Agenda Item 9

Report to:	**Adult Social Care and Community Safety Scrutiny Committee**
Date:	**5 September 2013**
By:	**Director of Adult Social Care and Health**
Title of report::	**Safeguarding Adults at Risk Annual report**
Purpose of report:	**To update the Adult Social Care Scrutiny Committee on the Safeguarding Adults Annual Report April 2012 – March 2013.**

RECOMMENDATION:

The Committee is recommended to consider and comment on the East Sussex Safeguarding Adults Board Annual Report April 2012 – March 2013

1. Financial Appraisal

1.1 There are no financial implications arising from the report

2. Background and Supporting Information

2.1 This report advises the Scrutiny Committee on work undertaken by the East Sussex Safeguarding Adults Board (SAB) during 2012-13. Attached at Appendix 1 is the Annual Report of the East Sussex SAB. The report provides an overview of its achievements and gives an opportunity to reflect on the Board's performance and future plans. The range of activities and achievements reflects the commitment across the partnership.

2.2 The key issues addressed by the SAB in 2012-13 were as follows:

- Extensive developmental work which focuses safeguarding planning and investigations on the wishes and safety of adults at risk.
- Revision of the Safeguarding Performance Quality Assurance Framework to draw together data, audit and feedback to inform monitoring and continuous improvement.
- Updating of the safeguarding policy and procedures to ensure the desired outcome for adults at risk themselves is central and to ensure the inclusion of views of all relevant parties.
- Commissioners of services are more engaged in the workstreams of SAB subgroups.
- Regular, close links established with the other relevant Boards and strategic agendas such as the Local Safeguarding Children Board and Safer Communities Partnership agenda.
- Preventive projects and guidance to reduce harm and abuse has occurred in relation to financial abuse and fire safety.
- Information about raising awareness and safety from abuse which has been tailored to the needs of stakeholders has been updated and promoted.
- A focused training programme which has been informed by recent national and local drivers as well as feedback from stakeholders
- An advisory group has been established to create a two-way link between clients and carers and the strategic agenda of the SAB

2.3 The work of the SAB has continued to focus on partnership working and prevention which has been progressed through the subgroups of the SAB and workshops have been held to enhance the links between partner agencies.

2.4 The annual report also includes statistical information regarding adult safeguarding activity for this period. This is summarised as follows:

- There is a 34% increase in alerts raised against the number of alerts reported during 2011/12. Of the 3,301 alerts that were raised, 1,318 went on to be investigated. Operational teams have been prioritising safeguarding investigations alongside other work priorities to manage the increase.
- The proportion of investigations relating to neglect has increased considerably from 30% to 37%. This increase follows the introduction of the multi-agency pressure ulcer policy which states that alerts received for some pressure ulcers would meet the threshold for a safeguarding investigation.
- Within the adult at risk's own home, the most common type of abuse is financial abuse, accounting for 41% of all cases. As a result, a raising awareness campaign is underway which focuses on issues relating to financial abuse. A financial abuse toolkit has also been developed to ensure awareness of the issues relating to financial abuse, including the more sophisticated forms of fraud.

2.5 There were no Serious Case Reviews during the period 2012-13; however, a multi-agency review was undertaken in relation to harm through self-neglect of a person living in the community. The learning from the review is being progressed through the subgroups, which includes raising awareness of the issues of self-neglect for vulnerable adults.

2.6 A multi-agency audit took place in November 2012 and reflected improvements in areas such as a proportionate response to investigations and improved engagement between stakeholders. Areas for future development were identified and include improving the quality of mental capacity assessments, the correct identification of adult at risk of abuse and using the most appropriate pathway to achieve the best outcomes for individuals.

3. Conclusion

3.1 This report describes the activity of the SAB to ensure there are effective measures in place to safeguard adults at risk in East Sussex. It details much of what has been achieved, set against specific objectives, but also recognises there is more to do in the future. The anticipated new legislation in relation to adult care and support will provide a formal mandate for adult safeguarding and for SABs, with statutory requirements to ensure their ongoing effectiveness and accountability. A tool has also been developed for SAB partners to self-audit their strategic and organisational safeguarding arrangements to ensure it maintains its commitment and focus to working together to prevent abuse from happening.

KEITH HINKLEY
Director of Adult Social Services and Health

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Local Member(s): All
Background Documents: None

Appendix 1

East Sussex Safeguarding Adults Board

Annual Report
April 2012 – March 2013

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Foreword

As Chair of the East Sussex Safeguarding Adults Board (SAB), I am responsible for ensuring that the partnership is effective in reducing harm to adults at risk from neglect and abuse. Each year, the Annual Report provides the SAB with an overview of everything which has been achieved in relation to safeguarding adults and the opportunity to reflect on the Board's performance and plan for the forthcoming year.

Over the past 12 months, the achievements of the Board have been considerable and reflect the strength of commitment and quality of relationships across the partnership. Important milestones have been achieved in each area of the identified work streams reflecting significant efforts on the part of both individuals and organisations across the county. The Board has shown its continued commitment to working with adults who are at risk of harm, developing and improving services to investigate neglect and abuse, and to protect people.

Our increasing engagement with those people who have experienced abuse or neglect and the subsequent safeguarding work, which enables our future practice and development to be shaped by their personal experiences, is extremely important. We need feedback on an ongoing basis from those who experience safeguarding to ensure we keep well-informed about what works best for those who need our services, and what we need to achieve to meet their expectations and aspirations. We also need to ensure that our responses to concerns raised are just and fair for all involved.

The Board is determined to ensure that every resident of East Sussex has the right to live a life free from abuse and to feel safe. It is committed to continuing to raise public awareness about safeguarding vulnerable adults and what to do when someone has a safeguarding concern. The Board recognises that some people find it difficult to protect themselves from harm without some support, and is committed to driving up standards and ensuring that when concerns arise individuals get the most supportive and skilled response.

The seriousness of these issues means that despite our achievements we can never be complacent. We see the number of people requiring support to safeguard themselves continuing to increase each year, and our developments strengthen our ability to safeguard the rights and safety of those in need of our support. We have set ourselves ambitious targets for 2013-14, as we remain committed to safeguarding the rights and safety of our citizens.

Finally, I would like to extend my thanks to Board members and to all those people and organisations across East Sussex, including the statutory, independent, voluntary and community sectors, who have helped us to achieve all that we have in the last twelve months, and will, I am sure, help us to achieve our plans for the forthcoming year.

Keith Hinkley
Director, Adult Social Care, East Sussex County Council

National context

Adult Social Care is going through many changes and facing new challenges. Financial constraints together with changes to the legislative framework and new Government guidance are impacting increasingly on the day-to-day work of frontline staff and management.

In 2011, the Government announced its intention to place Safeguarding Adults Boards on a statutory footing. This statement also set out the key principles that local authorities and their partners should use to establish and evaluate their adult safeguarding policies.

The White Paper and Care and Support Bill re-affirms the intention to make Safeguarding Adults Boards statutory. There is also an expectation that existing SABs will deliver effective local safeguarding arrangements within current resources.

The Government has published a consultation on the Care and Support Bill as well as a consultation on power of entry for social workers in safeguarding cases. It has recently published the decision not to introduce power of entry for social workers.

There is also more of a focus on better outcomes for individuals by balancing protection from harm with the need for individuals to exercise choice and control over how they live.

The Police Reform and Social Responsibility Act introduced the new Police & Crime Commissions which became effective from November 2012. The Government is seeking to ensure the public are able to set the direction of their policy and hold the Police to account.

Local context

Raising awareness of fire-related harm

Following an increase in the number of fire-related deaths of people in vulnerable situations in the community last year in East Sussex, the SAB agreed that a multi-agency response was required.

A multi-agency group comprising a wide range of partner organisations and agencies was established. Organisations represented on the group include Sussex Police, an independent home care provider, East Sussex Healthcare NHS Trust, East Sussex Fire & Rescue Services (ESFRS), Adult Social Care (ASC), Wellbeing (Telecare), Trading Standards and Sussex Partnership NHS Foundation Trust. The main focus of the group was to raise awareness of the risks of fire-related harm with the aim of increasing both the numbers of home safety visits by ESFRS to people in vulnerable situations and the uptake of the ESFRS Care Provider Safety Scheme.

In addition to publicity and training, work was completed to improve the ASC referral process for home safety visits by ESFRS. A mandatory requirement for fire awareness training within ASC home care contracts was also introduced. Joint working between ESFRS and ASC was enhanced through targeted sharing of information to increase referrals for home fire safety visits.

The increase in accidental fire-related deaths within the community has not been evidenced so far this year. However, actions to promote the safety of clients, to maximise awareness and training continue in order to reduce the risk of harm from accidental fires for the most vulnerable people in the community.

Domestic Homicide Review Action Plan

A multi-agency Domestic Homicide Review Action Plan has been developed to strengthen the response of all agencies participating in domestic homicide reviews. Board partners contributed to the content of the action plan to ensure there is a cohesive plan in place in the event of a review being required following a domestic homicide.

Annual multi-agency audit

The annual multi-agency audit on behalf of the SAB took place in November 2012. The auditors represented Sussex Police, Sussex Partnership NHS Foundation Trust, ASC and East Sussex Healthcare NHS Trust.

The audit reflected improvements in several areas such as proportionality of response and more active engagement with all stakeholders. Some areas for further development were identified: improving the quality of mental capacity assessments, and ensuring the correct identification of adults at risk and using the appropriate referral pathways in as timely a way as possible in order to achieve the best safeguarding response and outcome for individuals.

The mechanism used by the auditors to undertake the annual audit proved to be more effective than last year. It was noted by all parties that there was a willingness and openness from all agencies to identify learning within a shared environment. The multi-agency audit has demonstrated again that it is a useful tool for continuous improvement in safeguarding practice.

Serious case review

An application was received by the SAB for a serious case review in relation to harm through neglect of a person living in the community. A panel was convened representing relevant partners from the SAB. The decision was made that a proportionate response to this application was required and a multi-agency review should be undertaken by the SAB. This will be reported on later in 2013.

Campaigns to raise awareness of safeguarding

The SAB agreed that the Speak Up, Speak Out campaign would be refreshed and targeted to specific areas of need identified by available data. The campaign has been developed with three separate strands which complement each other. These are GPs and GP practices, home care providers and financial abuse. Some workshops and pilot training events have taken place, and information and publicity materials have been developed and were launched at the SAB Safeguarding Conference on 25 June 2013.

Information sharing protocol

The comprehensive review of the East Sussex SAB in August 2011 identified that a formal information sharing protocol was required to support the work of the SAB. The Operational Practice sub-group developed an information sharing protocol which provides a mechanism for the exchange of information between the partners of the SAB. It does not give an automatic right to receive information or a requirement to provide information but it creates a formal process through which information can be shared with the aim of safeguarding adults at risk of harm in East Sussex.

The protocol covers the key components required in an agreement to share information within the arena of safeguarding. This includes the principles of information sharing including legislation and guidance relating to data, the rights and welfare of people, types of information and measures for its security and storage. The protocol was agreed and implemented by the Board in October 2012.

Future of the East Sussex Safeguarding Adults Board

The Care and Support Bill gives local authorities a formal mandate for safeguarding adults. Local authorities will continue to have the lead role in establishing and maintaining Safeguarding Adults Boards which must comprise representatives from Adult Social Care, the National Health Service (NHS), the Police and other agencies dependent on local agreement.

The Bill specifies the following functions for the SAB:

- To keep under review the policies and practices of public bodies which relate to adult safeguarding.
- To provide advice or information, or make proposals, to any public body on the exercise of functions which relate to safeguarding adults.
- To improve the skills and knowledge of staff who have responsibilities relating to safeguarding adults.
- To produce a report every two years on the exercise of the functions of the SAB.
- To commission serious case reviews and contribute to these reviews.

The new legislation will, for the first time, place a duty on local authorities to make enquiries, or ensure enquiries are made, into suspected cases of abuse.

The terms of reference of the SAB will be reviewed to take account of changes in partner organisations such as the creation of the Clinical Commissioning Groups, Healthwatch and changes within other Boards such as the Health & Well-Being Board.

Development work will be undertaken in order for the Board to be able to demonstrate its efficiency and efficacy in protecting adults at risk of harm in East Sussex.

Safeguarding within prisons

Following the publication of the Prisoners and Safeguarding Advice Note in April 2012 by the Association of Directors of Adult Social Services, the Safeguarding Adults Board agreed in October 2012 to link with Lewes prison which is the only prison within East Sussex.

Meetings have been held between senior leads within Safer Custody, HMP Training and Probation Services and the Head of Service (Safeguarding) in Adult Social Care to discuss the issues regarding prisoners and safeguarding, and to develop the relationship between the prison and the Safeguarding Adults Board. Plans were agreed to develop links between the prison and the Board and its sub-groups, and information, training materials and case scenarios were shared with the prison.

Safeguarding Adults Board

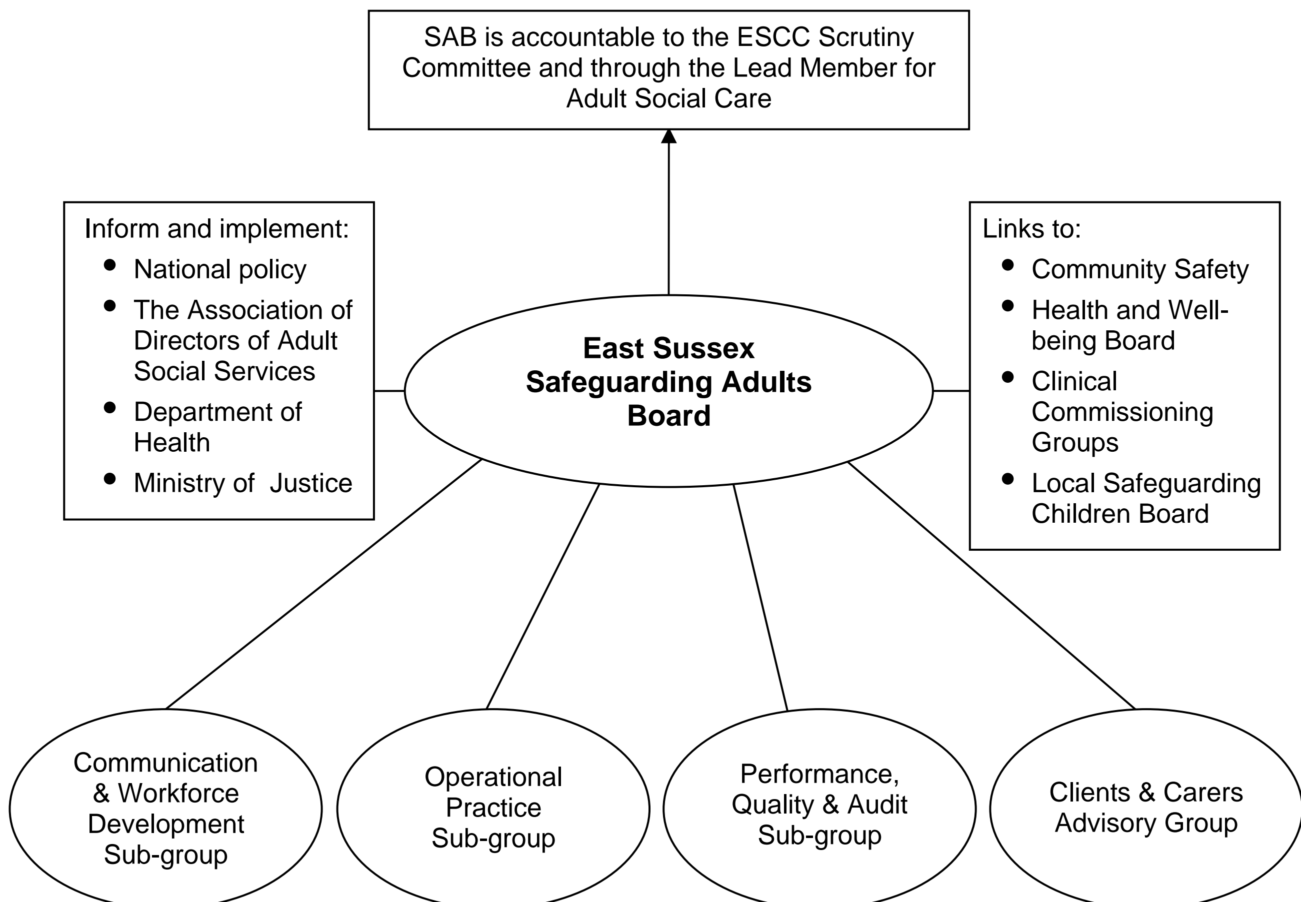
Governance

The East Sussex Safeguarding Adults Board (SAB) is accountable to the East Sussex County Council Scrutiny Committee and through the Lead Member for Adult Social Care. The Board produces a quarterly report for consideration by the Lead Member and an annual report available to partner Boards and other agencies.

The SAB Work Plan sets out the key themes and priorities for the Board from 2012 to 2014. Progress on key priorities is reported through the following sub-groups:

- Operational Practice sub-group
- Communication & Workforce Development sub-group
- Performance, Quality & Audit sub-group

Short-life groups are also established, as required, to undertake specific functions or work projects including Serious Case Reviews.



Priorities for the SAB 2012-2014

Activity has continued over the past year on the SAB priorities. These are:

- Focusing on outcomes and making safeguarding personal.
- Developing performance measures that focus on quality and outcomes reflecting the work that has been undertaken – what difference did we make?
- Developing a portfolio of responses to safeguarding circumstances that aim to bring both safety and people's wishes together.
- Developing a cross-system understanding of service quality, avoiding service failure.
- Ensuring a preventive approach to safeguarding activity.
- Ensuring that people are aware of safeguarding and know what to do if they have a concern.
- Ensuring people involved in safeguarding have the appropriate skills and knowledge to make sure that personalisation and safeguarding are two sides of the same coin.
- Involving clients and carers in the strategic agenda of the SAB.

Progress on the priorities

Progress has been made through concerted work within the sub-groups of the SAB including:

- Extensive developmental work which focuses safeguarding planning and investigations on the wishes and safety of adults at risk.
- Revision of the Safeguarding Performance Quality Assurance Framework to draw together data, audits and feedback to inform monitoring and continuous improvement.
- Updating of the policy and procedures to ensure the desired outcome for adults at risk is central and to ensure the views of all relevant parties are considered.
- Workshops and guidance to enhance the links between agencies and organisations to further partnership working are in development.
- Commissioners of services have engaged with the work streams of SAB sub-groups.
- Regular, close links have been established with other relevant Boards.
- Preventative projects and guidance have been developed to reduce the risk of harm and abuse in relation to financial abuse and fire safety.
- Information to raise awareness which has been tailored to the needs of stakeholders has been updated and promoted.
- A focused training programme which is regularly informed by national and local drivers and feedback has been established.

- An advisory group has been established to create a two-way link between clients and carers and the strategic agenda of the SAB.

Details of the progress made on the agreed priorities to 2014 are included in the SAB Work Plan (see Appendix 1).

Clients & Carers Advisory Group

Connecting clients and carers to the SAB strategic agenda is one of the key priorities of the SAB. Activity to progress this has been undertaken on behalf of the SAB.

Members of partnership boards in East Sussex were invited to volunteer to join a focus group to explore how connections could be made between clients and carers and the SAB.

The focus group agreed it was important for these links to be made so that the voice of clients and carers could be represented within the SAB. It was acknowledged that it would be a challenge to achieve this, and that a number of different channels and methods which take into account the sensitivity and complexity of adult safeguarding would have to be explored to enable this to happen.

It was concluded that a group made up of professionals and lay people should provide the link with the SAB, and that different types of engagement were needed in the medium term.

Following the focus group, an Advisory Group has now been established with a broad range of membership including voluntary and statutory organisations. The group meets quarterly to discuss key safeguarding issues raised by clients and carers who are connected to the organisations represented on the group, and there is a mechanism to share key messages from the SAB with these clients / carers. Activity so far has included an in-depth examination of feedback from clients and carers, and a consultation on new publicity materials for the safeguarding awareness raising campaign.

Performance, Quality and Audit (PQA) Sub-group

Safeguarding adults activity undertaken between 1st April 2012 to 31st March 2013

The key principle of the group is to establish systems for monitoring, reporting and evaluation of performance across organisations, linking annual reporting to improvement planning and a measurable work programme.

The group is responsible for:

- Reviewing available data from key agencies to inform annual priority setting for the Safeguarding Adults Board.
- Devising performance improvement actions to be incorporated into annual work programmes.
- Considering outcomes from clients and carers' experiences of safeguarding, including complaints and compliments, and ensuring they influence service improvements.
- Considering outcomes from the rolling user survey, case file audits and the multi-agency audits.
- Overseeing the Adult Case Review action plans, disseminating learning and ensuring integration of recommendations into appropriate service plans.
- Considering outcomes from Care Governance Panels and making recommendations for improvement (including reporting news from complex investigations).

Key developments, achievements and work in safeguarding

Following the review of the Performance Quality & Audit Framework (PQAF), the sub-group's action plan was reviewed and updated. Any outstanding actions from the previous plan were drawn into the current action plan.

Progress has been made on a number of key actions for the group. Some of these achievements include:

Priority 1: Develop a quality and outcomes focused set of performance measures

Develop national and local data collection lists and review to ensure all requirements are identified

Both the national and local data collection requirements have been documented to ensure all requirements are met. This has also taken into account the actions that are required as a result of the national Zero Based Review of data requirements.

Run a workshop to identify and create a coherent mechanism to collate and review all available intelligence

A workshop was held during the sub-group's February meeting when a number of new sources of intelligence were identified. Work is currently being undertaken to understand how this new information can be used to identify areas for further development and provide a more holistic view of the safeguarding and prevention agendas within East Sussex. This information will be presented to the Board in January 2014 through the mid-year Performance, Quality and Audit feedback report.

Increase the number of stakeholder feedback questionnaires circulated by Adult Social Care

In July 2012 a pilot was undertaken to obtain stakeholder feedback. 72 questionnaires were sent out and 10 responses were received. This project is now ongoing, focusing on specific localities for three month periods beginning with Lewes and Wealden Assessment and Care Management. The project is also being expanded to include all levels of response (1,2,3 and 4) as this will help to maximise opportunities for feedback.

Priority 2: Develop a whole systems understanding of service quality to avoid service failures

Define the quality standards for care

The quality standards are defined using the Adult Social Care Outcomes Toolkit (ASCOT) and the service specification in addition to the Care Quality Commission (CQC) essential standards. We have a continuous improvement programme in place and safeguarding remains the main priority of the Quality Monitoring Team. This work is overseen by the Care Governance Framework.

Priority 5: Establish a link between clients and carers and the strategic agenda of the SAB

Ensure communication and links with the CCSN advisory group activity

The chair of the Client and Carer Safeguarding Network Advisory Group (CCSN) is a member of the PQA sub-group and ensures that the links between the CCSN Advisory Group and the sub-group are maintained.

Priority 6: Ensure the efficiency, effectiveness and cohesiveness of the Board to deliver on its safeguarding objectives to the people of East Sussex

Ensure that policies regarding domestic abuse and safeguarding are strategically aligned

A group was set up to oversee the Domestic Homicide Action Plan. One of the recommendations from this group was that the safeguarding adults policy should state that the domestic abuse risk assessment toolkit should be used in domestic abuse cases. This recommendation was discussed with Brighton & Hove and West Sussex, and the Policy & Procedures updated.

Ensure that learning identified by the SAB, Local Safeguarding Children's Board (LSCB) and Community Safety is shared and embedded.

Links have been established between these Boards and Community Safety through representatives that sit on both Boards, and agendas are informed appropriately.

The Performance, Quality & Audit sub-group has achieved almost all of its targets within the given timescales and continues to make good progress towards its remaining objectives.

Planned developments, future plans and priority areas for 2013/14 and / or beyond

The objectives of the Performance, Quality and Audit sub-group over the forthcoming months are to:

- Review data collections to ensure local and national requirements are met.
- Develop a coherent narrative about safeguarding based on data, audit and feedback.
- Develop mechanisms to ensure the expectations within the PQAF are met.
- Establish an understanding of quality standards and the collective responsibility to challenge unsafe, unacceptable and inappropriate standards of service.
- Develop a process to evaluate and implement lessons learnt in safeguarding practice.
- Review the implementation of the Preventative Strategy.
- Undertake awareness raising targeted through data and feedback.
- Identify roles for clients and carers within the work of the SAB.
- Publish an annual report on the exercise of the Board's functions and its success in achieving its strategic plan.
- Work collaboratively with the Local Safeguarding Children's Board and the Community Safety Partnership on shared concerns.

In addition to the actions identified in the revised PQA action plan, a number of actions within the Safer Communities remit are being aligned where there are shared concerns. Actions being undertaken to improve the identification of domestic abuse and the effectiveness of agency responses include:

- Producing a five year domestic abuse partnership strategy.
- Reviewing the performance framework for domestic abuse.
- Developing and embedding effective risk identification and risk management practice, where domestic abuse is identified.
- Developing early help for all family members, including children, exposed to domestic abuse.
- Ensuring timely implementation of action plans, clear audit trails and effective partnership information sharing to improve the effectiveness of Multi-Agency Risk Assessment Conferences (MARACs).
- Developing and implementing behaviour change interventions for known perpetrators of domestic abuse, whilst supporting those who have been abused and their children.
- Improving the partnership approach to harm reduction through use of learning derived from formal reviews, such as domestic homicide, or serious case reviews.
- Reviewing the skills of the partnership workforce to inform training programmes.

In the future, the Board will receive updates on these actions alongside the PQA action progress.

Operational Practice Sub-group

Safeguarding adults activity undertaken between 1st April 2012 to 31st March 2013

The key principle of this sub-group is to ensure that all contact with adults at risk of abuse is based on our shared responsibilities to prevent, investigate and take action where a safeguarding concern exists. This multi-agency sub-group meets quarterly and its responsibilities include:

- Ensuring clarity, effectiveness and promoting consistency of procedures across organisations.
- Implementing, applying and measuring the effectiveness of the operational application of agreed protocols.
- Providing an active forum for multi-agency operational issues.
- Establishing links with other sub-groups and networks to feed into the development and implementation of their safeguarding adults strategies.
- Developing appropriate services to support individuals through the safeguarding process and identifying any shortfalls.

Key developments, achievements and work in safeguarding

SAB Priority 1: Making safeguarding personal through focusing on outcomes for individuals

The group examined the number of referrals for advocacy support within safeguarding and identified and implemented a range of responses to improve referral rates.

SAB Priority 2: Improve the range of responses to individuals bringing safety and people's wishes together

A gap analysis of current safeguarding responses and an audit of the 'success' rate of safeguarding plans has been completed to inform developmental work within Adult Social Care.

The joint pressure ulcer protocol between East Sussex Healthcare NHS Trust and Adult Social Care was reviewed and updated in line with recent research.

SAB Priority 3: Develop a whole system understanding of service quality to avoid service failures

Commissioners of services are now members of the sub-group and discussions have been initiated on how dignity and compassion in care are linked into service delivery and the safeguarding response within East Sussex.

Guidance has been developed and implemented regarding investigations into institutional abuse.

Objective 4.6.1 from the 2012 SAB work plan

The sub-group developed an Information Sharing Protocol between all agencies of the SAB which has now been implemented.

SAB Priority 4: Ensure a preventative approach to safeguarding is embedded

A representative from Trading Standards joined the sub-group to help us achieve our aim of preventing abuse. In particular, contributing to the SAB's awareness raising campaign in response to the rise in reported cases of financial abuse. A toolkit to assist in identifying and investigating cases of financial abuse was created and implemented through the sub-group.

Planned developments, future plans and priority areas for 2013/14 and / or beyond

The objectives of the Operational Practice Sub-group over the forthcoming months are:

- To contribute to the creation and implementation of a Sussex Multi-Agency Self-Neglect Policy.
- To ensure safeguarding responses across services uphold the principles of dignity and compassion in care.
- To reduce the number of cases of financial abuse.
- To increase awareness of domestic abuse, anti-social behaviour and hate crimes, and provide clarity on appropriate responses to human trafficking, forced marriage and honour-based violence. **SAB Priority 5: Ensure that people are aware of safeguarding and know what to do if they have a concern.**

The sub-group will also be involved in the review and implementation of updated safeguarding competencies and the development of Mental Capacity Act competencies**. SAB Priority 7: ensure that people involved in safeguarding have the appropriate skills and knowledge to deliver a personalised approach.**

The group will continue to strengthen its links with other sub-groups including the Advisory Group to the Client and Carer Safeguarding Network. **SAB Priority 8: Establish a link between clients and carers and strategic agenda of the Board.**

Communications and Workforce Development (CWD) Sub-group

Safeguarding adults activity undertaken between 1st April 2012 to 31st March 2013

This multi-agency group meets quarterly and members of the sub-group contribute to the delivery of outcome focused work programmes which are translated from specified priorities of the SAB,

The CWD sub-group is responsible for the delivery of a range of work streams spanning:

- Workforce development and training.
- Communication and awareness raising.
- Development and implementation of the communications and workforce development aspects of the safeguarding prevention strategy.

All three work streams have a degree of overlap and dependency with each other and are managed as a programme of interrelated activities. The emphasis is on delivery and improving outcomes for adults at risk of harm and abuse.

Key developments, achievements and work in safeguarding

SAB priorities which direct the focus of activity within the sub-group:

1: Making safeguarding personal through focusing on outcomes for individuals.

3: Improve the range of responses to individuals bringing safety and people's wishes together.

5: Ensure a preventive approach to safeguarding is embedded in practice.

6: Ensure people are aware of safeguarding and know what to do if they have a concern.

7: Ensure that people in safeguarding have the appropriate skills and knowledge to deliver a personalised approach.

A comprehensive action plan for the group was created based on these priorities and a wide range of activity has been completed. This includes workshops on safeguarding held at a conference on personalisation in May 2012 which were attended by a range of professionals including providers of services.

Information on alerting was shared at training events for personal assistants. A dementia toolkit was also developed to respond to a noted rise in safeguarding alerts in dementia care homes.

The sub-group leads on the activity of the refreshed 'Speak up, Speak out' safeguarding awareness raising campaign. Three strands of the campaign have been identified which have a separate focus but complement each other. Following analysis of referral rates the campaign has focused on raising awareness within GP practices and home care agencies. Positive professional relationships have been developed through networking events, and workshops and publicity material for both public and professional contexts have been designed.

A campaign to reduce the risk of financial abuse has been researched and planned. A range of articles have been published throughout the year to raise awareness of safeguarding including in Your County magazine and the Support with Confidence Directory.

A popular, general 'Guide to safeguarding and case conferences' has been reviewed and reprinted.

A training programme to promote the use of the domestic abuse, stalking and honour based violence risk tool was developed within the group. Also, a training plan for responding to self-neglect issues has been compiled to follow the creation of a Sussex-wide self-neglect policy.

The group ensures that ongoing feedback from safeguarding practice informs the training programme.

The sub-group has been overseeing the plans for the SAB Safeguarding Conference to be held in June 2013. The programme has a clear focus on prevention of abuse and harm.

A survey of confidence and knowledge of safeguarding by staff was devised and rolled out in ASC.

Safeguarding training

Safeguarding adults at risk training figures
April 1st 2012 – March 31st 2013

E-learning modules (source KWANGO)

Safeguarding adults at risk	April 2012 – March 2013
ESCC	487
Independent care sector	482
PCT	346
Hospital	112

Mental Capacity Act completions	April 2012 – March 2013
ESCC	142
Independent care sector	108
PCT	54
Hospital	5

Deprivation of Liberty completions	April 2012 – March 2013
ESCC	171
Independent care sector	166
PCT	42
Hospital	9

Safeguarding adults at risk courses (source ASC training team)

Course title	Number of courses	Total attendances
Safeguarding Train the Trainer	3	**52**
Safeguarding Refresher	15	**235**
Safeguarding Minute Taking for Administrators	3	**33**
Safeguarding Level 1 Investigations	5	**109**
Safeguarding Investigating Officer Workshop	2	**36**
Safeguarding Investigating Officer Two Day Training	7	**116**
Safeguarding Investigation Manager Reflective Practice Workshop	3	**53**
Safeguarding Basic Awareness	21	**408**
Mental Capacity Act: Who Decides	4	**53**
Mental Capacity Act: An Introduction	9	**197**
Deprivation of Liberty Safeguards: An Introduction	4	**71**
Deprivation of Liberty Safeguards Updates	4	**41**
Assessing under the Mental Capacity Act	6	**89**

Planned developments, future plans and priority areas for 2013/14 and / or beyond

The objectives of the Communications and Workforce Development Sub-group over the forthcoming months are:

- Developing a training programme to support the Mental Capacity Act competency framework.
- Increasing awareness of safeguarding through initiatives such as a postcard giving details of how to report safeguarding concerns.
- Raising awareness of safeguarding adults amongst carers.
- Implementation of learning from responses to hate crime to people with disabilities.
- Multi-agency review of the Safeguarding Competency Framework following internal audit of staff compliance within ASC.

Other information / areas / issues

Any proposals to deliver new or changing Safeguarding Board training priorities, eg. self-neglect training, will consider different models of delivery to ensure cost effectiveness. New and / or changing training requirements will require Board level agreement as not all sub-group members are in a position to commit training funding on behalf of their organisation.

Quality Monitoring Team (QMT) update

Safeguarding adults activity undertaken between 1st April 2012 to 31st March 2013

The Quality Monitoring (QM) Team, Adult Social Care provides background reports on care providers to the investigating team in Level 3 cases. QM is routinely involved in the follow-up to Level 4 investigations, normally monitoring the implementation of the agreed safeguarding action plan. QM on average receives 67 safeguarding referrals a month, the majority of these are Level 1 and 2 investigations with 14% at Level 3 or 4.

QM manages the suspension / lifting suspension process involving care providers, making recommendations for the director's decision, and taking responsibility for informing operational teams and neighbouring local authorities.

Key developments, achievements and work in safeguarding

The key focus for the QMT during April 2012 to April 2013 has been to respond to safeguarding investigations, and to continue to develop a continuous improvement function.

The Adult Social Care Outcomes Toolkit Control (ASCOT) continues to be used when monitoring care homes and there is now a clear way of red, amber, green (RAG) rating the care homes. This is determined by QMT visits to the homes, information gathered by independent interviewers, feedback from clients, complaints, CQC reports and safeguarding investigations which provides a holistic assessment of a service. The QMT focus their resources to work with those with more concerns / higher risks.

Planned developments, future plans and priority areas for 2013/14 and / or beyond

A Clinical Quality Review Nurse (CQRN) is being recruited in conjunction with health teams. The CQRN will have a specific role to monitor and have a strategic overview of the clinical quality of nursing care provided by the residential nursing homes in East Sussex. Through this innovative approach a nurse-led project will be introduced to improve the clinical care on offer to the residents of nursing homes across the county. Integrating the work of a CQRN into the Care Governance Framework will provide a more consistent approach to maximising the use of quality provision in the community.

The QMT will continue to work closely with CQC and develop the operational response building on the already positive relationships with individual inspectors.

There is a new process for monitoring low level safeguarding alerts (Level 1-2) which are recorded if there are three or more in a short period of time (3-4 months). The context is analysed and any similar themes can lead to a focussed visit. A recent example prompted a visit to check if a provider's systems of care regarding challenging behaviour was adequate.

Adult Safeguarding Development Team update

Safeguarding adults activity undertaken between 1st April 2012 to 31st March 2013

The Adult Safeguarding Development Team (ASDT) performs a quality assurance and developmental role for Adult Social Care (ASC).

The team has been engaged in a number of activities this year. Focusing primarily on quality assurance and developmental work with operational teams, there has also been significant developments in strengthening links with external organisations, alongside creating and improving guidance materials.

The independent chairs manage a proportion of case conferences where significant harm has occurred, and where institutional abuse has been identified. They have managed 103 case conferences this year. The chairs offer a level of impartiality to the conference, and are most often utilised where the dynamics of the case require careful and additional management. The chairs by nature of their separation from the investigation have identified wider improvement opportunities in some cases, taking learning forward as part of a safeguarding plan which links to continuous improvements across the health and social care sector.

The ASDT audited 73 safeguarding cases this year. The audit aims to identify and strengthen areas of practice that require development, and identify issues to inform departmental training needs. This is a quality assurance model that assists individual performance and team practice, and is also a measure for the organisation to assess its overall performance.

A pressure ulcer protocol has been introduced and reviewed in partnership with East Sussex Healthcare NHS Trust. This gives Adult Social Care and NHS staff direction on how to manage investigations – to identify how and if neglect may have had an impact on pressure damage. The protocol also offers guidance on how to formulate sustainable prevention plans. This guidance has been invaluable to health and social care staff in relation to recognising and reducing the impact of neglect through omission.

In response to the national increase in financial abuse, the ASDT has introduced a financial abuse toolkit. The toolkit promotes prevention, recognition, improved partnership working, advice and guidance for sharing with clients, and case examples, as well as legal advice and contact numbers of key partners. The aim of the toolkit is to raise the profile of financial abuse and also helps professionals plan investigations.

The ASDT keeps abreast of national policy and ensures that all advice to internal and external customers is up-to-date and appropriate, and this year this included a review of all printed information.

The team assisted Adult Social Care's single point of access by temporarily co-locating with Social Care Direct through a transitional period of change, ensuring that safeguarding adults continued to be prioritised and best practice was maintained.

Key developments, achievements and work in safeguarding

The safeguarding case file audit tool was reviewed and sections referencing client outcomes were added to promote a more outcomes focused approach.

A number of client interviews were undertaken by the safeguarding co-ordinators. The quality of this feedback from clients' experiences is extremely important, not only as a gauge of satisfaction, but also as a reference point for learning. All contributions are analysed and fed into team plans in a bid to promote continuous improvement. The team plans to increase the number of client interviews in the year ahead.

Safeguarding training

Internally, the team has carried out themed reflective workshops with investigation managers, officers and administrators across the county. These have included report writing, decision making, general safeguarding awareness, safeguarding planning, staff competency and auditing.

The team also presents safeguarding awareness for new staff as part of ESCC's quarterly welcome days, and delivers a module to newly qualified social workers in their first year of employment.

Externally, the team has carried out a number of tailored workshops with partner organisations this year. The list of agencies include:

- SAILS (Supported Accommodation & Independent Living Solutions who provide accommodation and support to clients across the county).
- The Troubled Families Programme (partners across the East Sussex Strategic Partnership, including Sussex Police, Job Centre Plus, the NHS and district and borough councils, to help troubled families get back on their feet and create a better future for their children).
- The Alzheimer's Society.
- Age UK.
- Independent support brokers (micro care providers).
- Local church groups.

Planned developments, future plans and priority areas for 2013/14 and / or beyond

The ASDT has contributed to the Sussex Multi-Agency Self-Neglect Policy. The policy is comprehensive and details responsibilities for staff and agencies on how to respond to people who are at risk of significant harm through self-neglect. The policy is due for launch this summer.

A falls and safeguarding toolkit is being developed to assist investigations into falls-related injuries in residential care, nursing home and hospital care settings. The toolkit is designed to promote prevention, and make best use of partner agencies to support individuals who fall, and also assist organisations in managing falls reduction. The toolkit is due for launch in June 2013.

A provider protocol has been developed. This details expectations in relation to safeguarding and outlines the responsibilities and accountabilities of providers, what they can expect from ASC staff, how providers should and can be included at the earliest stage of the investigation, and the benefits of safeguarding plans. This protocol is due for launch in July 2013.

The team is also reviewing staff guidance materials with a view to creating a staff booklet. This guidance will also be available on the intranet.

The team continues to strengthen links with private providers, Sussex police, Clinical Commissioning Groups, Sussex Partnership NHS Foundation Trust and East Sussex Healthcare NHS Trust. The team will be engaging and meeting regularly with these key partners to ensure issues and learning is shared between organisations on a continuing basis.

Audits will continue in the year ahead, but additional focussed audits for specific topics will also be delivered to offer a more sophisticated themed approach to local and national developments.

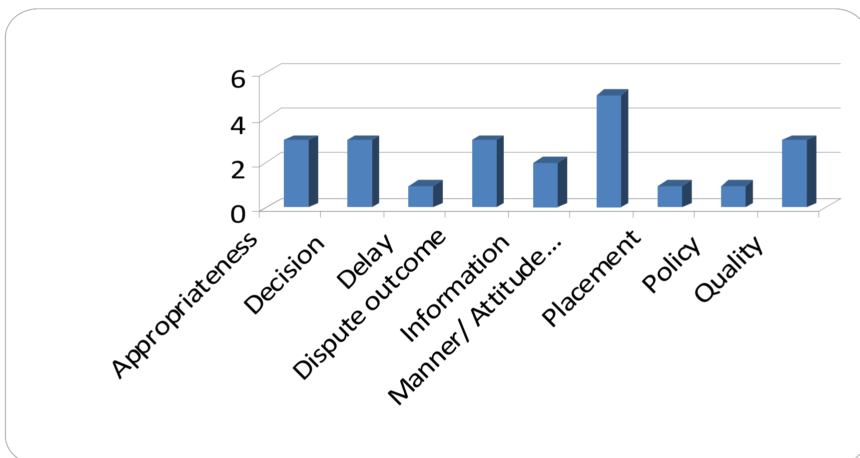
Provider / partnership workshops will be carried out in 2013/14, run jointly between the team and the Residential Care Homes Association. A successful inaugural workshop in Eastbourne delivered positive responses and broke down organisational barriers. The learning from this can be taken to other localities across the county.

Improving stakeholder feedback following an investigation is also scheduled for 2013/14. A questionnaire has been designed to elicit responses from participants in the safeguarding process, and their views will be collated as a way of improving practice, and again this will inform departmental training needs.

In addition to interviews with clients following an investigation, the team will be undertaking face-to-face interviews with partners, carers and other stakeholders.

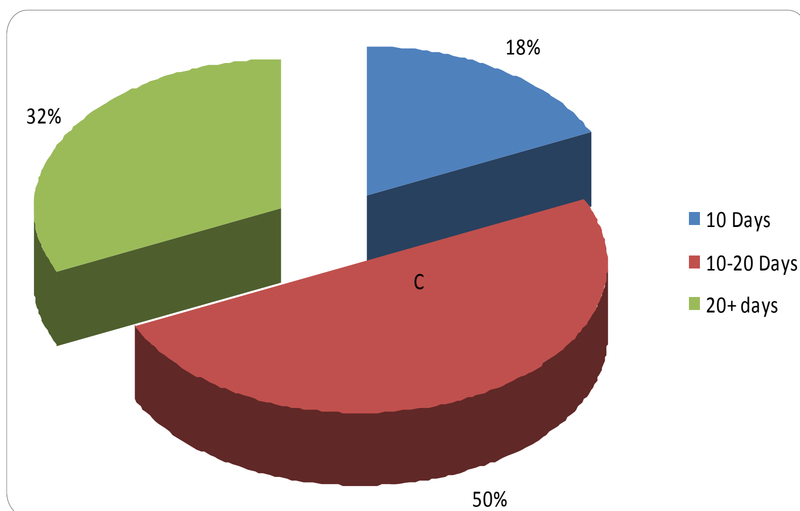
Summary of Adult Social Care safeguarding adults complaints 2012-13

Breakdown by complaint category



22 complaints were received by Adult Social Care about the safeguarding process. This is 5% of the total number of complaints recorded which was 443 and is 15% lower than the number of complaints received about safeguarding in 2011/12. 23% (5) were raised by or on behalf of the Person Alleged Responsible about the manner, attitude and / or respect of staff involved in the investigation. This category represents 11% (47) of the total of complaints made across Adult Social Care. The higher percentage for safeguarding may reflect the complex circumstances of the safeguarding investigation.

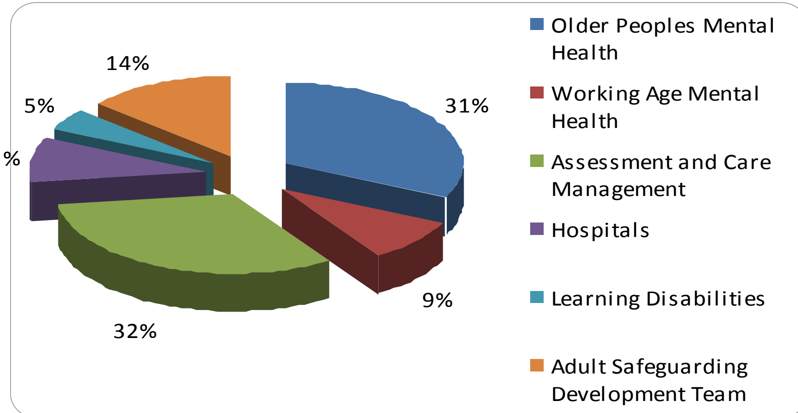
Length of time open



We aim to respond to complaints within 10-20 working days. A disproportionately high number of complaints about safeguarding exceed our 20 working day target. This can be because of a number of reasons, including:

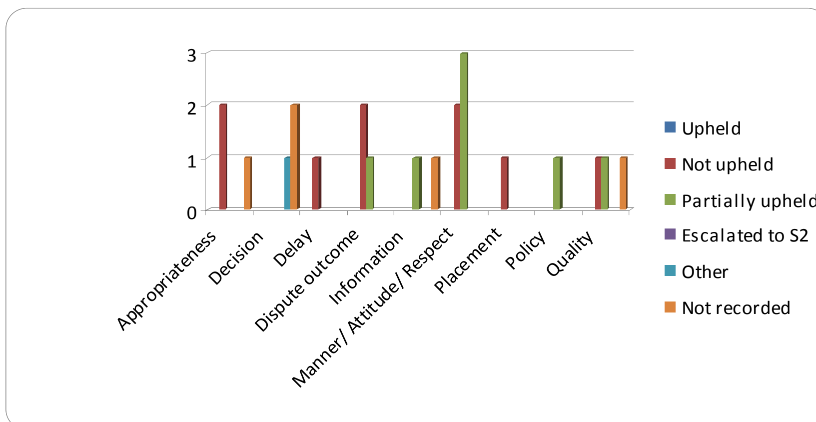
- The complexity of the issues and situation.
- The complaint is suspended pending the outcome of the investigation.

Breakdown by service area



As would be expected the majority of complaints were about the Assessment and Care Management Service and the Older People's Mental Health Service who deal with the highest volume of cases.

Outcome of safeguarding complaint by category



Learning

Of the 22 complaints received about the safeguarding process none were upheld but 7 were partially upheld. Of the 7 that were partially upheld the following learning has been recorded:

- A family member was concerned about the possibility of bias when the person alleged responsible was given voting powers at a case conference. The learning identified that consideration should be given on a case-by-case basis of who has decision making responsibilities at case conferences.
- A parent raised a safeguarding alert and was unhappy with the way in which the process was conducted. The complaint findings noted that in this instance the parent should have been

kept informed about the progress of the investigation, their views sought and been advised of the outcome. These points were shared with the team involved.

Compliments

An example of when an alerter was kept informed:

“I spoke to an advisor and raised the alert at 3.30pm on the Friday afternoon. I was called on Monday and informed of the outcome and that a strategy meeting was being held.”

Sussex Police update

Safeguarding adults activity undertaken between 1st April 2012 to 31st March 2013

Sussex Police Adult Protection Unit took part in the fire safety review process with East Sussex County Council. This was conducted due to related deaths which did not meet the criteria for Serious Case Review (SCR).

The annual multi-agency safeguarding case file audit was completed on behalf of the SAB. The following participated: Adult Social Care, Sussex Police, Sussex Partnership NHS Foundation Trust and East Sussex Healthcare NHS Trust.

Planning for the annual safeguarding conference, as agreed by the SAB, was conducted by a task and finish group of SAB partners. The conference is due to take place on 25th June 2013; the focus will be on prevention of harm and abuse and early intervention.

Key developments, achievements and work in safeguarding

The Sussex Police Safeguarding Adults Policy was reviewed by the Protecting Vulnerable People branch; this went live in March 2013. The policy was amended to reflect recent changes and to improve usability for officers / staff to assist them in identifying when victims and witnesses may be adults at risk of abuse and when a multi-agency investigation should be instigated.

The process for information requests received from other services has been streamlined for East Sussex Adult Protection Teams (APT). Requests are now sent directly to the Force Research Bureau, thereby reducing delay and improving efficiency.

Safeguarding training

Sussex Police engaged with their staff across the police service in relation to professional guidance relating to the Mental Health Act and specifically around capacity issues. This was included in the safeguarding adults policy. It was also communicated force-wide with guidance to staff.

We have started an external assessment of the training requirements of Adult Protection staff and intend to complete this work in the following 12 months.

Planned developments, future plans and priority areas for 2013/14 and / or beyond

Sussex Police have consented to a lecturer from Greenwich University working with and interviewing an area of APT staff with regard to their training requirements. The lecturer will use this study to form part of a PHD. During the interviewing process the lecturer will provide Sussex Police with information about training requirements and advice around gaps in performance.

The final product will be anonymised and used to develop APT staff across the force. This will be the first time we have utilised external academics to help us formulate a development plan for APT staff.

East Sussex Local Involvement Networks (LINk) update

Safeguarding adults activity undertaken between 1st April 2012 to 31st March 2013

A representative attended the SAB on behalf of clients and carers as well as the SAB's User & Carers Reference Group to provide initial representation, from a LINk perspective.

All new authorised representatives received safeguarding adults training before they undertook Enter and View visits to services on behalf of the LINk. It was emphasised that safeguarding issues take priority over all other LINk procedures.

Planned developments, future plans and priority areas for 2013/14 and / or beyond

From 1st April 2013, the activities of East Sussex LINk will be organised under the direction of HealthWatch East Sussex.

Safeguarding will remain a priority and volunteers undertaking Enter and View visits will continue to receive the appropriate training. Representation from HealthWatch East Sussex at the SAB will be agreed at a later date.

From April 2013 Local Healthwatch will be the local consumer champion for health and social care representing the collective voice of people who use services and the public. It will work to build up a local picture of community needs, aspirations and assets and the experience of people who use services. It will report concerns about services to commissioners, providers, the local authority and health for scrutiny. It will do this by engaging with the local community including networks of local voluntary organisations, people who use services and the public.

Local Healthwatch will have a role on the East Sussex Health & Well-Being Board and will also present information to Healthwatch England to help form a national picture of health and social care.

Sussex Partnership NHS
NHS Foundation Trust

Sussex Partnership NHS Foundation Trust update

Safeguarding adults activity undertaken between 1st April 2012 to 31st March 2013

Sussex Partnership NHS Foundation Trust (SPFT) participated in the multi-agency case file audit in November 2012 and provided the basis of the audit tool that was used by the team undertaking the audit.

SPFT is also involved in the work of the sub-groups of the SAB with representatives attending meetings and taking information back to the Director of Social Care and Partnerships in SPFT.

SPFT participated in the multi-agency fire safety project on behalf of the SAB and contributed to a range of ideas to raise awareness of fire-related harm in the community. As a service, SPFT agreed that older people with dementia and their carers will be offered a referral to ESFRS for a fire safety check.

Key developments, achievements and work in safeguarding

As part of the Domestic Homicide Case Review in East Sussex, the Domestic Abuse, Stalking and Honour Based Violence (DASH) documentation has been confirmed as the referral document for the Multi-Agency Risk Assessment Conference (MARAC). The advice, guidance and information has been included in SPFT's new Domestic Abuse Policy.

The SPFT's Safeguarding Policy has been updated and reviewed in line with the Sussex Multi-Agency Safeguarding Adults Policy & Procedures, to assist staff in recognising abuse in a variety of settings and alerting to Social Care Direct.

The Trust maintains data on safeguarding allegations when SPFT is implicated, whether it is an individual or a member of SPFT staff or as a provider.

Regular senior manager meetings between the Trust and ASC have taken place throughout the year, with minutes available. They outline some of the challenges experienced in data collection between the two agencies and the work that has been undertaken to rectify this.

The Trust has a Prevent Policy in place as part of the government's protocol to prevent harm through terrorism and domestic extremism. The Director of Social Care and Partnerships is the lead officer for this.

Safeguarding training

The SPFT's Safeguarding Policy includes a training strategy which requires all staff to attend adult safeguarding training at induction in accordance with the Sussex Multi-Agency Safeguarding Policy & Procedures.

Secure and Forensic staff at the Hellingly Centre had this as additional training when new services opened which continue on a regular basis. The inpatient service of the medium and low security facility is fortunate in having a lead Forensic Senior Practitioner who was a Practice Manager from East Sussex ASC and is fully conversant in safeguarding and has raised standards within forensic services.

An independent safeguarding chair from ASC has provided training to SPFT managers and senior staff on writing provider reports to improve the quality and content.

General Managers and Service Managers take back all learning points from safeguarding investigations to their teams. Training was also delivered to senior managers within the Trust on Prevent the anti-terrorism and domestic extremism protocol with individual team training on request.

Planned developments, future plans and priority areas for 2013/14 and / or beyond

There is an ongoing commitment to safeguarding within SPFT; to raise standards, to train staff and embed safeguarding within all aspects of patient care.

The Director of Social Care and Partnerships holds meetings with the ASC safeguarding leads across Sussex including the SPFT's professional Heads of Social Care to address any issues as required.

Any other information / areas / issues

ASC is represented by the Head of Social Care, Specialist Services, SPFT on the Strategic Management Board of Multi-Agency Public Protection Arrangements (MAPPA). They attend the Level 3 MAPPA meetings and the Secure & Forensic Social Work Senior Practitioners attend the Level 2 meetings. They link to ASC where required.

MAPPA has a close working relationship with MARAC and representation at the meetings is from SPFT managers. Both MAPPA and MARAC work to protect the public including previous and future victims of serious offences, including domestic violence and acts of terrorism.

East Sussex Healthcare NHS
NHS Trust

East Sussex Healthcare NHS Trust (ESHT) update

Key developments, achievements and work in safeguarding

ESHT participated in the multi-agency case file audit that was initiated by ASC. Overall, the process had a positive outcome demonstrating positive inter-agency working. It also revealed areas for development for ESHT which are included within our annual plan.

ESHT policy has been updated in relation to pressure ulcers; this includes referral pathways for category 3 and 4 ulcers to be raised as a safeguarding alert. ESHT has supported ASC in updating the pressure ulcer protocol, in line with national clinical guidance. The combined serious incident / safeguarding reporting form has been updated with joint input from ASC, CCG and ESHT. This ensures that maximum information is provided both for serious incidents and ASC investigations. Further work is underway to review the process for alerting and decision making in relation to early indication of pressure ulcers within the unavoidable and avoidable categories. ESHT has also supported ASC in the updating of the self-neglect joint policy.

ESHT continues to work in partnership with ASC, improving communication pathways between the two parties to support the smooth running of services. The ESHT bi-monthly operational group ensures continued communication including ensuring the timely production of reports / attendance at case conferences and that actions from case conferences are completed.

ESHT undertakes a number of regular audits ranging from weekly ward-based audits of patient's records, timely and accurate completion of assessments with correct subsequent personalised care planning and actioning of those care plans, to quarterly audits in relation to safeguarding alerts raised against ESHT. There was a reduction in generic alerts during 2012/13, however, there has been a notable increase in the number of pressure ulcer alerts during the same period. This is in part due to improved training and awareness of safeguarding processes within ESHT.

An updated Safeguarding Adults at Risk Policy is available for ESHT staff in line with the Sussex Multi-Agency Safeguarding Adults at Risk Policy & Procedures.

Safeguarding training

- Level 1 safeguarding adults at risk training – 100% of all staff are trained within ESHT.
- Level 2 safeguarding adults at risk training – 76.27% of required staff trained.
- Mental Capacity Act master class – 80.56% of required staff trained.
- Deprivation of Liberty Safeguards – 72.60% of required staff trained.
- Preventive training – delivered to targeted frontline services.
- Domestic abuse training – currently delivered in combination with safeguarding children training and currently have timetabled dates to offer this training to all staff who work within gateway services.

- Joint training between ASC and ESHT continues to be reviewed. Joint training has included pressure ulcer prevention training and domestic abuse training.

Planned developments, future plans and priority areas for 2013/14 and / or beyond

Objectives over the forthcoming months are:

- To work with adult safeguarding services to improve awareness of action required with regard to domestic abuse.
- To continue close collaborative working with ASC, ensuring continuing improved outcomes for our customers.
- Domestic abuse training will be extended to a wider range of staff during 2013/14.

Trading Standards update

Safeguarding adults activity undertaken between 1st April 2012 to 31st March 2013

Building Bridges project
The objective of the project is to form demonstrable links with key partners and, specifically, Adult Social Care with the aim of implementing the Community Services policy steer which states that Trading Standards should work towards "informed confident consumers and the protection of vulnerable consumers". Such work will assist vulnerable people to live safely and independently within the community, and to make considered transactional decisions.

Key developments, achievements and work in safeguarding

Development of financial abuse toolkit The toolkit was developed in response to an increase in reported incidents of financial abuse, both nationally and locally, and aims to provide practitioners with the information they need to respond appropriately to suspected cases of financial abuse.

Proof of concept pilot run for Scams Hub within the South East, London & East of England regions – development of Scams Hub The Scams Hub was set up to utilise intelligence from key partners, predominantly the Metropolitan Police, to identify potential serial victims of scam mail and provide a referral mechanism for these victims to get advice and support from appropriate agencies. The group was set up to co-ordinate a joint strategy for sharing information and tackling mass marketing scams. This project is of national interest and benefits both consumers and trading standards services across the country. In essence, details of victims that have fallen foul of scams have been shared with local agencies to either further investigations, or educate and protect the victim from further scams or financial abuse.

Safeguarding training

Forty-four presentations have been provided to Adult Social Care and partners, within our Building Bridges project. The partners ranged from Sussex Police, East Sussex Fire & Rescue Services to Care for the Carers and Age UK.

Planned developments, future plans and priority areas for 2013/14 and / or beyond

Objectives over the forthcoming months are:

- Training officers in Achieving Best Evidence (ABE). It is an aspiration of the service to be better equipped when engaging with vulnerable clients, where an allegation of financial abuse is being investigated by the service. For example, a rogue trader has targeted a vulnerable householder to undertake home improvements. Officers will need to establish what evidence is held by the client and secure that evidence to the satisfaction of the criminal courts. The ABE training will enhance our witness skills.

- Continuation of partner training (Building Bridges).

- Wise Guys website development. www.wiseguys.org.uk was established in 2008. The primary objective of the Wise Guys website was to educate students with learning disabilities in life skills, to empower them to become informed confident consumers. East Sussex County Council Trading Standards Service in partnership with the East Sussex Learning Disability Team launched its sister site. The extension of the site provides information and advice to assist all people to gain further understanding of their rights and ultimately more independence.

- Development of Scams Hub – evaluation of pilot and further work with national partners.

East Sussex
Fire & Rescue Service

East Sussex Fire & Rescue Service (ESFRS) update

Safeguarding adults activity undertaken between 1st April 2012 to 31st March 2013

Following the signing of an Information Sharing Agreement relating to vulnerable people on the ASC database, the first of the ESFRS Home Safety Visits (HSV) have been undertaken. To date, 286 people have been contacted by letter in order that consent can be granted, and the first 42 who replied have received visits from Community Safety Advisors.

ASC has now incorporated a mandatory question regarding an HSV referral at the point of contact (usually by phone) and of the 3,892 enquiries, 393 new referrals have been made. This strand of work is now being monitored by ASC through its quarterly Operational Practice Sub-group.

ESFRS is represented at the Safety, Prevention, Action and Early Intervention group (SPACE). The group works to an action plan and ESFRS has a number of actions relating to the increase in referrals for HSV to vulnerable people, the reduction in fire deaths and a reduction in kitchen fires. ESFRS is seen as a key contributor to the success of this group.

The revised self-neglect multi-agency procedures document has now been circulated for comment. ESFRS is seen as an important partner in this work, particularly around hoarding, debilitating loneliness and refusal to engage with statutory authorities.

ESFRS is considered to be relevant to many activities that ASC is involved in and we are included, or at least consulted, in a great many of their plans.

Key developments, achievements and work in safeguarding

ESFRS Safeguarding Panel continues to meet and the Director of Prevention and Protection now has the corporate lead for all safeguarding matters. The ESFRS Safeguarding Policy has been reviewed and agreed with staff and representative bodies. ESFRS has audited and reviewed its internal procedures, and simplified the process for staff to make safeguarding referrals through its ‘coming to notice’ form.

Safeguarding training

A good proportion of supervisory and middle managers have undertaken internal training. All new entrants to the service and staff being promoted into supervisory manager roles undertake safeguarding training. The ESFRS Safeguarding Panel has undertaken the online KWANGO training.

Planned developments, future plans and priority areas for 2013/14 and / or beyond

There will be a continuation and review of all the work that is being undertaken with ASC through representation at the Board and via the Operational Practice Sub-group and SPACE.

South East Coast Ambulance Service NHS Foundation Trust update

Safeguarding adults activity undertaken between 1st April 2012 to 31st March 2013

Over the past year, South East Coast Ambulance Service NHS Foundation Trust (SECAmb) has raised 325 adult concerns for vulnerable adults in the East Sussex area. This represents 12.13% of all adult concerns raised by SECAmb staff across the Trust. Work has also been undertaken to review referral paperwork in line with the East Sussex Domestic Homicide Group action plan.

Key developments, achievements and work in safeguarding

Improvements have been made regarding information sharing internally with the safeguarding team now being routinely informed of any serious incidents involving vulnerable adults and children.

Scoping was undertaken with Independent Domestic Violence Advocacy Service (IDVA) services in Brighton & Hove and West Sussex to develop a screening tool for SECAmb frontline and call centre staff to use in cases of suspected domestic abuse. A project lead was seconded to take this agenda forward.

Safeguarding training

A key area of work undertaken by SECAmb over the past year included the development and implementation of the Trust's safeguarding training needs analysis plan. The plan includes capturing training for all staff groups, both frontline and office based and utilises a mixture of both face-to-face training and e-learning modules. Frontline staff and the Trust Board have received vulnerable adult, domestic abuse and Mental Capacity Act training during this year.

Planned developments, future plans and priority areas for 2013/14 and / or beyond

The domestic abuse pilot will be launched in July 2013 followed by a period of evaluation. Future plans to roll the project out to all areas within the SECAmb boundaries are likely to be reliant on securing further funding.

Developments are planned for the Level 1 safeguarding adults e-learning training course for non-frontline staff and continued active engagement with the National Ambulance Safeguarding Group.

During 2012/13 SECAmb was awarded the contract for 111 services across the South East Coast area in partnership with Harmoni (out-of-hours doctor service). All 111 safeguarding referrals via

the South East Coast 111 system are now managed / reported through the SECAmb Safeguarding Department.

Deprivation of Liberty Safeguards (DoLS) update

Safeguarding adults activity undertaken between 1st April 2012 to 31st March 2013

A report was presented to the SAB on the transfer of the responsibilities of the Supervisory Body for hospitals from the PCT to East Sussex Adult Social Care in April 2013.

The DoLS team does not undertake stand alone safeguarding investigations. Nevertheless, any DoLS assessment may uncover wider safeguarding or best interest concerns alongside the matter of deprivation of a person's liberty. A non-authorised deprivation of liberty will be considered as a best interest or safeguarding concern, and the relevant manager, case worker, family member or deputy will be consulted.

Key developments, achievements and work in safeguarding

The team undertook 130 assessments of people in care homes and 63 in hospitals during 2012-13.

The work of the DoLS team and that of the DoLS authorisers has been audited by the Safeguarding Quality Assurance Team and found to meet a high standard. The person's wishes, views and dignity were found to be integral to assessments, family and friends fully consulted and advocates appointed to represent the person's wishes and views when unbefriended.

The DoLS team works in close partnership with safeguarding investigation managers where the Court of Protection may be called upon to further investigate matters of deputyship or rights to family life and where wider safeguarding concerns overlap with a DoLS authorisation.

Safeguarding training

All staff working in the DoLS team are trained to the required level of safeguarding competencies for ESCC ASC staff.

Staff in the team assist the ASC training team to deliver quarterly DoLS awareness training. A half-day DoLS training course and Best Interest Assessor (BIA) training is also provided to Brighton University. DoLS awareness briefing sessions are available to care homes and hospital wards on invitation and subject to availability.

DoLS Best Interest Assessors and authorisers attend annual refresher training on DoLS law and its links to safeguarding human rights.

Two new authorisers from ASC senior management have come forward to deal with the expanded work for ESCC with the change of responsibilities. They have been fully trained in DoLS authoriser duties and responsibilities.

The DoLS team attended a training day led by the Safeguarding Lead for the South East BIAs in March 2013. This training focused on the relationship between DoLS, MCA and safeguarding.

Planned developments, future plans and priority areas for 2013/14 and / or beyond

All Supervisory Body responsibilities are now located within East Sussex ASC. The work of the MCA DoLS Governance Board will reflect the change to ESCC becoming overall MCA DoLS lead in 2013-14 by working closely with providers and commissioners and the new Clinical Commissioning Group MCA DoLS Lead.

The DoLS team plans to recruit an additional half-time post in 2013-14 to reflect the increased responsibilities for delivering DoLS work throughout East Sussex and beyond.

Appendix 1

SAB Work Plan to 2014

	Objective	Action	Lead Reporting Responsibility	Timescale	Progress
1	Make safeguarding personal through focusing on outcomes for individuals	Increase formal, informal and self-advocacy within safeguarding activity Increase engagement with carers to improve safeguarding responses	OP (CWD) CWD (OP)	March 2013 June 2014	Completed and ongoing
2	Develop a quality and outcomes focused set of performance measures	Review data collections to ensure local and national requirements are met Develop a coherent narrative about safeguarding based on data, audit and feedback	PQA PQA	Dec 2012 March 2013	Completed Revised Safeguarding Performance & Quality Assessment Framework completed and ongoing
3	Improve the range of responses to individuals bringing safety and people's wishes together	Develop a menu of responses to safeguarding situations Ensure a culture of outcome focused practice is embedded in safeguarding	OP CWD	Sept 2013 Jan 2014	In development Outcomes included in revision of safeguarding policy and procedures. Adult Social Care workshops planned to ensure a greater focus on outcomes by operational teams.
4	Develop a whole systems understanding of service quality to avoid service failures	Establish an understanding of quality standards and the collective responsibility to challenge unsafe, unacceptable and inappropriate standards of service Link the dignity and compassion in care agenda to safeguarding responses	PQA OP	June 2013 June 2013	Commissioners and Head of Service (Contracts) are now members of sub-groups Connections established through Care Governance Board

	Objective	Action	Lead Reporting Responsibility	Timescale	Progress
		Establish and review links to commissioners and all purchasers of services to ensure a coherent and robust approach to safeguarding across East Sussex	OP	June 2013	
5	Ensure that a preventive approach to safeguarding is embedded in practice	Develop a process to evaluate and implement lessons learnt in safeguarding practice	PQA (CWD)	June 2013	
		Address the recent increase in financial abuse	OP (CWD)	July 2013	Adult Social Care Financial Abuse Toolkit developed
		Review the implementation of the Preventive Strategy	PQA (OP & CWD)	April 2013	
6	Ensure that people are aware of safeguarding and know what to do if they have a concern	Review and update information for all stakeholders	CWD	Sept 2013	Review of provider guidance and information fact sheets completed. Awareness and alerting booklet for providers published.
		Increase awareness of domestic abuse, anti-social behaviour and hate crime	CWD (OP)	April 2013	Information on domestic abuse updated and circulated. Anti-social behaviour and hate incident pathways established and audited.
		Undertake awareness raising targeted through data and feedback	CWD (PQA)	April 2013	Refresh of raising awareness campaign scoped focussing on key areas targeted through data
7	Ensure that people involved in safeguarding have the appropriate skills and knowledge to deliver a personalised approach	Develop training and awareness raising specific to personalised safeguarding practice	CWD	June 2013	Regular feedback to ensure training responds to changes in policy and practice issues through Adult Safeguarding Development Team

	Objective	Action	Lead Reporting Responsibility	Timescale	Progress
		Review and update the safeguarding competencies	CWD (OP)	April 2013	Audit undertaken and review planned
		Undertake an annual multi-agency safeguarding case file audit	PQA	Jan 2013	Completed
8	Establish a link between clients and carers and the strategic agenda of the Board	Identify roles for clients and carers within the work of the SAB	Advisory group to the CCSN (Client and Carer Safeguarding Network)	September 2012	Advisory group established
		Establish two-way communication between the Board and clients and carers		February 2013	
		Confirm targeted areas of activity for clients and carers		February 2013	Evaluation of safeguarding data completed by the group and linked to the activity in sub-groups
9	Ensure the efficiency, effectiveness and cohesiveness of the Board to deliver on its safeguarding objectives to the people of East Sussex	Safeguarding Adults Board members to attend a development half-day to prepare for statutory footing and develop a strategic plan	SAB	March 2014	
		Publish an annual report on the exercise of the Board's functions and its success in achieving its strategic plan	SAB	June 2013	Draft completed
		Work collaboratively with the Local Safeguarding Children's Board and the Community Safety Partnership on shared concerns	SAB	December 2012	Established and ongoing

OP – Operational Practice sub-group
CWD – Communication & Workforce Development sub-group
PQA – Performance, Quality & Audit sub-group
CCSN – Client and Carer Safeguarding Network Advisory group

Appendix 2

Summary of performance data 2012-2013

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Definitions

Alert The reporting of concerns or allegations of adult abuse to Adult Social Care.

Referral This is the term used by the Department of Health to describe an adult safeguarding investigation.

Investigations are broken down into four levels:

- **Level 1 investigation** A concern / allegation that harm has occurred / appears to have occurred or there is risk of significant harm to an adult at risk, and it is appropriate for a service provider to investigate this overseen by an Adult Social Care Investigation Manager.

- **Level 2 investigation** A concern / allegation that harm has occurred / appears to have occurred or there is risk of significant harm to an adult at risk, and it is appropriate for an investigation to be undertaken by a practitioner from a statutory service.

- **Level 3 investigation** A concern / allegation that significant harm appears to have occurred / has occurred to one adult and at this point there is no clear indication this has affected other adults at risk.

- **Level 4 investigation** A concern / allegation that more than one adult at risk appears to have / has experienced harm or significant harm and there appears to be some link in relation to the underlying cause or in relation to the person alleged responsible, or there are possible indicators of institutional abuse.

Types of abuse:

- **Physical abuse** Hitting, pushing, slapping, scalding, shaking, kicking, pinching, hair pulling, the inappropriate application of techniques or treatments, involuntary isolation or confinement and misuse of medication.

- **Sexual abuse** Direct or indirect involvement in sexual activity without valid consent, including rape and sexual assault or sexual acts to which the adult at risk has not consented, or could not consent to or was pressured into consenting.

- **Emotional / psychological abuse** The use of threats, humiliation, bullying, swearing and other verbal conduct, or any other form of mental cruelty, that results in mental or physical distress. It includes the denial of basic human and civil rights, such as choice, self-expression, privacy and dignity.

- **Financial abuse** The unauthorised and improper use of funds, property or any resources belonging to an individual including theft, fraud, exploitation, pressure in connection with wills, property or inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits.

- **Neglect** This can take several forms and can be the result of an intentional or unintentional act(s) or omission(s). Concerns relating to self-neglect will not usually lead to the initiation of adult safeguarding procedures unless the situation involves an act of commission or omission by someone else with established responsibility for that person's care or financial affairs.

- **Discriminatory abuse** This is the exploitation of a person's vulnerability which excludes them from opportunities in society, for example, education, health, justice, civic status and protection.

- **Institutional abuse** Institutional abuse occurs when systems or processes and / or management of these is failing to safeguard a number of adults leaving them at risk of, or causing them, harm. Institutional abuse can also occur when the routines, systems and norms of an organisation override the needs of those it is there to support, or fail to provide those individuals with an appropriate quality of care.

Case conclusion

- **Substantiated** All of the allegations of abuse are substantiated on the balance of probabilities.

- **Not substantiated** It is not possible to substantiate any of the allegations of abuse on the balance of probabilities.

- **Partly substantiated** This would apply to cases where it has been possible to substantiate some but not all of the allegations. For example, 'it was possible to substantiate the physical abuse but it was not possible to substantiate the allegation of financial abuse'.

- **Not determined / inconclusive** This applies to cases where it is not possible to record an outcome against any allegations. For example, where there is insufficient evidence to outcome the investigation.

Other definitions

Person alleged responsible This is the person who the adult at risk, or other person(s), has alleged to have committed the abuse, but this has not yet been proved.

Introduction

A Safeguarding Performance Quality Assurance Framework is in place across the partnership to drive improvements in safeguarding outcomes. Part of this framework includes a comprehensive and systematic approach to assessing and auditing the quality of safeguarding practice.

This report, produced by the Performance, Quality and Audit sub-group, summarises safeguarding activity between 1 April 2012 and 31 March 2013, and sets out the main conclusions, learning points and key areas for development.

The report provides details of the activity that has been undertaken in relation to reported alleged abuse (alerts) and cases under investigation (referrals) as well as details of the types of alerts that were reported and a summary of the outcomes of the investigations.

Please note that there are a number of sets of data that allow for multiple entries when a referral is recorded. This means that although the totals of two different tables look like they should all add up to the same value, they will in fact differ slightly. An example of this would be when looking at the total number of referrals started by type of abuse and then by location of abuse. It is possible to record more than one type of abuse therefore this figure will be higher.

1. Alerts and investigations by category of adult at risk

There were 3,301 alerts of abuse recorded in East Sussex between April 2012 and March 2013. This is a 34% increase on the number of alerts reported (2,460) during 2011/12. Operational teams are prioritising safeguarding investigations alongside other work priorities to manage the increase. A breakdown of these alerts is shown below:

Table 1 – Alerts in period

Client Type	Apr 11 - Mar 12	Apr 12 - Mar 13	% difference
Physical/ sensory/ frailty	1366	2159	58%
Learning Disability	199	208	5%
Mental Health	691	703	2%
Substance Misuse	51	44	-14%
Other	151	184	22%
Not recorded	2	3	50%
Total	**2460**	**3301**	34%

Of the 3,301 alerts that were recorded in East Sussex, 1,318 went on to be investigated. This equates to 40% of the alerts received. In the previous year, 1,485 alerts went on to become investigations (60% of all alerts). Auditing has identified alternative options are being adopted where appropriate such as care management arrangements or the Quality Monitoring Team working with providers.

The table below shows the alerts that went on to become investigations by client type:

Table 2 – Alerts to investigations in period

Client Type	Apr 11 - Mar 12	Apr 12 - Mar 13	% difference
Physical/ sensory/ frailty	822	842	2%
Learning Disability	156	124	-21%
Mental Health	418	284	-32%
Substance Misuse	32	16	-50%
Other	57	52	-9%
Not recorded	0	0	-
Total	**1485**	**1318**	-11%

2. Ethnicity of alleged victims

The highest alert rate (85%) has been reported from the ‘White British’ category. This is a slight decrease on the proportion reported for 2010/11 (88%) and is slightly lower than the White British population of East Sussex which, according to the 2011 Census, was just under 92%.

Excluding alerts received for people from a ‘White British’ background and those where the ethnicity has either been refused or is not yet available, there were 167 other alerts, a 14% increase on the number received during 2011/12 (143).

The following table provides a full breakdown of the alerts by ethnic group:

Table 3 – Ethnicity of alleged victims

Ethnic background	Apr 11 - Mar 12	% of all alerts	Apr 12 - Mar 13	% of all alerts
White-British	2170	88%	2808	85%
White-Irish	19	1%	16	0%
White-Gypsy/Romany	1	0%	3	0%
White-Traveller	0	0%	4	0%
White-Any other background	66	3%	80	2%
Mixed-White & Black Caribbean	4	0%	2	0%
Mixed-White & Asian	6	0%	3	0%
Mixed-White and Black African	3	0%	2	0%
Mixed-Any other mixed bakground	9	0%	14	0%
Asian/ Asian British-Bangladeshi	1	0%	7	0%
Asian/ Asian British-Indian	5	0%	4	0%
Asian/ Asian British-Pakistani	1	0%	0	0%
Asian/ Asian British-Any other Asian	6	0%	4	0%
Black/ Black British-Caribbean	4	0%	4	0%
Black/ Black British-African	6	0%	3	0%
Black/ Black British-Any other black background	5	0%	5	0%
Any other ethnic group-Chinese	0	0%	6	0%
Any other ethnic group	7	0%	10	0%
Information not yet obtained	114	5%	275	8%
Ethnicity refused	28	1%	31	1%
No ethnicity recorded	5	0%	20	1%
Total	**2460**		**3301**	

3. Incident by type of abuse

There are seven types of abuse that are recorded in East Sussex, these are:

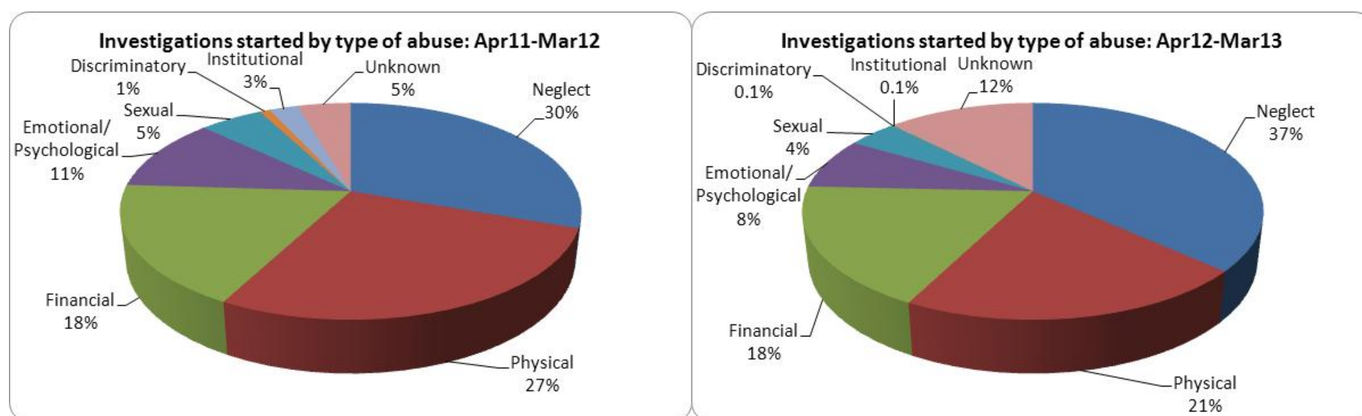
- Physical abuse
- Sexual abuse
- Emotional / psychological abuse
- Financial abuse
- Neglect
- Discriminatory abuse

Institutional abuse is an additional category of abuse and is abuse that arises from an unsatisfactory care regime. It occurs when the routines, systems and norms of an organisation override the needs of those it is there to support. During 2012/13, institutional abuse was recorded for just four investigations compared to 30 in 2011/12.

The types of abuse that were recorded are presented in the pie charts below. These illustrate the spread of the types of abuse across all investigations and provide a comparison between 2011/12 and 2012/13.

It should be noted that the pie charts are based on the first type of abuse recorded in each investigation to provide an idea of the spread. Where multiple forms of abuse have been recorded, further details are also provided.

Fig. 1: Type of abuse for referrals



At the time of writing, of the 1,343 investigations started, 163 still required a type of abuse to be recorded. All of these cases were still being investigated which accounts for why information is not yet available.

The proportion of investigations relating to neglect has increased considerably from 30% to 37%. This is likely to be due to the introduction of the multi-agency pressure ulcer policy which states that alerts received for a grade 3 or 4 pressure ulcer would meet the threshold for investigation.

Of the 1,343 investigations undertaken in 2012/13, 122 cases involved multiple forms of abuse compared to 167 in 2011/12. The table below provides further detail:

Table 4 – Multiple abuse investigations

Client Type	Apr 11 - Mar 12	Apr 12 - Mar 13	% difference
Neglect	123	45	-63%
Physical	132	70	-47%
Financial	63	45	-29%
Emotional/ Psychological	133	80	-40%
Sexual	22	15	-32%
Discriminatory	10	0	-100%
Institutional	34	3	-91%
Total	**517**	**258**	-50%

This shows that in cases of multiple abuse, 31% include emotional / psychological abuse and 27% include some form of physical abuse.

When we report our safeguarding activity nationally through the Abuse of Vulnerable Adults (AVA) return, the focus is on numbers of alleged victims under various categories. However, it is possible for cases of institutional abuse to be raised without a specific known victim. An example of this would be when a whistle blower writes a letter raising a number of concerns but doesn't name any individuals. As a result of this, although four cases have been reported in the AVA return where an individual's case has been investigated under institutional abuse, there have in fact been 16 investigations relating to institutional abuse.

4. Level of investigation

The table below shows the initial levels set for all the investigations started within the period. During the course of an investigation, it is possible for the level to change.

Table 5 – Levels of investigation

Initial level set for investigation	Apr 11 - Mar 12	% of all investigations	Apr 12 - Mar 13	% of all investigations
Level 1	296	19%	263	20%
Level 2	384	25%	337	25%
Level 3	680	45%	682	51%
Level 4	146	10%	38	3%
Other inc. not recorded	21	1%	23	2%
Total	1527		1343	

As seen in previous reports, the highest percentage of investigations in both reporting periods are level 3 investigations, followed by level 2, level 1 and then level 4 investigations.

5. Timescales

The table below shows the recorded length of time between an alert being made and a decision made as to whether the case should be investigated or not. These timescales are based on working days.

Table 6 – Alert timescales – all alerts

Alert timescales	Apr 11 - Mar 12	% of all alerts	Apr 12 - Mar 13	% of all alerts
Less than 2 days	1859	76%	2440	74%
3-7 days	466	19%	687	21%
More than 7 days	85	3%	145	4%
Alert left open	50	2%	29	1%
Total	**2460**		**3301**	

The table above shows that the length of time it takes to make a decision about alerts is taking slightly longer than in 2011/12. This could be attributed to the increase in the volume of alerts that are being received. The following table looks more specifically at the alerts that went on to be investigated.

Table 7 – Alert timescales – alerts that were investigated

Timescales for alerts that were investigated	Apr 11 - Mar 12	% of all alerts	Apr 12 - Mar 13	% of all alerts
Less than 2 days	1145	77%	1001	76%
3-7 days	304	20%	273	21%
More than 7 days	36	2%	44	3%
Alert left open	0	0%	0	0%
Total	1485		1318	

When comparing the results for 2011/12 with those for 2012/13, the proportion of alerts that went on to be investigated within two days has reduced by 1% whilst the proportion taking three to seven days and more than seven days has increased marginally.

The final table in this section reflects the time taken to complete the safeguarding investigation:

Table 8 – Investigation timescales – all investigations undertaken during the period

Investigation timescales	Apr 11 - Mar 12	% of all investigations	Apr 12 - Mar 13	% of all investigations
7 days or less	82	5%	55	4%
8-14 days	180	12%	102	8%
15-28 days	418	27%	313	23%
More than 28 days	716	47%	597	44%
Investigation still open	131	9%	276	21%
Total	**1527**		**1343**	

6. Incidents by location

The types of location where incidents of abuse took place are presented in the table below.

Table 9 – Location of abuse

location of abuse	Apr 11 - Mar 12	Apr 12 - Mar 13
Residential/ nursing homes	628	494
Vulnerable adults own home	398	345
Acute hospital setting	77	96
Public place	64	41
Mental health inpatient setting	53	41
Supported accommodation	34	42
Alleged perpetrators home	64	31
Day care/ service	21	14
Community hospital	15	11
Other	28	17
Education/ training/ work establishment	6	4
Other health setting	6	2
Location not known	32	35
Not recorded	101	170
Total	**1527**	**1343**

The investigations illustrated in the table above reflect all investigations started in the period.

The most common category for location of abuse is residential and nursing care homes accounting for 37% of investigations. This is followed by the vulnerable adult's own home (26%) and closely reflects the trend seen last year.

The number of cases of abuse that have been reported in acute hospital settings has increased by 19 cases in 2012/13. As with the increased proportion of neglect cases reported, this is as a result of the increased emphasis on investigating grade 3 and 4 pressure ulcers through the safeguarding process.

There are 170 cases where the location of abuse was not recorded which is an increase when compared to the number reported last year, however, of these 170 cases, 165 are still open and therefore will not have all relevant information recorded on the system.

When looking at the location of abuse, it is also important to analyse the types of abuse that have occurred at each location so that any variances can be identified and investigated.

Within the residential / nursing care setting, the most common types of abuse are 'Neglect' 54% and 'Physical' 29%.

Within the vulnerable adult's own home, the most common type of abuse is 'Financial Abuse', accounting for 41% of all cases. The next greatest within the vulnerable adult's own home was 'Neglect', accounting for 24% of the referrals that were started in the period. This is the first time that neglect has been reported more frequently than physical abuse in a number of settings which links to an improvement in awareness.

As a result of the increased prevalence of financial abuse over the last 18 months, an awareness raising campaign is being undertaken which specifically focuses on issues relating to financial abuse. A financial abuse toolkit has been developed to ensure awareness of the issues relating to financial abuse and, in particular, the more sophisticated forms of fraud. The toolkit has an emphasis on prevention.

7. Source of referrals

The sources of referrals to be investigated are presented in table 10:

Table 10 – Source of referral

Source of referral	Apr 11 - Mar 12	Apr 12 - Mar 13
ASC - Domiciliary staff	31	35
ASC - Residential care staff	174	222
ASC - Day care staff	26	25
ASC - Self directed care staff	2	1
ASC - Other social care staff	269	194
NHS - Primary/ community health staff	63	67
NHS - Secondary health staff	174	226
NHS - Mental health staff	-	53
Self referral	35	33
Family member	122	100
Other service user	1	-
Friend/ neighbour	15	14
Care Quality Commission	40	15
Housing	55	46
Education/ training/ workplace	2	3
police	92	82
Other	315	212
Not recorded	111	15
Total	**1527**	**1343**

The investigations illustrated in the above table are investigations that started in the period.

The category of 'other' includes the following sources of referral:

- Anonymous referrals
- Other service providers
- Other independent / voluntary organisations
- Independent community services
- Other local authority departments
- Youth Offending Team
- Probation
- Drugs service

For the first time since reporting this information, the category of 'other' is not the most common category. The most common source of referral is now NHS secondary health staff (17%) followed by Adult Social Care residential staff (16.5%). The category of 'other' accounts for just below 16%.

Regular reviews of this safeguarding data indicated that the number of safeguarding alerts from General Practitioners (GPs), Practice Nurses and Community and District Nurses (Primary and community health care staff) is low. This reflects the national picture with regards to GPs and Practice Nurses. The Safeguarding Adults Board agreed that a campaign to increase alerts should take place and planning for this campaign is underway. Raising awareness will be supported by publicity, training opportunities and reference materials.

8. Relationship of the alleged perpetrators of abuse to their victims

The relationship of the alleged perpetrators of abuse to their victims is presented in the table below:

Table 11 – Alleged perpetrator's relationship to victim

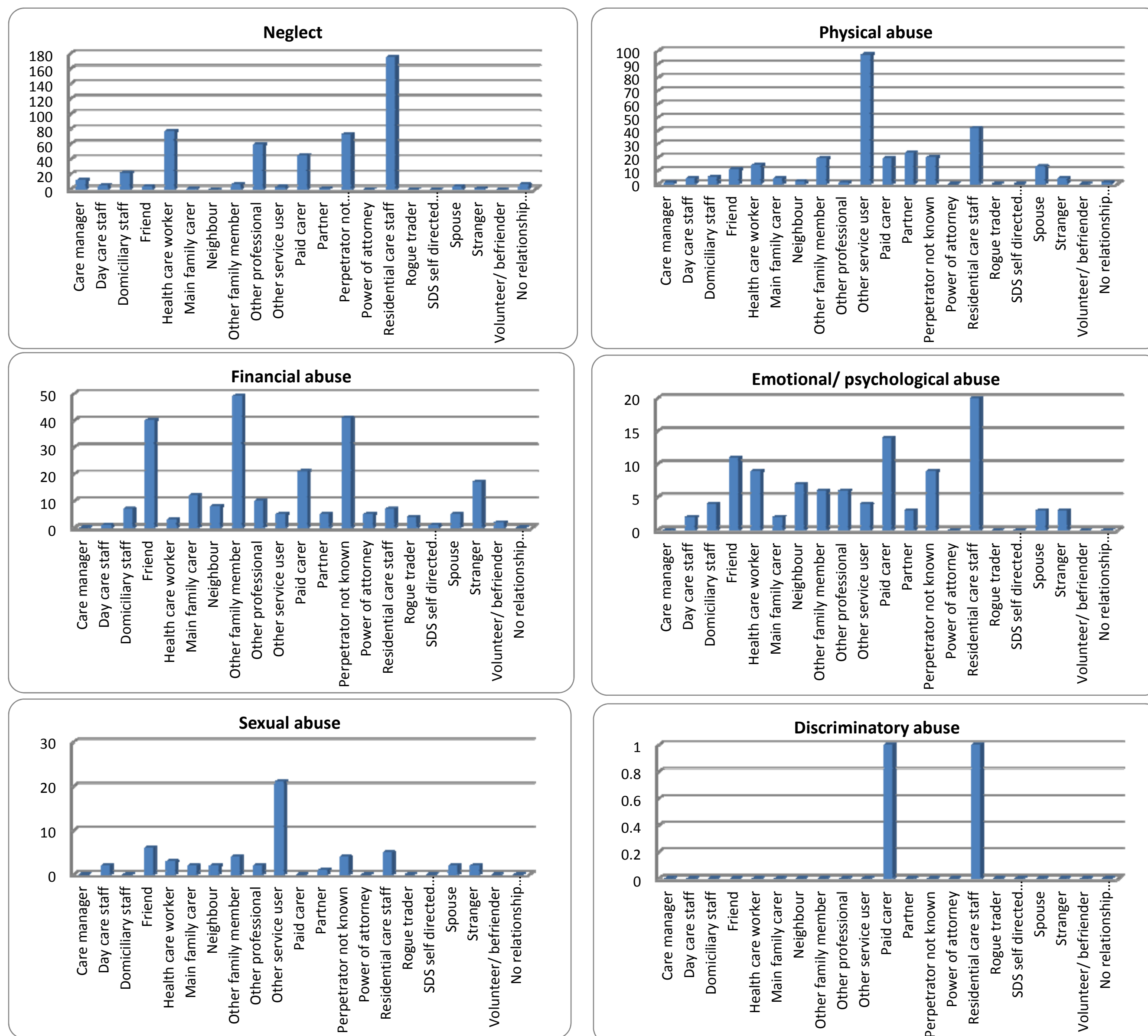
Relationship between alleged perpetrator and victim	Apr 11 - Mar 12	Apr 12 - Mar 13
Care manager	8	13
Day care staff	17	14
Domiciliary staff	61	38
Friend	79	72
Health care worker	132	107
Main family carer	43	21
Neighbour	32	19
Other family member	125	84
Other professional	56	78
Other service user	185	130
Paid carer	93	100
Partner	85	33
Perpetrator not known	113	147
Power of attorney	3	5
Residential care staff	379	251
Rogue trader	11	4
SDS self directed care staff	0	1
Spouse	-	27
Stranger	31	27
Volunteer/ befriender	3	2
No relationship recorded	71	170
Total	**1527**	**1343**

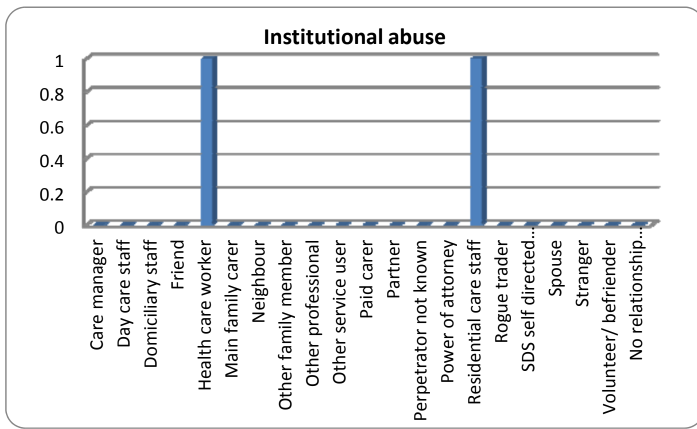
There are 170 cases with no relationship recorded. All of these cases are still under investigation which accounts for the information not yet being available.

The most common alleged perpetrator relationship to client is ‘residential care staff’, accounting for 19% of all investigations. Last year they accounted for 25%. With the exception of cases where the perpetrator is not known, the second most common alleged perpetrator is ‘another service user’, accounting for 10% of the investigations undertaken. By analysing the alleged perpetrator’s relationship with the client against the type of abuse, it is possible to identify and investigate any variances. The following charts show the number of investigations by type of abuse and the relationships between the alleged victim and perpetrator.

Please note that due to the variation in the number of investigations under each type of abuse, the chart scales do vary.

Fig. 2 – Alleged perpetrator relationship to client



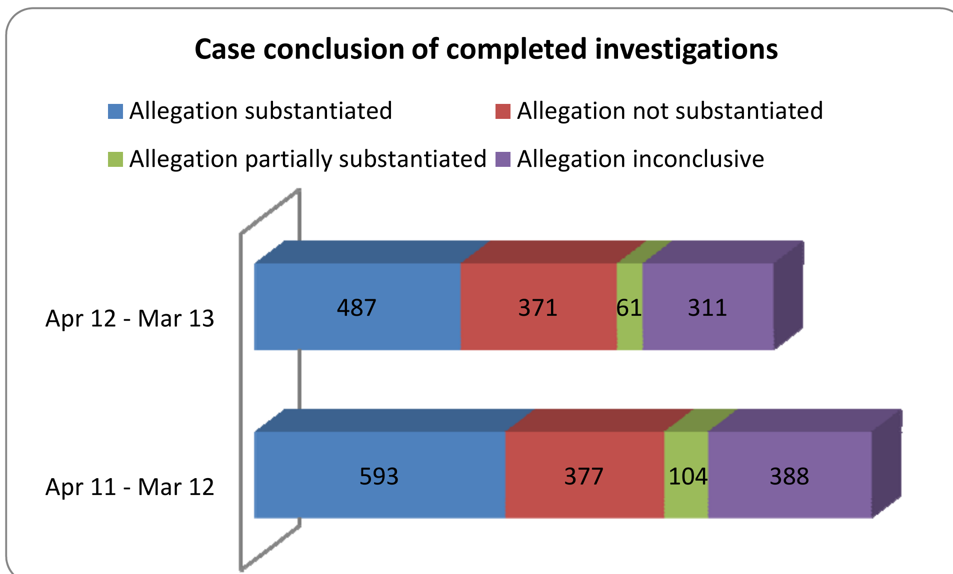


Excluding the cases with no relationship recorded, an analysis of the perpetrator's relationship to the client against the type of abuse has shown:

- The most common perpetrator relationship to the client for 'Neglect' was residential care staff (35%) followed by a health care worker (16%).
- The most common perpetrator relationship to the client for 'Physical Abuse' was another service user (35%) followed by residential care staff (15%).
- The most common perpetrator relationship to the client for 'Financial Abuse' was a family member (20%) followed by cases where the perpetrator is unknown (17%).
- The most common perpetrator relationship to the client for 'Emotional / Psychological Abuse' was residential care staff (19%) followed by a paid carer (14%).
- The most common perpetrator relationship to the client for 'Sexual Abuse' was another service user (38%) followed by a friend (8%).

9. Case conclusion of the investigations

Fig. 3 – Completed referrals within the period by case conclusion



Compared to 2011/12, the proportion of each category of case conclusion remains broadly the same however there has been a slight increase in allegations that have not been substantiated from 26% to 30%.

10. The outcomes for the alleged victims

The outcomes for the alleged victims are presented in table 12. This table illustrates all completed investigations in the period.

Table 12 – Outcomes for alleged victims

Outcome for alleged victim	Apr 11 - Mar 12	% of completed investigations	Apr 12 - Mar 13	% of completed investigations
No further action	580	40%	507	41%
Increased monitoring	438	30%	314	26%
Other	218	15%	220	18%
Restriction/ management of access to alleged perpetrator	99	7%	84	7%
Management of access to finances	29	2%	39	3%
Vulnerable adult removed from property	37	3%	31	3%
Referral to counselling/ training	45	3%	28	2%
Referral to advocacy scheme	5	0%	1	0%
Guardianship/ use of Mental Health Act	5	0%	2	0%
Civil action	6	0%	4	0%
Total	1462		1230	

The outcome of 'No further action' is not to say that nothing has changed as a result of the investigation. In a large proportion of these cases, measures are put in place at the beginning of the investigation to mitigate any further risks associated with the alleged victim. If at the end of the investigation it is deemed that these actions are sufficient to prevent any further abuse, no further actions will be required and this is what will be recorded as the investigation is concluded. This is supported by some case file audits which have shown that risk assessments and safeguarding plans are robust with a proportionate response to the concerns raised. One audit noted that "The safeguarding plan identified training needs for the provider to safeguard all residents and improve the quality of record keeping". This will have wider benefits to all residents in that particular service.

To improve the support available to victims of abuse, the SAB has agreed, in principle, to set up an 'Action on Elder Abuse Buddy Scheme'. Piloted in partnership with Age UK and Comic Relief and established in three areas across England already, voluntary community groups are established to raise awareness of elder abuse in their local community and undertake visits to residential and nursing homes and hospitals. They also train volunteer 'buddies' to befriend people who have experienced elder abuse and assist people who have been harmed or abused to recover from the experience.

11. Outcomes for alleged perpetrators

The outcomes for alleged perpetrators are presented in the table below. Again, this table illustrates only completed investigations to identify the distribution of outcomes for alleged perpetrators.

Table 13 – Outcomes for alleged perpetrators

Outcome for alleged perpetrator	Apr 11 - Mar 12	% of completed investigations	Apr 12 - Mar 13	% of completed investigations
No further action	398	27%	384	31%
Continued monitoring	374	26%	301	24%
Other	126	9%	122	10%
Exoneration	75	5%	79	6%
Discipliniary action	63	4%	73	6%
Police action	86	6%	70	6%
Management of access to vulnerable adult	76	5%	51	4%
Referred to PoVA list/ ISA	30	2%	32	3%
No outcome recorded	100	7%	25	2%
Removal from property or service	30	2%	28	2%
Counselling/ training/ treatment	26	2%	21	2%
Community care assessment	16	1%	14	1%
Action by Care Quality Commission	8	1%	4	0%
Criminal prosecution/ formal caution	31	2%	8	1%
referral to registration body	7	0%	10	1%
Referral to MAPPA/ MARAC	2	0%	2	0%
Action under Mental Health Act	11	1%	1	0%
Action by Healthcare Commission	3	0%	5	0%
Total	1462		1230	

This table shows a significant reduction in the number of investigations without an outcome for perpetrator recorded. In 2010/11, this accounted for nearly 32% of all completed cases whereas in 2011/12 only 7% of completed cases lacked an outcome. In 2012/13, this has fallen further to just 2%.

The most frequent outcome for the alleged perpetrator was ‘No further action’, accounting for 31% of all outcomes. ‘Continued monitoring’ accounted for 24% of outcomes suggesting that victims are receiving continued support after an incident has occurred. This was the highest proportion compared to previous biannual and annual reports.