (Community Protection)

Achievements
The main focus of this group over the last year was to implement the recommendations from two Serious Adult Reviews. The key areas were in relation to the management and co-ordination of complex cases, risk assessment, risk management and escalation and working with self-neglect and hoarding. In addition the group has also produced some additional documents for the partnership.

The following actions have been achieved:-
- The launch of the HSAB Self-Neglect and Hoarding Guidance
- The production of complex case guidance
- The development of a Board Escalation Guide
- A review of SAR Guidance for practitioners
- The delivery of a Supervision Guide for organisations across Hertfordshire
- A review of key appendices in the Safeguarding Procedures – Domestic Abuse and MAPPA

Challenges
- Identifying appropriate persons and achieving engagement with district councils and housing providers to agree a standard guidance document that can be used across all partners.

Priorities for 2018 -2020:
- The review of the Board’s Information Sharing Agreement
- A Full Review of the Safeguarding Adults Policy and Procedure documentation

Kate Linhart
Chair of Policy & Procedure Sub Group
April 2019
Safeguarding Adults Reviews Subgroup

The Safeguarding Adult Review sub-group met eight times in 2018/19 as a whole group. There were various smaller task and finish groups that met throughout the year to undertake specific pieces of work in relation to the key priorities. The group’s objectives are to ensure that recommendations from SARs both locally and nationally are effectively followed through in Hertfordshire and that actions are completed and learning is embedded into practice.

The group also seeks assurance that all agencies and practices understand their role and the expectations of participation in Safeguarding Adults Reviews under the Care Act and support the involvement of their staff at all levels in the Adult Case Review process.

Membership
- East and North Herts and Herts Valleys CCGs [Chair]
- Hertfordshire Constabulary [Vice-Chair]
- Hertfordshire Partnership Foundation Trust
- West Herts Hospital NHS Trust
- Hertfordshire Community NHS Trust
- Hertfordshire County Council [Adult Safeguarding]
- Hertfordshire County Council [Legal Services]
- National Probation Service
- Hertfordshire County Council [Children’s Services]
- Hertfordshire County Council [Adult Care Services]

Achievements
- There have been 8 referrals for SAR’s during this year. To date there have been a total of 26 referrals; since the Act came in 2015. Only four of these have become a SAR, and three [which did not meet the criteria] became partnership reviews.
- Develop of an easy read guide for practitioners on what constitutes a Serious Adult Review
- Review of leaflet for families
- Development of a triage system and governance structure within the Business Unit to assess SAR’s

Challenges
- Although there is good representation and attendance from agencies at the SAR Sub Group there is limited engagement and commitment from some of the attendees.

Priorities for 2019 -2020:
- To review governance arrangements for SAR sub-group
- Implement systems for quality markers for SARs
- Develop a toolkit for practitioners involved in SARs
- In conjunction with the Learning and Development sub-group to produce key learnings from SARs (local and national) which can be delivered across the partnership using various mediums

Tracey Cooper
Chair Safeguarding Adults Review Sub Group
April 2019
Glossary and acronyms

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

**Adult at risk** means adults who need community care services because of mental or other disability, age or illness and who are, or may be unable, to take care of themselves against significant harm or exploitation. The term replaces ‘vulnerable adult’.

**Advocacy** is taking action to help people say what they want, secure their rights, represent their interests and obtain services they need.

**Concern** is a worry that an adult at risk is or may be a victim of abuse or neglect. A concern may be a result of a disclosure, an incident, or other signs or indicators.

**Capacity** is the ability to make a decision about a particular matter at the time the decision needs to be made.

**Care setting/services** includes health care, nursing care, social care, domiciliary care, social activities, support setting, emotional support, housing support, emergency housing, befriending and advice services and services provided in someone’s own home.

**Carer** refers to unpaid carers, for example, relatives or friends of the adult at risk. Paid workers, including personal assistants, whose job title may be ‘carer’, are called ‘staff’.

**CMHTs** (community mental health teams) are made up of professionals and support staff that provide specialist mental health services to people within their community.

**Consent** is the voluntary and continuing permission of the person to the intervention based on an adequate knowledge of the purpose, nature, likely effects and risks of that intervention, including the likelihood of its success and any alternatives to it.

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

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

**DAISU (Domestic Abuse, Investigation and Safeguarding Unit)** – Herts Police Team investigation allegations of domestic abuse where there is an intimate relationship.

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

**DSL (Designated Safeguarding Lead)**

**Enquiry** establishes whether any action needs to be taken to stop or prevent abuse or neglect, and if so, what action and by whom the action is taken.
IMCA (Independent Mental Capacity Advocate) established by the Mental Capacity Act (MCA) 2005 IMCAs are mainly instructed to represent people where there is no one independent of services, such as family or friend, who is able to represent them. IMCAs are a legal safeguard for people who lack the mental capacity to make specific important decisions about where they live, serious medical treatment options, care reviews or adult safeguarding concerns.

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

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

Making Safeguarding Personal is about person centred and outcome focussed practice. It is how professionals are assured by adults at risk that they have made a difference to people by taking action on what matters to people, and is personal and meaningful to them.

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

Modern Slavery encompasses slavery, human trafficking, forced labour and domestic servitude. Traffickers and slave masters use whatever means they have at their disposal to coerce, deceive and force individuals into a life of abuse, servitude and inhumane treatment.

Person alleged to cause the harm is the person or adult who is alleged to have caused the abuse or harm.

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.

Safeguarding adults is used to describe all work to help adults at risk stay safe from significant harm. It replaces the term ‘adult protection’.

Safeguarding adults review is undertaken by Hertfordshire Safeguarding Adult Board when a serious case of adult abuse takes place. This is a requirement of the Care Act 2014 and the aim is that agencies and individuals to learn lessons to improve the way in which they work.

SI (Serious Incident) is a term used by the National Patient Safety Agency (NPSA) in its national framework for serious incidents in the NHS requiring investigation. It is defined as an incident that occurred in relation to NHS-funded services resulting in serious harm or unexpected or avoidable death of one or more patients, staff, visitors or members of the public.

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

Wilful neglect is an intentional or deliberate omission or failure to carry out an act of care by someone who has care of a person who lacks capacity to care for themselves.
### Appendix 1 – Board meeting attendance for April 2018: March 2019

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<th>Agency</th>
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<td>Head of Adult Safeguarding; Sub group Chair</td>
<td>YES</td>
<td>Represented</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>East of England Ambulance Service</td>
<td>Head of Service</td>
<td>YES</td>
<td>YES</td>
<td>Apologies</td>
<td>YES</td>
</tr>
<tr>
<td>MH Prison The Mount</td>
<td>Head of Service</td>
<td>YES</td>
<td>Apologies</td>
<td>YES</td>
<td>Apologies</td>
</tr>
</tbody>
</table>
Appendix 2 – Learning Hub Feedback: You Said, We Did

**Learning Hub: Gangs and Knife Crime**
*“You Said, We Did” Feedback July 2019*

In March 2019, front line practitioners fed back their thoughts and ideas about how multi-agency partners could work better together to keep children and vulnerable adults safe from gangs and knife crime in Hertfordshire. This is what happened with your feedback:

<table>
<thead>
<tr>
<th>You said….</th>
<th>We did….</th>
</tr>
</thead>
<tbody>
<tr>
<td>Young people and vulnerable adults should be supported and encouraged to report issues anonymously.</td>
<td>We identified <a href="http://www.fearless.org">www.fearless.org</a> as an effective anonymous reporting mechanism, aimed at young people. A county wide launch of Fearless.org will take place soon.</td>
</tr>
<tr>
<td>There is an effective partnership approach to safeguarding children and lots of good services, but clearer pathways and information about available services is needed.</td>
<td>Work is underway to ensure there is an effective single online portal to services in the county, and this will capture all diversionary and activities and gangs related support services. See the current Families First portal here.</td>
</tr>
<tr>
<td>There is a need to ensure adequate funding for timely interventions and services for the different level of risk, as well as diversionary activities.</td>
<td>We are looking at the new funding streams coming on line from government and local agencies will be working together on bids to increase the chances of success.</td>
</tr>
<tr>
<td>It is important to prevent young people from becoming involved through education and raising awareness at an early age.</td>
<td>An education toolkit is being developed and will be promoted to all schools in Hertfordshire. The Police Gangs and School team are also supporting schools.</td>
</tr>
<tr>
<td>It can be challenging to engage parents and young people in interventions, particularly at the stage when they are voluntary.</td>
<td>This is often difficult, and we encourage all agencies to adopt a holistic approach to family issues, in order to secure engagement as far as possible.</td>
</tr>
<tr>
<td>Parenting is a key contributing factor, with improving parental awareness an important area to look at.</td>
<td>Families First, the Gangs and Schools team and Targeted Youth Support teams are already seeking to do more work directly with parents.</td>
</tr>
<tr>
<td>Awareness and approach to addressing cuckooing and its impact on vulnerable adults is variable across the county.</td>
<td>Police and community safety managers are working to ensure the approach to cuckooing becomes more consistent, with support from the Safeguarding Adults Board.</td>
</tr>
<tr>
<td>Young people not attending school are very vulnerable to becoming involved in gangs and knife crime.</td>
<td>Active work to address this is ongoing with integration officers, Targeted Youth Support and the Gangs and Schools team. We are also addressing the Timpson Review of School Exclusions.</td>
</tr>
</tbody>
</table>
Hertfordshire Adult Care Services – 2018-19 Safeguarding Adults

Every Year Hertfordshire County Councils Adult Care Services submits the Safeguarding Adults Collection (SAC). The Collection monitors new safeguarding activity for the financial year. It references "Concerns" & "Enquiries" Started and Ended in the year. A Safeguarding Concern is "A sign of suspected abuse or neglect that is reported to the local authority or identified by the local authority" An Enquiry is "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 to a more formal multi-agency plan or course of action."

9,504 Safeguarding Concerns Started

9.4% compared to 2017 - 18
Involved 7154 Clients
This equates to a rate of 1044 concerns per 100k population

Conversion Rate 59% (2017-18 59%)

Type of Abuse

<table>
<thead>
<tr>
<th>18-19</th>
<th>17-18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Modern Slavery</td>
<td>(0.1%)</td>
</tr>
<tr>
<td>Sexual Exploitation</td>
<td>(0.5%)</td>
</tr>
<tr>
<td>Discrimination</td>
<td>(1%)</td>
</tr>
<tr>
<td>Sexual Abuse</td>
<td>(10%)</td>
</tr>
<tr>
<td>Domestic Abuse</td>
<td>(10%)</td>
</tr>
<tr>
<td>Self Neglect</td>
<td>(10%)</td>
</tr>
<tr>
<td>Organisational Abuse</td>
<td>(13%)</td>
</tr>
<tr>
<td>Financial &amp; Material</td>
<td>(14%)</td>
</tr>
<tr>
<td>Psychological</td>
<td>(17%)</td>
</tr>
<tr>
<td>Physical</td>
<td>(31%)</td>
</tr>
<tr>
<td>Neglect &amp; Omission</td>
<td>(60%)</td>
</tr>
</tbody>
</table>

Location of Abuse

- Own Home 46%
- Residential/Nursing Home 35%
- Hospital 9%
- Community 6%
- Other 4%

Source of Abuse

- Service Provider 33%
- Known to Person 55%
- Unknown to Person 12%

5,654 progressed to a Safeguarding Inquiry

9.6% compared to 2017 - 18
Involved 4,499 Clients

Source of Referral*

- Social Care Staff 36%
- Health Staff/GP 33%
- Family, Friend or Neighbour 7%
- Other 24%

Making Safeguarding Personal*

84% of clients involved in a safeguarding adults enquiry were asked what their desired outcomes were, with 16% either not asked or not recorded.

Of those who expressed outcomes, 96% had their outcomes fully or partially achieved.

84% 19% 4%

76%

Safeguarding Outcome*

Of those enquiries with an outcome recorded, 47% were substantiated or partially substantiated.

- Concern Substantiated/Partially Substantiated 47%
- Concern Unsubstantiated 25%
- Enquiry ceased at individuals request 16%
- Concern Inconclusive 12%

76% of clients had only 1 referral recorded within 2018-19. 22% had between 2 and 4 referrals, whilst 1.3% had more than 5 referrals recorded within 2018-19.*

42% of concerns involved an adult aged 18-64, with 58% involving an adult aged 65+.

9.5% of concerns involved a female adult, with 41% involving a male adult.

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Essential Information

Annual Report compiled in July 2019 on behalf of the Hertfordshire Safeguarding Adult Board by:

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Approved by the Strategic Board in 25/09/2019

Available on HSAB web site: 26/09/2019