Agenda Item 8

Report to:	**Adult Social Care and Community Safety Scrutiny Committee**
Date:	**4 September 2014**
By:	**Director of Adult Social Care and Health**
Title of report::	**Safeguarding Adults at Risk Annual Report**
Purpose of report:	**To update Committee on the Safeguarding Adults Annual Report April 2013 – March 2014.**

RECOMMENDATIONS:

The Adult Social Care Scrutiny Committee is recommended to note and comment on the East Sussex Safeguarding Adults Board Annual Report April 2013 – March 2014

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 2013-14. Attached as 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 reflect the commitment across the partnership.

2.2 The key developments by the SAB in 2013-14 were as follows:

- Developing a personalised approach to adult safeguarding moving toward more meaningful dialogue and involvement throughout the safeguarding intervention. There is greater emphasis on the safeguarding plan which is pivotal in working with individuals to achieve their desired outcomes. An implementation plan has been developed and includes workforce development, communication strategies and change management to embed this approach within East Sussex County Council and partner agencies' practice.
- Information from audits, questionnaires and safeguarding interviews has been monitored and analysed to inform good practice changes such as the development of the safeguarding plan and promoting the use of advocacy within safeguarding interventions.
- Developmental workshops with Care Home Providers have taken place across the County to enhance positive partnership working.
- Preventive projects have been developed to reduce the risk of harm and abuse in relation to financial abuse, fire safety and pressure area care.
- Continued raising awareness campaigns including raising awareness of financial abuse.

2.3 The SAB's annual multi-agency audit of safeguarding cases took place in January 2014 focusing on risk and decision making. No major concerns were identified with the majority of cases demonstrating appropriate and positive responses. The areas for development included instances where a safeguarding concern could have been identified earlier as well as improving consistency in undertaking Mental Capacity Assessments.

2.4 The SAB hosted a multi-agency conference which was well attended by a wide range of partner agencies. The conference provided an opportunity to increase safeguarding knowledge and explore good practice. Small interactive workshops were held and provided an insight into current developments in areas of honour-based violence, domestic abuse, anti-social behaviour and 'mate crime'.

2.5 The safeguarding activity data for the period April 2013 – March 2014 is included in the Annual Report and contains the following:

- There were 3,607 alerts received between April 2013 and March 2014. This is a 9% increase compared to the previous reporting year.
- Eastbourne and Hastings areas have received the highest percentage of alerts in East Sussex.
- Cases of neglect continued to increase; however, this increase is a lot less smaller than in previous years. The reduction in the rate of increase is due to the improvement in standards of practice relating to pressure areas.
- The most common location of abuse was residential and nursing care homes accounting for 48% of investigations. Within this setting, neglect was the most common form of reported abuse. The next most common location was in individual's own home which remained at 26% - the same as reported in 2012/13.

2.6 A SAB awayday took place in February 2014 to review the SAB's achievements and agree the priorities for 2014/15. The SAB work plan has been developed for this period alongside other areas to focus in anticipation to SABs being placed on a statutory footing. This plan details areas for development that includes reviewing the terms of reference of the SAB and its subgroups, chairing arrangements and a review of all the SAB policies and procedures. Areas of focus also include how we will work with other agencies when making safeguarding enquires and supplying and sharing information to ensure the SAB is effective as the new legal framework comes into place from April 2015.

3. Conclusion

3.1 This report describes the activity of the SAB to ensure we continue to have effective measures in place to safeguard adults at risk of abuse in East Sussex.

3.2 The report highlights the achievements made by organisations represented on the East Sussex SAB which have enabled individuals to lead safer lives whilst retaining as much choice and control over their own lives as possible.

3.3 The East Sussex SAB remains proactive in its need to continue the development of our approach and response to adult safeguarding embracing challenges and opportunities as we move towards the SAB becoming statutory.

KEITH HINKLEY
Director of Adult Social Care and Health

Local Member(s): All
Background Documents: None

Appendix 1

SAR East Sussex Safeguarding Adults at Risk

East Sussex
Safeguarding Adults Board

Annual Report
April 2013 – March 2014

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Foreword

Welcome to the East Sussex Safeguarding Adults Board (SAB) Annual Report 2013-2014. This report provides an overview of the Board, its member organisations, its workstreams and achievements over the last twelve months.

It has been a very busy year, during which, the SAB's work plan has further developed as the safeguarding landscape has seen some important changes both nationally and locally. The high level of care that we expect to be delivering can sometimes fail, and in the past year we have seen evidence of this in the findings of the Francis Report as well as the continued learning from the Winterbourne View review.

For the SAB to remain effective, partnership working between member organisations must remain strong to ensure consistency and good standards of care are delivered to those who need support. The focus always remains on delivering the best outcomes for the residents of East Sussex.

I am pleased to report that over the last year a lot of progress has been made locally; for example, the work we have done in partnership with the Police and Trading Standards to raise awareness about financial abuse. Raising public awareness is an important aspect of the work we do to prevent abuse from happening.

This report provides a key summary of priorities for the SAB in the coming year including widening the range of people we offer awareness sessions to, such as Parish Councils and Primary Care services.

This report also provides a summary of the work by our partners who are committed to preventing abuse from taking place and responding effectively and proportionately.

I am delighted that the SAB has decided to commission a Peer Review that focuses on what is working well and will provide an opportunity to learn from each other about improvements we can make in adult safeguarding.

This will assist us with our aim to strive for continuous improvement so that East Sussex is a place where adults are safe and empowered to make their own decisions and where safeguarding is everybody's business.

I would like to thank the SAB members and all those working within adult safeguarding for their continued commitment to ensure that people in East Sussex are safeguarded from harm, given safe care and enabled to live their lives independently and free from abuse.

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

National Context

Care Act

In July 2012, the Government published the draft Care & Support Bill, setting out plans for transforming adult social care and support. It creates a single law for adult care and support, replacing more then a dozen different pieces of legislation. A response to pre-legislative scrutiny changed the title to the Care Act in May 2013. The new Care Act has been through the House of Lords and the House of Commons, and received Royal Assent in May 2014.

What will it mean for Safeguarding?

Adult safeguarding is currently a non-statutory policy directive in No Secrets and is discharged through the use of community care legal provisions, referrals between agencies and lawful information sharing. This, alongside concepts within the Mental Capacity Act 2005 and Human Rights Act 1998, has remained the legal underpinning to safeguarding even though the last two years has seen many Judicial Reviews and Court of Protection judgements.

In relation to adult safeguarding, the Care Act will do the following:

- Make Safeguarding Adults Boards statutory
- Make safeguarding enquiries a corporate duty for local authorities
- Make Serious Case Reviews mandatory
- Place duties to co-operate over the supply of information
- Place a duty on local authorities to find advocacy for people who do not have anyone else to speak up for them
- Re-enact existing duties to protect people’s property when in residential care or hospital
- Place a duty of candour on providers about failings in hospital and care settings and create a new offence for providers of supplying false or misleading information.

Safeguarding Adults Boards

Members of the SAB must include the Local Authority, the NHS Clinical Commissioning Groups (CCGs) and the Chief Police Officer. The Local Authority can decide who else should be a member of the SAB, such as Housing or Provider organisations. The SABs will be required to produce a strategic plan, progress on which must be reported annually. This should also include an audit of the effectiveness of the SAB. Where serious abuse or neglect has contributed to the death or harm of an individual, the SABs must carry out a Safeguarding Adults Review.
There is a new duty to supply information to the SAB on request. This mirrors a duty in Children’s safeguarding. The information must be requested for the purpose of assisting the SAB to perform its functions. The person or body required to supply information should have functions that the SAB considers relevant to a function of the SAB. This could include GPs, volunteers or a minister of the Church. It is clear that this duty is to be widely applied.

Care Act and Wider Relevance to Safeguarding

Whilst the safeguarding schedule details the main elements, there is also a strong emphasis in the Act on:

- Prevention of abuse and neglect
- Multi-agency working
- The key role of assessment in protecting people from abuse and neglect
- Emphasis on involving the person and the outcomes the adult wishes to achieve
- Good information and advice on helping to protect those at risk of abuse and neglect.

The Act will provide for 20-30 sets of regulations and will require new statutory guidance which is expected to be published by October 2014. The new legal framework comes into effect from April 2015.
The changes clearly give rise to the need to consider the workforce and training challenges, particularly around the Mental Capacity Act. In the interim, a review of the Terms of Reference of the SAB will be undertaken, including membership, functions and chairing arrangements alongside a costing exercise to ensure the SAB will be fit for purpose and there is sufficient funding to support these new duties.

HealthWatch England

HealthWatch is a new national body that is a statutory committee of the Care Quality Commission. Local HealthWatch organisations have replaced the Local Involvement Networks and have additional functions to help ensure the views and feedback from patients and carers are an integral part of local communities across Health and Social Care.

Local Context

Making Safeguarding Personal Outcomes Project/Pilot

The Making Safeguarding Personal' (MSP) Outcomes project has two main strands:

1. Bringing the adult at risk and/or their representative to the centre of the investigation, making it personal and relevant to them and involving them in the process and decision making so they are able to learn from the experience. In this way it is thought they may be in a better position to self-protect in the future and be supported to do so by those closest to them.
2. To facilitate a shift in emphasis from processes to a commitment to improve outcomes for people at risk of harm. The key focus is on developing a real understanding of what people wish to achieve, recording their desired outcomes and then seeing how effectively they have been met.

At the start of the national project there was recognition that national data collection requirements focus heavily upon the inputs and outputs of safeguarding activity but provide little or no focus upon the outcomes achieved and what difference is being made to people's lives. The project will provide a sense of how to achieve a cultural shift at all levels.

The Pilot in East Sussex

The pilot in East Sussex ran between October 2013 and December 2013 with participation from the Hastings and Rother Neighbourhood Support Team service and Older Peoples Mental Health Team West. Approximately 30 adult safeguarding investigations were involved. The pilot in East Sussex consisted of:

- Discussion at the start of the investigation with the adult at risk/their representative over what they hoped could be achieved by the investigation and what resolution they wanted.
- Discussion at the mid-way point to share with the adult at risk/representative the factors found to have contributed to abuse occurring, consideration of actions to address these factors and a review of their hoped for outcomes.
- Discussion at the end/safeguarding plan review stage with the adult at risk/representative to ascertain what difference has been made to their life and whether their hoped for outcomes were achieved.
- Collection of data of outcomes requested and those achieved. This to be made available in aggregated form.

Findings

The key findings of the pilot were as follows:

- Hearing from the client/representative at the start of the investigation what they hoped to achieve gave improved focus to the investigation both for the client and the Investigating Officer. In terms of safeguarding practice it was better to record this in the clients own words as opposed to ticking a predetermined list.

- Whilst client outcomes expressed in their own words were important to support and focus safeguarding practice, aggregated information is difficult to draw off the system when expressed individually. It was agreed a predetermined list of outcomes would be best located at the end of the investigation (at the point of safeguarding plan review) for data collection purposes.
- Several Investigating Officers expressed the view that the outcomes pilot had freed them to apply social work practice as opposed to being constrained by a formal procedure. The relationship with the client moved more to the centre of the investigation.
- For various reasons some clients were unwilling or unable to be at the centre of the investigation (e g due to recent bereavement) and it was found counter-productive to push dialogue where this is not wanted. A degree of professional judgement is always required.
- Some practitioners found it easier than others to separate the client's view of desired outcomes from their own professional view of what needed to be achieved. Some were able to distinguish and others less so. One client ceased engagement due to professional views dominating.
- In some instances workers found that being explicit about possible outcomes helped in the process of managing expectations.
- The pilot ceased before any investigations had reached the point of safeguarding plan review. Five clients however gave feedback at the point of case conference and said they had achieved what they hoped for. One had not.

<u>Case example</u>

A client was able to express and achieve their own specified outcome in relation to an investigation of alleged financial abuse. The client had been diagnosed with early onset dementia and carers had raised concerns that they were being financially abused by a long-standing friend. The client was known to be generous with money and give to people they would then befriend in the community. The client was clear they wanted to remain friends and remain in close contact with this person. An Independent Mental Capacity Advocate supported the client throughout the investigation as they lacked capacity to manage their finances overall and time was also spent with the friend to raise their awareness of the client's limitations and understanding regarding finances. Safeguards were subsequently put in place for the client's money, but importantly they were able to keep their friendship and contact as had been their desired outcome at the start of the investigation.

<u>Recommendations</u>

- Follow the national Making Safeguarding Personal pilot recommendation to continue to develop this approach locally, not waiting for completion of their three-year programme.
- Continue the practice of identifying at the start of an investigation what the client hopes to achieve. Allow the option for clients writing in their own words their hoped for outcomes.
- Move towards more meaningful dialogue and involvement throughout the investigation, including planning meetings.

- Review safeguarding documents to ensure compliance with MSP and outcome requirements.
- Have a ‘pick list’ of predetermined outcomes on the CareFirst system which will allow aggregated information to be collated. This to be located on the system at the point of safeguarding plan review.
- An implementation plan to include workforce development, communication strategy and change management to ensure this is embedded within East Sussex County Council and partner agency practice and systems.
- Greater emphasis is required on the safeguarding plan which will be pivotal in working with the adult at risk to achieve their outcomes
- Develop a toolkit with partners in line with the Local Government Association toolkit to support the realisation of outcomes people want. This will enable East Sussex to work towards a Silver level. The toolkit can be found at: http://www.local.gov.uk/home/-/journal_content/56/10180/3510238/ARTICLE

  The Making Safeguarding Personal toolkit is designed to support and empower people to make difficult decisions. A range of options will be developed to offer a more creative and personal response. The toolkit covers twelve areas, some tried and tested and others yet to be adapted to an adult safeguarding context, for example, restorative justice, mediation and conflict resolution.

  As well as providing practical advice, the toolkit is intended to be the basis of dialogue with partners about developing new responses to improve outcomes for people who have experienced harm and abuse.

Financial Abuse Campaign

The Safeguarding Adults Board ran a financial abuse awareness raising campaign” *Is something not adding up?”* from October 2013 to April 2014 across East Sussex. The campaign raised awareness of financial abuse amongst the public and professionals across a wide range of agencies and organisations through events and training jointly delivered by Adult Social Care and Trading Standards. Over 3,000 members of the public engaged in the events and many took time to discuss their issues or concerns. Branded leaflets, bookmarks and fridge magnets were created through consultation with clients and carers and were distributed to over 80 GP surgeries and across 24 East Sussex libraries. Since the campaign started, an increase in alerts and investigations of financial abuse has already been noticed particularly in the Hastings area, where the campaign began. Trading Standards have also seen an increase in referrals to and from Adult Social Care in relation to financial abuse.

Safeguarding Adults: A Quick Guide to Awareness and Alerting in East Sussex for Providers’

A short booklet has been developed on behalf of the SAB to give agencies and people who provide care and support to others a basic guide of adult safeguarding and how to report safeguarding concerns. The booklet is available electronically on the ESCC website and as a paper booklet.

Multi-Agency Audit

The SAB’s annual multi-agency audit of safeguarding cases took place in January 2014 with a focus on risk and decision-making and eight partner agencies took part. No major

concerns were identified and all cases reflected consideration and proportionate responses to positive safeguarding. Partnership working and person centred responses were also noted. Areas of learning and development noted several occasions when the safeguarding concern could have been raised earlier by some agencies. Information sharing and multi-agency working was demonstrated well and improvements in the quality of the presentation of information within investigations. There are still some areas which require further work to ensure consistency including undertaking Mental Capacity Assessments.

Serious Case Reviews

No Serious Case Reviews have taken place this year. The policy for Serious Case Reviews has been updated to take account of the change to Safeguarding Adults Reviews within the Care Act and to provide a more proportionate range of responses to reviews of cases on behalf of the SAB.

Conference

The Safeguarding Adults Board hosted a multi-agency conference for professionals in June 2013. This was well attended by a wide range of partners and associated organisations and agencies and received very positive feedback. The conference was an opportunity to increase safeguarding knowledge and tools, explore beyond the immediate response to safeguarding and towards the prevention of abuse, make and strengthen connections with a wide range of professionals and explore good practice in recognising and addressing self-neglect. Small interactive workshops offered information and opportunity for in-depth discussion to gain insight to current thinking and responses to honour-based violence, domestic abuse, financial abuse, fire safety, anti-social behaviour and 'mate' crime.

Pressure Ulcers

The introduction of guidance on how to respond to Pressure Ulcer Alerts has assisted Adult Social Care staff to work with health colleagues in respect of prevention and the management and treatment of pressure ulcers. As a result of investigations evidencing good prevention, management and treatment of pressure ulcers and collaborative work with health colleagues from East Sussex Healthcare Trust (ESHT) there has been improvement in standards of practice in response to and in the prevention of pressure ulcers.
The pressure ulcer reporting process has now been revised and from December 2013 there is no longer the requirement for pressure ulcers to be routinely raised as alerts providing that ESHT are confident that the following is in place:

- A pressure ulcer risk assessment having been carried out
- A treatment plan has been developed
- Care has been provided in accordance with the treatment plan, and
- The treatment plan has been reviewed and revised as deemed necessary

Many of the alerts received are not passed on for safeguarding investigation. Some of these cases do not meet safeguarding thresholds however some concerns are dealt with through care assessment procedures or the complaints process. Further work is planned during 2014-15 within the community to drive quality improvements in avoidable harm.

Falls

In July 2013 a 'Falls and Safeguarding Toolkit' was introduced to assist Adult Social Care staff during safeguarding investigations to determine whether neglect was a contributory factor to a person experiencing harm from a fall. The Toolkit aims to promote falls prevention and is particularly useful where a fall has occurred in a residential care home, nursing home or hospital ward.

Prevention of Harm from Fire in the Community

Increased multi-agency activity has been ongoing over the last two years on behalf of the Safeguarding Adults Board (SAB) in response to a spike in 2011/2012 of accidental deaths from fire related harm. This activity, including raising general awareness through publicity and training, has continued to decrease the risk of harm by increasing both the numbers of free home safety visits by East Sussex Fire and Rescue Service (ESFRS) to people in vulnerable situations and the uptake of ESFRS Care Provider Safety training.
Since January 2013, Adult Social Care staff ask all clients and carers at the point of assessment and review of their needs if they would like a referral for a home visit by ESFRS. Over 10,000 people have been offered a referral with a significant increase in fire checks taking place. Furthermore, a targeted group of 900 potentially high-risk clients, already known to Adult Social Care, have been contacted directly by letter to offer safety visits and as a consequence 224 have agreed to be visited.

Deaths and injury from fire related harm have reduced however the focus on maximising opportunities to prevent harm and to enable ESFRS to reach people at high risk remains a key SAB priority.

Deprivation of Liberty Safeguards (DoLS)

There is a dedicated DoLS team of qualified Best Interest Assessors (BIAs) that access and review applications made under the Deprivation of Liberty Safeguards. The team work closely with care managers and ensure that the least restrictive care plans and safeguarding plans are implemented for clients to avoid any deprivation of liberty.

In 2013/14 there were 164 DoLS assessments completed in East Sussex of which 104 were in care homes and 60 in Hospitals.

There have been significant advances in working relationship with hospitals as the local authority took over as the DoLS supervisory body for hospitals in April 2013.
In addition to the statutory activity of undertaking DoLS assessments, the team provides help and advice to providers and care professionals on the use of safeguards.

The Supreme Court ruling on deprivation in March 2014 defines and extends the previous criteria used for identifying Deprivation of Liberty. This is likely to have a significant impact on all aspects of social care interaction with vulnerable clients including safeguarding. A multi-agency action plan outlining the East Sussex response to the judgement has been developed and will be monitored by the East Sussex Safeguarding Adults Board.

Also, in March 2014 the House of Lords presented the finding of their review of the Mental Capacity Act and a response from the Government is expected in summer 2014.
The impact of the Supreme Court ruling and the House of Lords review may present serious challenges to a wide range of services and have significant resource implications for all service areas.

Vetting & Barring Scheme

Under the Protection of Freedom Act 2012, the Criminal Referencing Bureau (CRB) and the Independent Safeguarding Authority (ISA) merged to form the Disclosure & Barring Service (DBS), a single, new public body in April 2013. Changes have included a redefined scope of regulated activities, abolishing "controlled activities" and introducing 'portability' of CRB checks. Briefings were delivered in conjunction with the Local Safeguarding Children's Board.

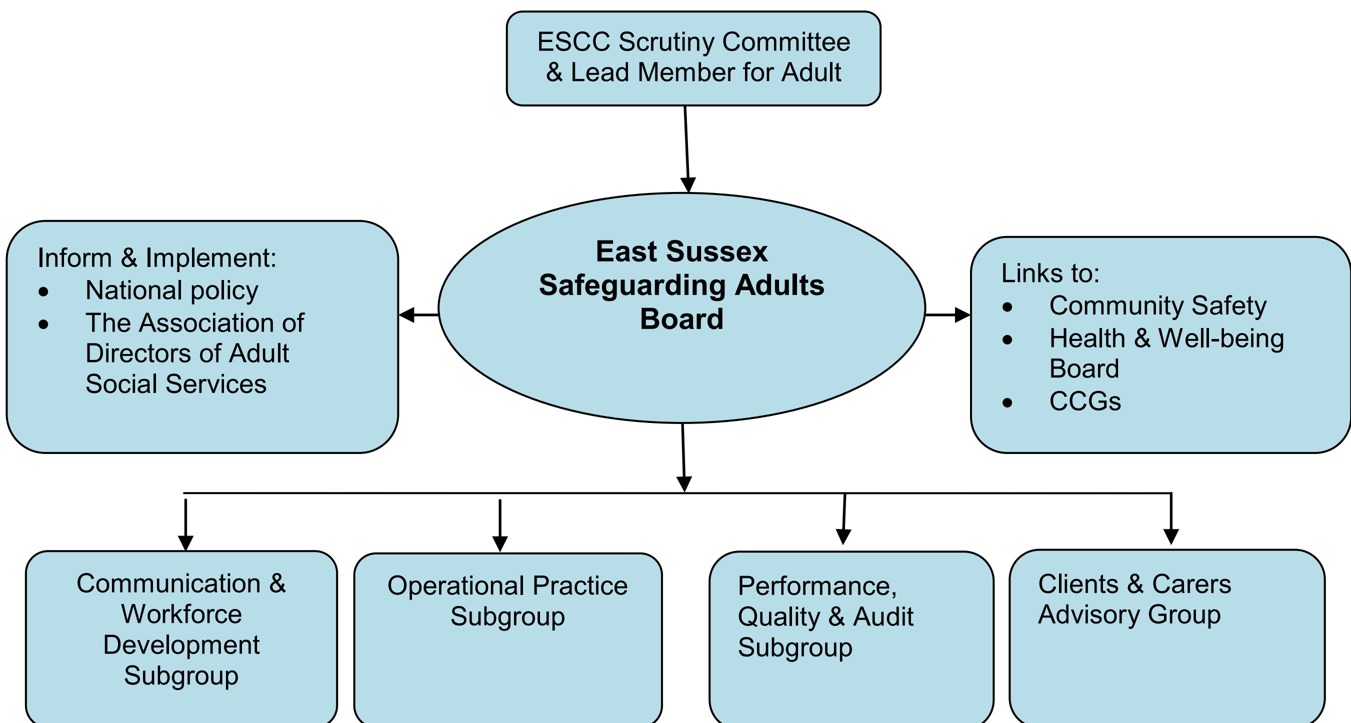
Safeguarding Adults Board

Governance

The East Sussex Safeguarding Adults Board 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 is progressed and reported through its subgroups:

- Operational Practice Subgroup
- Communication & Workforce Development Subgroup
- Performance, Quality & Audit Subgroup
- Clients & Carers Advisory Group.



Other Adult Safeguarding Networks/Meeting

- Sussex-Wide Mental Health Meeting
- Social Care Safeguarding Leads Meeting
- Sussex-Wide Police and Adult Social Care Safeguarding Leads Meeting
- East Sussex, Clinical Commissioning Groups, Adult Social Care and Care Quality Commission Meeting
- Sussex-Wide NHS Leads Meeting
- East Sussex Mental Health and Adult Social Care Meeting
- South East ADASS Safeguarding Network
- ADASS/LGA Safeguarding Adults Coordination Group

Priorities for the SAB

Progress on the Priorities 2012-2014

- Development of a personalised approach to safeguarding has continued with involvement in the national Making Safeguarding Personal project.
- Information from data, audits, questionnaires and post-safeguarding interviews with people who have been involved in safeguarding and their families and carers was monitored and analysed to inform monitoring and continuous improvement.
- The SAB undertook an audit of strategic and organisational arrangements to safeguard & promote the wellbeing of adults at risk in East Sussex. This self-assessment provided an opportunity for each agency to demonstrate compliance and provide examples of evidence that may be relevant when considering minimum safeguarding arrangements.
- The Adult Safeguarding Competency Framework has been reviewed to take account of changes to safeguarding policies & procedures. The main changes are in the Investigating Officer roles and responsibilities to better reflect the Safeguarding Practice Standards as well as a more outcomes focused approach to safeguarding investigations. There are also additional competencies for recognising and reporting child abuse as well as risks to children due to parenting skills.
- Developmental work with partners to promote adult safeguarding and effective multi-agency safeguarding planning has taken place.
- The SAB Conference and Provider Workshops enabled the links between agencies and organisations to enhance positive partnership working.
- 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 including carers has been updated and promoted.

- A focused training programme which is regularly informed by national and local drivers and feedback has been established.

- Improved engagement with providers and better links with the Safer Communities Partnership and the Local Safeguarding Children's Board.

Work Plan

A SAB Away Day took place on 3rd February 2014 to review the SAB's achievements and agree the safeguarding principles and priorities going forward.
The SAB's priorities have been reviewed for the year 2014-15 and areas of focus to progress these priorities were identified. These have been incorporated into the SAB's Work Plan 2014-15 (attached as Appendix1). The implications of the Care Act have also been included in the Work Plan.

SAB Priorities 2014-2015

The Board's priorities over the last two years remain very relevant and have been refreshed and streamlined to six priorities for the next year:

- Ensure the effectiveness of the SAB.
- Focus on personalising safeguarding outcomes to develop a portfolio of responses to safeguarding circumstances that bring safety and people's wishes together.
- Develop performance measures that focus on quality and outcomes which account for the way work undertaken has made a difference.
- Develop a cross system understanding of service quality and to avoid service failure.
- Ensure that people are aware of safeguarding and know what to do if they have a concern.
- Ensure that all people involved in safeguarding have the appropriate skills and knowledge to make sure that personalisation and safeguarding are two sides of the same coin.

Next Steps

- The subgroups of the SAB will develop their Action Plans for 2014/15 and provide regular progress updates to the SAB
- The SAB Work Plan will be monitored and will be flexible to accommodate any emerging national guidance
- Task & Finish groups will be convened as appropriate to progress the work of the Board as required.

Clients & Carers Advisory Group

Connecting clients and carers to the strategic agenda of the Safeguarding Adults Board's (SAB) is threaded throughout the SAB's priorities.

This subgroup was formed last year and meets quarterly. Core membership of the group has been established with regular attendance by key stakeholders and includes representatives from statutory and third sector groups.

Activity undertaken

The group has undertaken activity which has included an examination of the feedback from clients and carers which is currently available to the SAB. Key development issues from this activity were followed through within relevant SAB work streams. The group will continue to undertake this analysis bi-annually.

The group also advised on the development of new publicity materials within the SAB's refreshed safeguarding awareness campaign.

On behalf of the group, links were established for raising awareness of safeguarding within the Lesbian Gay Bisexual Transgender (LGBT) community through the Equalities Facebook page.

Additionally, the group has explored using social media itself to meet its objectives. However, the group concluded that there is a greater benefit to develop robust connections between existing platforms such as Twitter and Facebook with established organisations and groups rather than creating separate entities.

A mechanism has also been developed within by the group to ensure that information is circulated to existing networks.

Training

Safeguarding awareness raising information has been distributed by subgroup members to a range of stakeholders and individual contacts.

Future Plans

This subgroup is now established and the members are keen to maximise the opportunities to meet the SAB's priority to establish a sustainable communication network between clients and carers and the SAB.

The priorities of the SAB were reviewed in February 2014 and the group continues to have a role in addressing the SAB's new and renewed objectives. The group will have a significant role in supporting the activity to promote the development of the 'Making Safeguarding Personal outcomes focused practice. This will include raising awareness of this concept and its implications within safeguarding interventions and assessing how it is experienced for clients, carers and their families.

The group will develop and lead a survey to seek the views of people on their experience of safeguarding with a particular focus on including whether it has a positive impact.

Performance, Quality and Audit (PQA) Subgroup

The Performance, Quality and Audit Group oversee the systems for monitoring, reporting and evaluation of performance across organisations, linking annual reporting to improvement planning and a measurable work programme.
The key purposes of the group include:

- Reviewing available data from key agencies to inform annual priority setting for the Safeguarding Board's work programme.
- Devise performance improvement actions to be incorporated into annual work programme.
- Consider outcomes from clients' and carers experiences of safeguarding, including complaints and compliments, and ensuring they influence service improvements.
- Consider outcomes from the rolling user- survey, case file audits and the multi-agency audits
- Will oversee the Safeguarding Adult Review's action plans, disseminate learning and ensure integration of recommendations into appropriate service plans.
- Consider outcomes from Care Governance Panels and make recommendations for improvement (including reporting news from complex investigations).

Activity Undertaken

- A workshop was held to review partners information to inform the annual report, and 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.
- 27 full case audits and eight threshold audits undertaken by the Adult Safeguarding Development Team. Themes demonstrate improvements in the quality of investigations and partnership working. Further progress is needed to keep the focus on improving safeguarding plans and promote engaging advocates. Areas for development are fed back into training and developmental work.
- Client feedback interviews took place and an area of development highlighted further work needed in sharing and developing safeguarding plans with clients and carers. Areas of development are fed back into training and development work.
- A link between clients and carers and the strategic agenda of the SAB has been established, with the chair of the Clients & Carers Safeguarding Network (CCSN) as a member of the PQA subgroup and ensures that the links between the CCSN and the subgroup's are maintained.
- All Safeguarding Adults policies state that the domestic abuse risk assessment toolkit will be used in domestic abuse cases.

Future Plans

The SAB priorities will inform the work of the Performance, Quality & Audit subgroup moving forward.

Operational Practice Subgroup

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 subgroup 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 subgroups 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.

Activity undertaken

- The number of referrals for advocacy support continues to be monitored and raising awareness sessions have been undertaken to improve referral rates. Further work is ongoing as referral rates still need to be increased.
- This subgroup oversaw the Making Safeguarding Personal (MSP) pilot that ran between October 2013 and December 2013 in East Sussex. The pilot aimed to bring the adult at risk and/or their representative to the centre of the investigation, making it personal and relevant to them. The key focus is on developing a real understanding of what people wish to achieve, recording their desired outcomes and then seeing how effectively they have been met. The recommendation is to continue to develop this approach locally.
- The Making Safeguarding Personal pilot has placed greater emphasis on the Safeguarding Plan, which is pivotal in working with adults at risk as well as partner agencies to link as appropriate the dignity and compassion in care agenda to individual responses. This has been reviewed and updated to reflect recommendations from the pilot.
- A task & finish group led by Commissioners, has been developing revised contracts and specifications for specialist providers undertaking restrictive physical interventions.
- The subgroup contributed to the development of the revised Self-Neglect Policy and was involved in the implementation of the Mental Capacity Act (MCA) Capability Framework.

- The Financial Awareness Campaign “Is Something Not Adding Up?” took place to support people in our community in response to the increase of incidents of financial abuse locally and nationally. This included an engagement event with front line workers such as home carers, nurses, and policy community support officers. A Financial Abuse Toolkit has been developed to assist Operational staff in safeguarding work and is also a benefit to Finance Officers and Trading Standards officers.

- This campaign was hugely successful for Trading Standards in that it raised awareness with ASC colleagues in relation to the work that Trading Standards does, specifically relating to mass marketing fraud and doorstep crime. It has given Trading Standards the platform to develop this work further and agree a job swap between Trading Standards and ASC to help promote a more cohesive approach to financial abuse and how we can support each other’s roles to safeguard.

Future Plans

The objectives of the Operational Practice Subgroup for 2014/15 are:

- To explore learning from national best practice and develop robust process to share and implement. This includes learning from Serious Incidents.
- Establish and embed outcomes focused engagement with clients including the Making Safeguarding Personal approach.
- Undertake a gap analysis on current safeguarding responsibilities and revising the multi-agency delivery model.
- Develop frontline staff skills of professional curiosity alongside wider training to make safeguarding personal. A skills audit to be carried out.
- Implement the Care Act and access its operational implications for adult safeguarding including implications for Prisons and associated duties.
- Further work to ensure the Mental Capacity Act (MCA) is embedded in practice and the use of the Independent Mental Capacity Advocacy (IMCA)
- Further development to share data/information.
- Learning from the Safeguarding Peer Review.

Communications & Workforce Development (CWD) Subgroup

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

The CWD subgroup 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.

SAB priorities which direct the focus of activity within the subgroup:

- Making safeguarding personal through focusing on outcomes for individuals.
- Improve the range of responses to individuals bringing safety and people's wishes together.
- Ensure a preventive approach to safeguarding is embedded in practice.
- Ensure people are aware of safeguarding and know what to do if they have a concern.
- Ensure that people involved in safeguarding activity have the appropriate skills and knowledge to deliver a personalised approach.

Activity Undertaken

- 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 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 subgroup 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 & 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 subgroup has been overseeing the plans for the SAB Safeguarding Conference held in June 2013. The programme had 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 Adult Social Care.

Training

Please see Appendix 2

Future Plans

Future plans for this subgroup include:

- Developing support to increase safeguarding and domestic abuse awareness for Primary Health partners including GPs.

- Informing partners of the impact of the Care Act on safeguarding

- Developing mechanisms to ensure that local and national learning and best practice is shared and implemented to ensure real change in promoting a preventive focus within safeguarding.

- Analysing the challenges and gaps in training and developing joint and multi-agency training on key safeguarding related topics such as Self Neglect and Mental Capacity Act activity.

Quality Monitoring Team (QMT)

Activity Undertaken

As a result of joint working with Safeguarding Coordinators, the QMT have been able to identify ways of improving partnership work with Operational teams and providers.
The QMT have been monitoring safeguarding concerns and have been able to identify themes and patterns of low level concerns.

We have increased further awareness for other teams to inform us of safeguarding alerts by working jointly with Safeguarding Coordinators. We are also active in how to provide best advice for providers on raising alerts, especially those pertaining to incidents. We receive regular updates from the Adult Safeguarding Development Team to help us inform providers of any new developments in adult safeguarding.
Our relationships with providers have been strengthened and we have received more positive feedback from them this year following safeguarding review visits.

Training

A bespoke safeguarding workshop was delivered for the QMT in conjunction and with assistance from the ASC Training Team.

Joint training with the Adult Safeguarding Development Team has been undertaken to broaden our understanding of safeguarding procedures and investigations. This included the Safeguarding Competencies, understanding safeguarding levels training and keeping up to date with roles and responsibilities within the safeguarding processes.

Future Plans

- To develop more safeguarding outcomes measures through the quality monitoring safeguarding action plan review processes to enable preventive measures to be implemented.
- To continue our joint partnerships work with Operational teams and Safeguarding Coordinators as well as working with providers.

We are furthering our joint working relationship with Working Age operational teams to ensure consistency. Providers who are not familiar with the pathway process have been informed to ensure the correct pathway for alerting via Social Care Direct.

Safeguarding Alert & Referral Form: We have worked jointly with Safeguarding Coordinators to ensure Operational teams advise the QMT of safeguarding issues, especially those relating to institutional abuse as most cases focus on individual clients.

Adult Safeguarding Development Team

The Adult Safeguarding Development Team (ASDT) has been involved in a wide range of activities over the last year with a primary focus on quality assurance and developmental support for operational teams and external partners. In addition, the ASDT creates, contributes and reviews safeguarding related policies and guidance

Activity Undertaken

The chart below demonstrates the volume of activity the team has undertaken.

Activity between April 2013-March 2014	Number completed
General safeguarding case audits	114
Themed audits	37
Threshold audits	62
Case Conferences with Independent Chair	124
Client feedback interviews	18
Stakeholder feedback questionnaires	26
Workshops and presentations	78

The team has audited over 200 cases this year. The quality assurance function of auditing assists in the evaluation of individual performance and team practice. The focus is to identify and strengthen areas of practice which require development and link into individual and departmental training needs in order that continuous improvement provides the best service possible to clients and carers who experience the safeguarding process. An example of improvement is that noted in the quality of investigation reports following developmental and reflective practice workshops and one-to-one support.

The team has provided independent chairing of safeguarding case conferences in over 120 cases this year. The independent chair provides a level of impartiality to the conference and are most often engaged when the complexity of cases require additional objectivity and support. Chairs promote a greater focus on safeguarding planning both within investigations and at case conferences. They also provide developmental support and ensure that wider risks and improvement needs are identified and responded to e.g. the guidelines have revised on the provision of pressure relieving equipment within the community to avoid delays and potential harm to people at risk. Practice Standards for chairing safeguarding conferences have also been developed.

The ASDT keep up-to-date with local and national research and policy changes, including the implications of the Care Act for safeguarding. In turn they provide support and advice to Adult Social Care and external partners. The team co-ordinated the national project ‘Making Safeguarding Personal '. The pilot (ran from October to December 2013) involved 30 cases across two service areas that were supported to develop the outcomes focused approach. The emphasis was to develop a real understanding of what adults themselves, or their representative, wished to achieve alongside ensuring people’s safety. The team devised a review document and guidance to support and promote the enhancement of safeguarding planning with adults at risk to ensure that plans are monitored consistently throughout the investigation. The evaluation of the pilot was reported to the SAB in January 2014 and the results fed into the national project.

The ASDT has supported a range of activities on behalf of the Safeguarding Adults Board including joint working with East Sussex Fire & Rescue Service to increase home safety

visits to people in vulnerable circumstances to reduce the risk of fire harm. Additionally, the team contributed extensively to the successful financial abuse awareness raising campaign 'Is something not adding up?'. The campaign saw engagement with over 3,000 members of the public. The team facilitated workshops and stalls involving over 300 Home Care providers and Health staff in partnership with Adult Social Care Training, operational teams and Trading Standards. The ASDT has also delivered follow up awareness sessions to voluntary organisations.

The team developed guidance 'Partnership working: Adult Social Care and providers' to enhance working between Adult Social Care and providers. This protocol supports openness, transparency and consistent partnership collaboration during safeguarding investigations. To promote this work, the team facilitated engagement workshops with providers across the County in partnership with the Training Team. Feedback from these workshops was positive and has improved the quality of partnership working with providers and engagement with adults at risk and persons alleged responsible, where appropriate. Guidance to staff on the promotion of improvements in practice to identify and ensure that individuals/organisations alleged responsible participate in investigations, as appropriate has been incorporated into the Investigating Officers Toolkit.

The team has supported the implementation of the Sussex Wide Self-Neglect Policy.

'Falls & Safeguarding Toolkit' has been developed to assist staff when investigating allegations of harm due to falls and to promote preventative measures to reduce future risks.
An external audit in April 2013 highlighted the need to more consistently feedback to people who raise alerts. The process to feedback has been clarified to ensure that people who raise safeguarding concerns are appropriately informed of the outcome of their alert.

Training

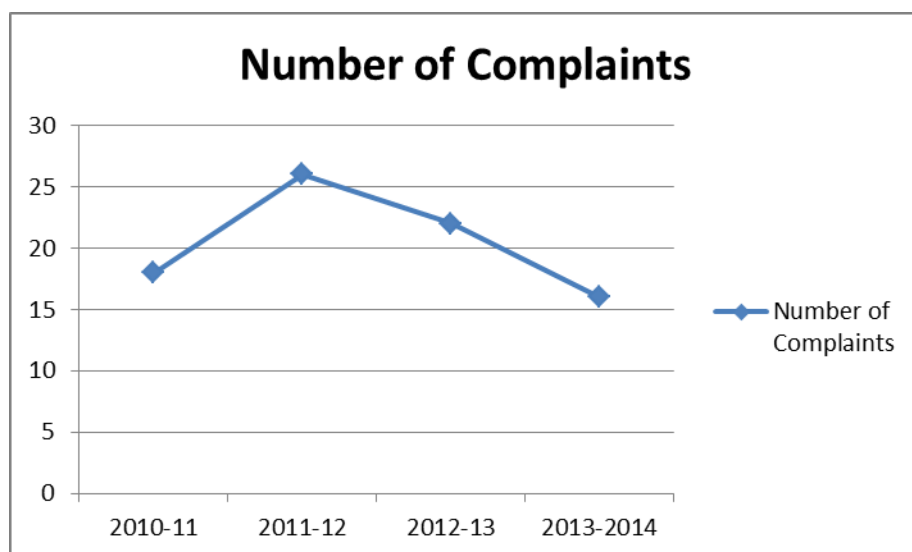
The team delivered workshops and presentations to ASC operational teams, on a wide range of safeguarding related subjects including those to support improvements on investigation report writing, safeguarding planning and safeguarding minute- taking. Additional workshops have been delivered to external organisations and agencies mainly focussed on raising awareness of safeguarding covering topics such as alerting concerns, prevention and compassion in services.

Future Plans

The ASDT continue to be involved in supporting the development and outcomes focused safeguarding practice across Adult Social Care. The team will also continue to be engaged in the Making Safeguarding Personal project. This will include developing a set of responses in partnership with SAB partners to support improvements in personalised safeguarding practice. The pilot project highlighted the need to promote advocacy services within safeguarding and further work is planned to achieve this.
The team continue to have a key role in supporting the implementation of a revised safeguarding planning tool and the safeguarding plan review mechanism to ensure that safeguarding practice is both robust and inclusive.

Following the financial abuse campaign, a project has been planned to enhance and promote links and the exchange of knowledge and expertise between Adult Social Care and Trading Standards.

Summary of Adult Social Care Safeguarding Adults Complaints 2013-14



Sixteen complaints were received by Adult Social Care about the safeguarding process. This is 27% lower than the complaints received about adult safeguarding in 2012/13, when 22 complaints were recorded. Looking back we can see that the number of complaints received in year 2013-14 is the lowest in the last four years.

The numbers of complaints are very small in relation to the number of alerts received and investigations undertaken; particularly considering the complex circumstances that are involved.
The reasons why people complained varied considerably and the numbers were low in all categories. Given the low numbers it is not possible to identify a theme or trend. One or two complaints were recorded for the following categories: disputing the outcome or decision of an investigation, appropriateness, accessibility of the process, staff manner and attitude, information and delay. This is different from last year when five (23%) of complaints were about the manner and attitude of staff involved in the investigation.

Of the 16 complaints received, six (37.5%) were upheld in full or in part. Three (50%) of these were in relation to the appropriateness of the investigation. These complaints did not identify any organisational learning but reinforced the need for staff to ensure that they involve people appropriately and make sure that they speak to people alone to get a true picture of events.

The Local Government Ombudsman (LGO) investigation team looked at two complaints that both disputed the outcomes of the safeguarding investigations.
The LGO investigation discontinued one investigation at the complainant's request. This was because the manager had met with the complainant and provided a full explanation. The other complaint found that Adult Social Care were at fault in the way it carried out the safeguarding investigation. However, because the original complaint had led to a reinvestigation and the outcome was changed to unsubstantiated the LGO decided this was an appropriate remedy and so the complaint was discontinued.

Compliments

Compliments are a valuable source of information to the board. When expectations are exceeded it helps identify where there is excellent practice and reinforces understanding about what people value. Here is an example of a compliment from a residential service provider:
'I would like to pass on to all concerned that we found the whole experience to be professional, transparent and supportive. The Investigating Officer was especially very supportive to our service user by keeping her updated and also to us as a service in terms of providing us with advice and clear guidance throughout the investigation. The Investigating Officer worked in full partnership with us as a Provider and my senior Team Leader was very grateful for her support and time given throughout the investigation.'

'We would like to thank you for your time and excellent presentation. This subject concerns us all directly and indirectly, now and in the future. Thank you once again.'

Sussex Police

Activity Undertaken

The following activity was undertaken in year 2012-13:

- Steps have been undertaken to improve multi-agency working in relation to safeguarding adults. This includes the development of a Multi-Agency Safeguarding Hub at County Hall North in West Sussex. Where the force's Adult Protection Team is co-located with adult safeguarding colleagues from the Local Authority.
- Sussex Police undertook an audit looking at the quality and quantity of Vulnerable Adult at Risk (VAAR) forms completed by officers and staff. This form provides a mechanism to refer adults at risk of abuse to the Local Authority. Recommendations were provided from this audit and will be implemented throughout the next year.
- The Protecting Vulnerable People Branch was involved in planning and attending the Multi-Agency Audit held in January 2014. This audit provided the opportunity to consider good practice and areas of improvement.
- A representative from the Protecting Vulnerable People Branch has attended the Safeguarding Adults Board and relevant sub groups throughout the year.

Training

- Sussex Police had an intake of new Police Constables (PCs) last year. Each new PC undertakes a comprehensive Foundation Training course, which includes theoretical and practical training that covers several areas relating to safeguarding alerts. This includes how to recognise and respond to an adult at risk, accurate recording and risk assessment of safeguarding matters and features talks from victims and case studies. The training also includes a two week community placement which often includes working with vulnerable members of the community.
- Sussex Police are also working with a PhD student who is undertaking work with each Adult Protection Team to establish what training is currently provided in relation to safeguarding adults and whether there are any gaps in knowledge or improvements required.

Future Plans

- Sussex Police are implementing a new Single Combined Assessment of Risk Form (SCARF). This will replace the VAAR form and once completed by an officer or member of staff will be forwarded to the relevant Local Authority. This new form avoids duplication and allows officers and staff the opportunity to provide more information about the adult at risk. In turn, this will improve the referrals received by the Local Authority.
- In addition to the above, further PCs are being recruited and will undertake relevant safeguarding adults training. The PhD student will also continue their work and report back on their findings.

Sussex Police are currently working more closely with Surrey Police and collaborating in several areas. The Protecting Vulnerable People Branch is currently being aligned with their counter parts in Surrey Public Protection. Overall this will improve the work undertaken by the Protecting Vulnerable People Branch; however there may be initial challenges whilst these two branches align. The Protecting Vulnerable People Branch will change its name to the Public Protection Branch in June 2014.

Sussex Partnership NHS Foundation Trust

Sussex Partnership NHS
NHS Foundation Trust

Activity Undertaken

Sussex Partnership has continued to work closely with the Local Authority and local partners to support safeguarding vulnerable adults across East Sussex.
During the year an additional governance and performance framework has been implemented to capture specific information on alerts relating to our services and where our staff may be alleged perpetrators. We took part in the Adult Social Care survey on staff understanding of safeguarding and the learning from this will be used to further develop local staff's awareness and competences.

Further work has also been undertaken to improve the links between adult safeguarding and serious incident investigations. This work has enabled the Trust to ensure safeguarding is a more prominent part of our work around service quality.

The Sussex Partnership Safeguarding Policy was reviewed during 2013 in line with Sussex Multi-Agency Policy for Safeguarding Adult at Risk.

Training

Safeguarding training is a core element of the Trust's induction programme and further training is available to support this through our adult safeguarding on line e-learning package. A specific programme of self- neglect training has been rolled out jointly with Adult Social Care. The Trust has also supported additional programmes of training around Mental Capacity Act to be delivered to staff across our services during the year.

Future Plans

- To continue self neglect multi-agency training.
- To continue management meetings between SPFT and ASC to ensure learning from safeguarding activity and investigations are informing practice and outcomes.
- To continue to produce safeguarding data when the Trust is involved as a provider of a service or a member of our staff is the alleged perpetrator.
- To develop confidence and competence in responding to domestic violence and sexual abuse across our services through a three year funded program run in partnership with the Against Violence & Abuse Stella Project / Department of Health.
- To further develop our training strategy on Mental Capacity Act.

East Sussex Healthcare NHS Trust (ESHT)

East Sussex Healthcare NHS Trust

Activity Undertaken

The Trust has continued to work in partnership with ASC over the last year to ensure joint Safeguarding policies are adhered to within ESHT. ESHT continues to have focused senior leadership for safeguarding adults and children.
Activities throughout 2013/14 included:

- SAB representation from ESHT
- Collaborative working to ensure all safeguarding alerts are dealt with in an appropriate and timely fashion.
- Ensuring robust action plans are delivered within ESHT in relation to the safe provision of care.
- Continuing with the collaborative working through monthly operational meetings and quarterly strategic safeguarding adults meetings.
- Identifying key themes and trends within alerts investigated and ensuring preventative action planning is in place for the Trust.
- The Multi-Agency Audit was presented and discussed at the SAB. Overall the process had a positive outcome demonstrating positive interagency working. It included areas for development for ESHT which is included within our annual plan.
- ASC and ESHT have agreed that the Pressure Ulcer prevention Pathway is well embedded within the Trust. All category 3 and 4 pressure ulcers no longer go into safeguarding automatically. However, should neglect be suspected, those cases will be referred to Safeguarding for ASC to decide on whether to investigate or not.
- ESHT have supported ASC in the updating of the Self Neglect joint policy, which has now been ratified and is in use.
- The Falls policy and the relevant assessments have been reviewed and are now embedded within the Trusts working practice.
- ESHT continue to work in partnership with ASC, improving communication pathways between the two parties to support the smooth running of services. The ESHT monthly operational group ensures continued communication including ensuring the timely production of reports/ attendance at case conference and that all actions from case conference are delivered in a timely manner.
- Joint training between ASC and ESHT continues to be reviewed. Joint training has included Disclosure and Barring training, the annual Adult Safeguarding conference in June 2013, Pressure Ulcer prevention training and Domestic Abuse training. Training regarding the application of the Self Neglect Policy is also in progress.

- A number of regular audits ranging from monthly 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. Audits have noted a reduction in alerts during 2013/14, compared to 12/13. This is in part due to improved prevention processes and maintaining a high percentage of training and awareness of safeguarding processes within ESHT.
- An updated Safeguarding Adults at Risk Policy is available for ESHT in line with the Sussex Multi-Agency Safeguarding Adults At Risk policy (last updated May 2014).

Training

- Level 1 safeguarding adults training - 100% of all staff are trained within ESHT
- Level 2 safeguarding adults training - 79.22% of required staff trained
- Mental Capacity Act Master class - 87.86% of required staff trained
- Deprivation of Liberty Safeguards - 81.54% of required staff trained
- Prevent training was delivered to targeted frontline services
- Domestic Abuse training – currently delivered in combination with safeguarding children training, with timetabled dates to offer this training to key staff over the next financial year. ESHT is working with Adult Social Care to deliver Domestic Violence in Adults joint training, in 'light bites' of a one hour session commencing with staff in the gateway services and the District Nursing Service.

Future Plans

- To work with both adult and child safeguarding services to improve awareness and action required with regard to domestic abuse.
- ESHT strategic meetings are now combined adults and children to ensure issues such as domestic abuse are tackled jointly within ESHT.
- To continue close collaborative working with Adult Social Care – ensuring continuing improved outcomes for our customers.

Trading Standards

Activity Undertaken

- We have worked in partnership with ASC to complete the financial abuse campaign, supporting training and awareness raising events all over the county.
- 1054 people have been trained on the work of trading standards specifically the protection of adults at risk in relation to doorstep crime and mass marketing fraud.
- There are now 132 members of the Support with Confidence scheme. This is a scheme to help people find a range of care & support services from people and organisations that have been vetted and approved on the grounds of quality, safety and training.
- We have retrieved £39,526 in civil redress from local consumers (these would all be considered vulnerable as we have a strict intervention policy).
- We have responded to 23 Rapid Action Team calls relating to consumers and doorstep crime.

The National Scams Team (Hub)

This initiative was in its pilot stage last year and has been given main stream funding – it is considered a national priority by the National Trading Standards Board. The Scams Hub was set up to utilise intelligence from key partners, to identify potential serial victims of scam mail and provide a referral mechanism for these victims to get advice and support from appropriate agencies. 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.

Training

Four officers were trained in Achieving Best Evidence (ABE) to allow us 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 also enhance our witness skills.

Future Plans

Further development of the National Scams Team - we currently have 108 Local Authorities signed up and 16 national partners. We have recorded just over £3 million of consumer detriment and £2 million savings from local interventions. Our focus is now on safeguarding the most at risk but also tackling the UK based enablers of mass marketing fraud.
We have also agreed a job swap with our partners in Adult Social Care so that we can each develop more of an expertise in each other's fields.
We will be launching a witness support pack in 2014 and the Consumer Support Network and Building Bridges are being given an injection of life and we are looking at how those services can be improved.
Resources continue to be a challenge, the same as all across the county. The emphasis is even more so on partnership working and sharing resources to have the most impact. We

have achieved this with the Financial Abuse campaign which was excellently organised and co-ordinated by our Adult Social Care partners.

East Sussex Fire & Rescue Service (ESFRS)

Activity Undertaken

- ESFR have Introduced a mandatory requirement for staff to complete the online KWANGO safeguarding training and structured training for managers. 137 staff have completed the training.
- Reviewed our staff structure in relation to safeguarding responsibilities for senior managers.
- Updated our internal Manual Note guidance regarding safeguarding outlining staff roles and responsibilities.
- The Fire Service is now represented on the County Street Community and Rough Sleepers Board.
- Training has been delivered in-house to 48 members of staff by the Local Safeguarding Children's Board (LSCB).

Future Plans

Our future plans include:

- Development of awareness training for staff in respect of modern slavery.
- Development of awareness training for staff in respect of rough sleepers and homeless individuals.
- Development of training in respect of self-neglect, particularly in relation to hoarding.

Some of the challenges for us include the delivery of safeguarding training that is appropriate to staff groups based on their likelihood of identifying risk.
Also, staff roles and responsibilities change with staff moving which poses a certain challenge for the trainers.

South East Coast Ambulance Service NHS Foundation Trust

South East Coast Ambulance Service NHS
NHS Foundation Trust

Activity Undertaken

The South East Coast Ambulance Service (SECAmb) has made 521 vulnerable person referrals to East Sussex over the past year, which equates to approximately 11% of the 4654 adult referrals generated by SECAmb staff. These were a combination of social care issues (such as increasing care needs) and safeguarding concerns.
SECAmb piloted a domestic abuse programme, offering support to victims of domestic abuse identified by SECAmb crews. This was delivered in partnership with one of the domestic abuse charities in the area.

Training

The Trust has a five year safeguarding training needs analysis in accordance with the Level1 safeguarding adults training that was scheduled in 2012-13. The figures below demonstrate the delivery for different staffing groups, based on enrolment:

- Accident & Emergency: 94%
- Emergency Operations Centre: 76%
- Patient Transport Service: 92%
- 111(non-urgent care): 95%
- Non-operational: 83%

2013-14 was focussed on Level 2 safeguarding children. Further safeguarding adults training will take place in 14/15 in line with the organisational training plan.

Future Plans

The Trust is looking at how the work undertaken under the domestic abuse pilot could be taken forward and expanded across the whole Trust. We are also looking to launch a web-based reporting tool for crews to refer vulnerable person concerns, replacing the current paper-based system, which will facilitate closer scrutiny of concerns being raised and make reporting against these more robust. We are introducing benchmarking this year, and will be reporting against anticipated volumes of referrals based on area specific targets, using demographics and national and local reporting figures to determine expected ratio of referrals to emergency calls received. We will use this data to inform targeted programmes of education and information to local crews.
A full departmental review is also underway including revision of Trust policy to take into account the most recent intercollegiate document publication and the Care Act.

Continued increase in activity across the Trust, particularly from the 111 Call Centres, leaves little resilience within the department from a resourcing perspective. This has a knock-on impact in regard to our ability to respond to information requests in a timely manner and also contributes to these responses not being of the quality we would hope

for. It also compromises our ability to attend local Safeguarding Adults Boards, however, we are very aware that how crucial working closely with partners is and improving this will be another area of focus within SECAmb for the coming year; this will be supported and informed by the outcomes of the departmental review.

Clinical Commissioning Groups (CCGs)

Eastbourne, Hailsham & Seaford
Hastings & Rother
High Wealds Lewes & Havens

Activity Undertaken

The following developments and activity were undertaken by the CCGs:

- Appointment of a permanent Designated Safeguarding Adults Nurse by the Hastings & Rother CCG but working across Eastbourne, Hailsham & Seaford CCG and High Wealds Lewes & Havens areas.
- Joint appointment (CCG and East Sussex County Council) of the Clinical Quality Review Nurse, working with the CCG and East Sussex County Council Quality monitoring Team to give clinical input into quality monitoring of Care Homes (with Nursing).
- Safeguarding Adults Policy & Procedures have been written and approved.
- 'Criteria for Provision of Objective Health Opinion' from the CCG for adult safeguarding investigations had been produced and now circulated to teams within Adult Social Care.
- Designated Nurse involvement in safeguarding investigations relating to health related issues has been increasing and further developing also providing health input into investigations and case conferences and participating in action plans to promote high quality safe care.
- Participation in the annual Multi- Agency Audit of Adult Safeguarding.
- Development of links and effective proportionate information sharing pathways with Integrated Continuing Health Care Team, Quality Monitoring Team and Care Quality Commission.
- Attendance and participation in East Sussex Domestic Abuse Steering Group.
- Participation in a Domestic Homicide Review led by West Sussex.
- Attendance and participation in newly formed Domestic Homicide Review Learning Group.
- Participation in Safeguarding Adults and Children Strategic Group CCG & East Sussex Healthcare Trust.
- Designated Safeguarding Adults Nurse attends East Sussex Health and Social Care Learning Disability Commissioning Group.
- Close liaison with colleagues re progress of the Winterbourne View action plans.
- Attendance and participation in the work of the SAB and its subgroups.

Training
Fourteen clinical and non-clinical staff have undergone safeguarding training in High Wealds Lewes & Havens CCG.

Across Hastings & Rother and Eastbourne, Hailsham & Seaford, a total of 45 of clinical and non-clinical staff have undergone training.

Future Plans

- Further safeguarding training to be delivered.
- Continued liaison with colleagues regarding Winterbourne View action plans and to continue to improve health and social outcomes for people with Learning Disabilities.
- To work with provider organisations to increase awareness and staff training in recognition and response to domestic abuse (as per East Sussex Domestic Abuse Strategy).
- Development of a policy relating to domestic abuse for CCG employees.
- To continue to work with provider organisations to ensure recommendations from the Francis Report are taken forward.

- Further development of information sharing pathways to ensure CCGs are aware of the safeguarding issues in provider organisations where CCG patients may be placed. This includes sharing information with Adult Social Care and out of area providers where CCG funded patients may be located.

- Promoting awareness of the Mental Capacity Act and Best Interest Processes in Primary Care. Safeguarding training availability in Primary Care is variable – the CCG would wish to ensure that Primary Care colleagues are more consistent in their approach to safeguarding and the level of training that they commission for the practices.

Summary of Performance Data 2013-2014

Introduction

Across the partnership we have in place a Safeguarding Performance Quality and Audit Framework. The intention of this framework is to drive improvements in safeguarding outcomes. Part of this framework includes the collection and review of safeguarding activity data to identify gaps in service provision and support the allocation of resources. The following report, produced by the Performance, Quality and Audit sub-group of the East Sussex Safeguarding Adults Board, summarises the safeguarding activity undertaken between 1 April 2013 and 31 March 2014.
The report provides details of 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.

1. Alerts and investigations by category of adult at risk

There were 3,607 alerts of abuse received in East Sussex between April 2013 and March 2014. This is a 9% increase on the number of alerts reported during 2012/13 (3,301 alerts). One of the reasons for this increase was the introduction of guidance relating to responding to Pressure Ulcer alerts in 2012/13. The guidance assisted adult social care staff to work with health colleagues in respect of prevention, management and treatment of pressure ulcers. As a result of investigations evidencing good prevention, management and treatment of pressure ulcers and collaborative work with health colleagues from East Sussex Healthcare Trust (ESHT) there has been improvement in standards of practice in response to and prevention of pressure ulcers.
To manage the increase in alerts, operational teams are prioritising safeguarding investigations alongside their other work priorities. A breakdown of these alerts is shown below:

Table 1 – Alerts in period

Client Type	Apr 12 - Mar 13	Apr 13 - Mar 14	% difference
Physical/ sensory/ frailty	2137	2437	14%
Learning Disability	209	216	3%
Mental Health	732	680	-7%
Substance Misuse	44	59	34%
Other	179	215	20%
Total	**3301**	**3607**	9%

Of the 3,607 alerts received in East Sussex, 1,101 went on to be investigated. This equates to 31% of the alerts received. In the previous year, 40% of alerts received were investigated. Many of the alerts received are not passed on for safeguarding investigation. Some of these cases do not meet safeguarding thresholds however many concerns are dealt with through care assessment procedures or the complaints process. The table below shows the alerts that went on to be investigated by client type:

Table 2 – Alerts investigated in period

Client Type	Apr 12 - Mar 13	Apr 13 - Mar 14	% difference
Physical/ sensory/ frailty	834	721	-14%
Learning Disability	122	105	-14%
Mental Health	296	196	-34%
Substance Misuse	15	33	120%
Other	50	46	-8%
Total	**1317**	**1101**	-16%

The table below shows the number of safeguarding alerts received between 1st April 2013 and 31st March 2014, by district / borough. The table shows an indicative percentage of the population in each district / borough for whom a safeguarding alert was received. This is indicative only as some people may have more than one alert raised in the period, although these numbers are fairly low.

Table 2a - Safeguarding alerts by district / borough

District / Borough	Number of alerts received	Percentage of alerts received (3,607)	Indicative percentage of population in that district / borough for who a safeguarding alert was received
Eastbourne	901	25.0%	1.12%
Hastings	784	21.7%	1.10%
Lewes	489	13.6%	0.62%
Rother	657	18.2%	0.88%
Wealden	705	19.5%	0.59%
Unknown / Out of area	71	2.0%	-

2. Incidents by type of abuse

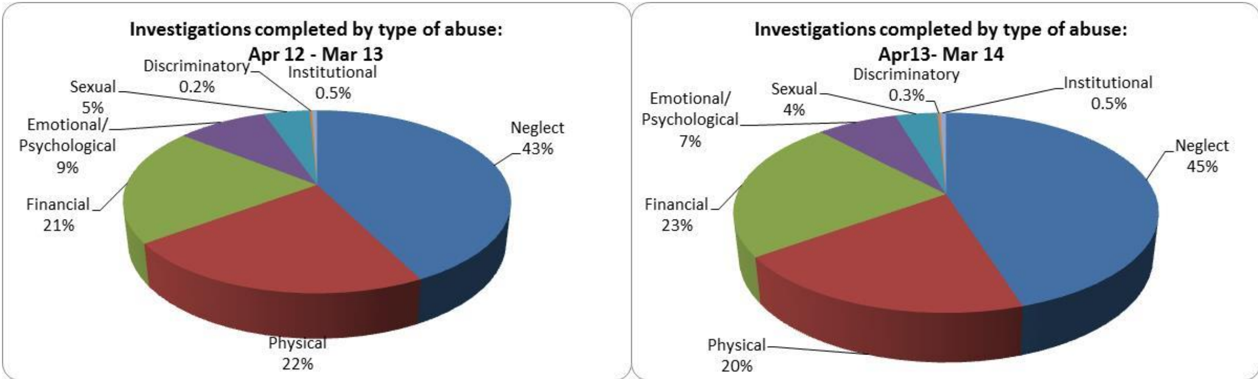
There are seven types of abuse that are recorded in East Sussex:

- 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 2013/14, institutional abuse was recorded for six investigations, the same number as undertaken in the previous year.

The types of abuse that were reported are presented in the pie charts overleaf. These illustrate the spread of the types of abuse across all investigations and provide a comparison between 2012/13 and 2013/14.
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



Previous years have seen considerable increases in the proportion of investigations where neglect was the presenting concern. Cases of neglect have increased again from 43% in 2012/13 to 45% of investigations in 2013/14 however, this increase is a lot less smaller than in previous years. Again, this is likely to be due to the multi- agency pressure ulcer policy that was introduced in 2012/13.
Of the 1,146 investigations completed in 2013/14, 156 cases involved multiple forms of abuse. This compares to 130 cases in 2012/13. The table below provides further details:

Table 3 – Completed multiple abuse investigations

Client Type	Apr 12 - Mar 13	Apr 13 - Mar 14	% difference
Neglect	53	64	21%
Physical	69	82	19%
Financial	45	65	44%
Emotional/ Psychological	88	95	8%
Sexual	16	14	-13%
Discriminatory	0	3	-
Institutional	3	3	0%
Total	**274**	**326**	19%

The data indicates that in cases of multiple abuse, 29% include emotional/ psychological abuse and 25% include some form of physical abuse.

The following table shows the number of safeguarding investigations started between 1st April 2013 and 31st March 2014, by district/borough. The map of the areas is attached as Appendix 3. The table shows an indicative percentage of the population in each district / borough for who a safeguarding alert was received. This is indicative only as some people may have more than one alert raised in the period, although these numbers are fairly low.

Table 3a - Safeguarding investigations by district / borough

District / Borough	Number of investigations started	Percentage of investigations started (1,104)	Indicative percentage of population in that district / borough for who a safeguarding investigation was started
Eastbourne	281	25.5%	0.35%
Hastings	255	23.1%	0.36%
Lewes	147	13.3%	0.19%
Rother	198	17.9%	0.27%
Wealden	191	17.3%	0.16%
Unknown / Out of area	32	2.9%	-

*Please note that numbers shown in table 3a will differ slightly from those in table 1.

3. Timescales

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

Table 4 – Alert timescales – all alerts

Alert timescales	Apr 12 - Mar 13	% of all alerts	Apr 13 - Mar 14	% of all alerts
Less than 2 days	2288	69%	2465	68%
3-7 days	779	24%	1012	28%
More than 7 days	230	7%	119	3%
Alert left open	4	0%	11	0%
Total	**3301**		**3607**	

The table above shows that on average the length of time it takes to make decisions about alerts is slightly longer than in 2012/13 with 1% fewer decisions being made within two days. This could be attributed to the volume of alerts being received and the complexity of the alleged incidents.

Table 5 – Investigation timescales – all completed investigations

Investigation timescales	Apr 12 - Mar 13	% of all investigations	Apr 13 - Mar 14	% of all investigations
7 days or less	54	4%	23	2%
8-14 days	105	8%	62	5%
15-28 days	329	26%	213	19%
More than 28 days	754	61%	848	74%
Total	**1242**		**1146**	

The table above shows that although the number of investigations is decreasing, a greater proportion is taking longer to complete. This is due to the way cases are

recorded as well as more complex cases being investigated. If input is required from a number of different partner agencies, the investigations often take longer to complete.

4. Incidents by location

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

Table 6 – Location of abuse

Location of abuse	Apr 12 - Mar 13	Apr 13 - Mar 14
Residential/ nursing homes	521	513
Vulnerable adults own home	341	330
Acute hospital setting	105	86
Public place	51	46
Mental health inpatient setting	40	27
Supported accommodation	51	20
Alleged perpetrators home	34	28
Day care/ service	12	12
Community hospital	17	15
Other	21	18
Education/ training/ work establishment	4	0
Other health setting	3	10
Location not known	34	26
Not recorded	8	15
Total	**1242**	**1146**

The investigations illustrated above reflect all investigations completed in the period. The most common category for the location of abuse is residential and nursing care homes accounting for 48% of investigations. This is an increase compared with last year when residential and nursing care accounted for 41% of cases. The next most common location of abuse is in the vulnerable adults own home, accounting for 26% of cases. This is the same as the proportion reported in 2012/13.
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 variance can be identified and investigated.
Within the residential/ nursing care settings, the most common form of reported abuse is neglect, accounting for 59% of cases, and physical abuse, accounting for 21%.
Within the vulnerable adults own home, the most common form of abuse is financial abuse, accounting for 47%, followed by neglect which accounts for 24% of the investigations that were completed in the period.

5. Source of referrals

The sources of referrals to be investigated are presented in table 7

Table 7 – Source of referrals

Source of referral	Apr 12 - Mar 13	Apr 13 - Mar 14
ASC - Domiciliary staff	32	33
ASC - Residential care staff	194	193
ASC - Day care staff	20	18
ASC - Self directed care staff	1	1
ASC - Other social care staff	181	173
NHS - Primary/ community health staff	62	40
NHS - Secondary health staff	202	192
NHS - Mental health staff	50	43
Self referral	26	20
Family member	98	96
Friend/ neighbour	10	12
Care Quality Commission	12	10
Housing	46	41
Police	82	63
Other service user	1	0
Education/ training/ workplace	3	1
Other	209	191
Not recorded	13	19
Total	**1242**	**1146**

The investigations illustrated in the table above are investigations that were completed 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

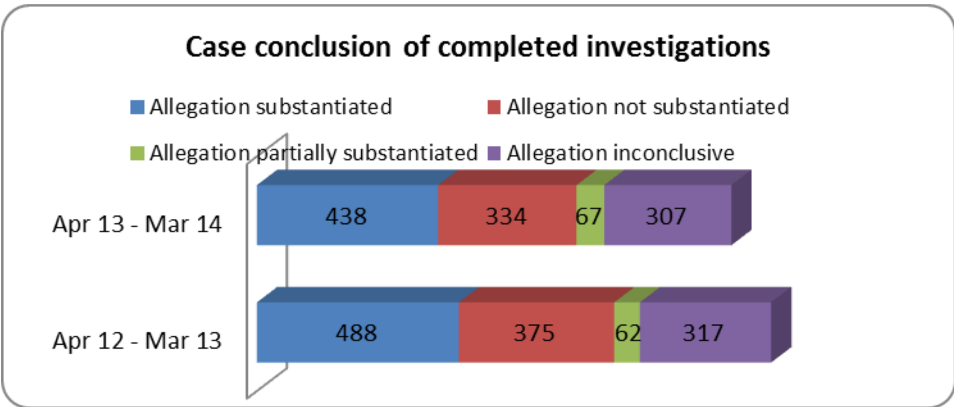
In 2013/14, the categories of 'ASC – Residential care staff', 'NHS secondary health staff' and 'other' each account for 17% of the sources of alert for completed investigations.

As in previous years a focussed awareness raising campaign continues as notably low numbers of alerts have been received from primary and community health staff (GP's, practice nurses and community/ district nurses). In response, information has been circulated such as posters and flyers to GP surgeries as well as an engagement event with district nurses in rural Wealden.

6. Case conclusions of investigations

Figure two below shows the conclusions for the cases that were completed in 2013/14, compared to those completed in 2012/13.

Fig 2 – Completed referrals within the period by case conclusion



Compared to 2012/13, the proportions of each category of case conclusion remains broadly the same, with just 1% variances in each category.

7. The actions implemented to support alleged victims

Following investigation, the actions implemented to support the alleged victim are presented in the table below.

Table 8 – Actions taken to support victims of abuse

Actions supporting alleged victim	**Apr 12 - Mar 13**	**% of completed investigations**	**Apr 13 - Mar 14**	**% of completed investigations**
No further action	513	41%	446	39%
Increased monitoring	320	26%	288	25%
Other	220	18%	231	20%
Restriction/ management of access to alleged perpetrator	84	7%	75	7%
Management of access to finances	39	3%	41	4%
Vulnerable adult removed from property	31	2%	30	3%
Referral to counselling/ training	28	2%	26	2%
Referral to advocacy scheme	1	0.1%	3	0.3%
Guardianship/ use of Mental Health Act	2	0.2%	4	0.3%
Civil action	4	0.3%	2	0.2%
Total	1242		1146	

The chart shows the most common outcome as 'no further action'. In a large proportion of these cases, measures are put in place at the beginning of the investigation to mitigate any further risk 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.
Between October and December 2013, a pilot was undertaken to establish a more outcomes focussed safeguarding process. The emphasis of this process is on finding out what victims of abuse would like to achieve from the safeguarding investigations. Following the success of this pilot, the process is being rolled out to the rest of East Sussex Adult Social Care during 2014/15 and the outcome will be reported alongside the activity data in this report.

8. Resulting actions for the person alleged responsible

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

Table 9 – Actions for alleged perpetrators

Actions for alleged perpetrator	Apr 12 - Mar 13	% of completed investigations	Apr 13 - Mar 14	% of completed investigations
No further action	396	32%	349	30%
Continued monitoring	307	25%	268	23%
Other	123	10%	152	13%
Exoneration	78	6%	59	5%
Disciplinary action	72	6%	67	6%
Police action	70	6%	73	6%
Management of access to vulnerable adult	51	4%	37	3%
Referred to PoVA list/ ISA	32	3%	17	1%
No outcome recorded	21	2%	31	3%
Removal from property or service	27	2%	28	2%
Counselling/ training/ treatment	21	2%	10	1%
Community care assessment	14	1%	12	1%
Action by Care Quality Commission	4	0%	5	0%
Criminal prosecution/ formal caution	8	1%	11	1%
Referral to registration body	10	1%	14	1%
Referral to MAPPA/ MARAC	2	0%	5	0%
Action under Mental Health Act	1	0%	5	0%
Action by Healthcare Commission	5	0%	3	0%
Total	1242		1146	

Compared to 2012/13, the proportions under each category have maintained fairly consistent. The most common outcome is 'no further action' however, as with the actions supporting alleged victims, this only reflects the final outcome at the end of the investigation and not any actions that have been implemented at earlier stages of the investigation to protect the adult at risk.

Definitions

Alert – The reporting of concerns or allegations of Adult Abuse to Adult Social Care Services.

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

Levels of investigation are broken down into 4 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 Investigations 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 Institution abuse.

Types of Abuse:

- **Physical abuse -** hitting, pushing, slapping, scalding, shaking, pushing, 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 vulnerable adult has not consented, or could not consent 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 the systems, 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 on the balance of probabilities any of the allegations of abuse made;
- **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 as there is no clear evidence.

Other Definitions:

- **Person alleged responsible** - This is the person who the vulnerable adult, or other person/s, has alleged but not yet proven to have committed the abuse.

Appendix 1

Safeguarding Adults Board (SAB) Work Plan 2014/15

SAB Priority	Action/Measure
Priority 1 Ensure the effectiveness of the SAB	• Lead on safeguarding and invite relevant local representatives as required.
	• Ensure that each member is a champion for safeguarding within their own organisations as described in the Terms of Reference (TOR) of the SAB.
	•Review funding arrangements for the safeguarding adults partnership by agreeing the SAB funding formulae.
	• Develop a mechanism to ensure that the voices of clients and carers are integrated into the strategic activity of the SAB.
	• Ensure SAB members are aware of their responsibilities and implications of the Care Act.
	• Inform relevant partners of the impact of the Care Act by attendance at workshop/launch.
	• Review existing structures in light of the Care Act through focused peer review action plan.
	• Develop strategic learning across agencies, boards and borders, learning from national best practice.
Priority 2 Focus on personalising safeguarding outcomes and develop a portfolio of responses to safeguarding circumstances that brings safety and people's wishes together.	• Establish outcomes focused engagement with clients through the Making Safeguarding Personal (MSP) roll-out.
	• Engage with informal carers by updating written guidance. • Continue with awareness raising events.
	• Develop a toolkit of responses that incorporate client's views through collated outcome data.

Priority 3 Develop performance measures that focus on quality and outcomes reflecting and accounting for how work undertaken has made a difference.	• Review and refresh the SAB Information Sharing Protocol. This reflects the Care Act. • Address gaps regarding information sharing by agencies sharing required information quarterly in line with Care Act requirements. • Monitor the use of information and its strategic application through audits, client feedback and national returns.
Priority 4 Develop a cross system understanding of service quality and avoid service failure.	• Proactively identify service failure and share information across agencies. • Agencies to offer support depending on their expertise to address failure. • Commissioners to develop market specifications in line with the Care Act that will be agreed via the Operational Practice Subgroup.
Priority 5 Ensure that people are aware of safeguarding and know what to do if they have a concern.	• Develop and deliver a targeted awareness raising campaign with primary care, the police and home care providers, evaluating alerts after 6 months. • Review targeted awareness raising in rural areas through parish boundaries.
Priority 6 Ensure that all people involved in safeguarding have the appropriate skills and knowledge to make sure that personalisation and safeguarding are two sides of the same coin.	• Develop frontline staff skills of professional curiosity through workshops and training. • Consider challenges, gaps and next steps in training through agencies' own internal arrangements as well as contributing to multi-agency SAB training. • Explore joint/multi-agency training opportunities.

Appendix 2

Safeguarding Adults at Risk Training Data
April 1st 2013 – March 31st 2014

E-learning Modules (source KWANGO) – number of completions:

Safeguarding Adults at Risk	
East Sussex County Council	271
Integrated Care Services	304
Primary Care Trust	61
Hospital	4

Mental Capacity Act completions	
East Sussex County Council	193
Integrated Care Services (ICS)	203
Primary Care Trust	51
Hospital	5

Deprivation of Liberty completions	
East Sussex County Council	130
Integrated Care Services (ICS)	243
Primary Care Trust	24
Hospital	1

Formal Training Events (as advertised through the on-line training brochures)

The courses below represent the training delivered across adult social care. Whilst some courses are specific to internal Assessment & Care management staff (Investigating Officer (IO), Investigation Manager (IM)), other courses are available to the Independent care sector and our directly provided services.

Course Title	Number of courses	DPS attendances	ACM attendances	ICS attendances	Total attendances
Safeguarding Train the Trainer	4	2	1	39	42
Safeguarding Refresher	7	84	7	65	156
Safeguarding Minute Taking for Administrators	2	0	16	0	16
Safeguarding Level 1 Investigations	3	3	1	44	48
Safeguarding IO Workshop	4	0	61	0	61
Safeguarding IO two day training	5	1	70	0	71
Safeguarding IM Reflective Practice Workshop	4	0	62	0	62
Safeguarding Basic Awareness	12	65	44	158	260
Mental Capacity Act: Who Decides	4	2	26	23	51
Mental Capacity Act: An Introduction	9	41	36	116	193
Deprivation of Liberty Safeguards: An Introduction	5	15	25	62	102
Deprivation of Liberty Safeguards Updates	2	3	12	15	30
Assessing under the Mental Capacity Act	4	1	26	42	69
Safeguarding and the Law	2	1	27	12	40
Court of Protection (Mental Capacity Act)	1	0	21	0	25
Safeguarding Chair of Meetings & Case Conferences	1	0	15	0	15
Safeguarding Investigating Manager - New Manager	1	0	15	0	15
Safeguarding Trainers Forum	2	0	7	25	32

Bespoke Training

In addition, the Adult Social Care Training team has provided an increased amount of bespoke training. This is either as a result of specific requests from Assessment & Care Management (ACM), the Integrated Care Services (ICS), Supported Accommodation (SAILS) and Directly Provided Services (DPS), or specific requests from the Quality Monitoring Team following visits to providers.

Course title	Number of courses	ACM attendances	ICS attendances	DPS attendances	SAILS attendances	Charities/ 3rd sector	GP surgeries	Total attendances
6 Principles of Safeguarding in Health & Safety Care	3			38				38
Safeguarding Refresher	31		250	111	28			389
Mental Capacity Act & Deprivation of Liberty Safeguards	5		73					73
Mental Capacity Act –Supported Decision Making	19			183				183
Mental Capacity Act bespoke sessions	9	100						100
Safeguarding/ Deprivation of Liberty Safeguards	2					22		22
Safeguarding/ Mental Capacity Act	5						105	105

Other Training

Financial Abuse campaign
The Adult Social Care Training Team has been jointly supporting this campaign by offering a Mental Capacity Act refresher of the basic principles of the Act and its relevance to Financial Abuse. These sessions ranged between 1.5 and 2 hours long and were offered to a broad range of internal and external staff. These sessions formed part of a coordinated multidisciplinary approach led by the Safeguarding Development Team and co delivered by the Safeguarding Development Team, the Trading standards Team and the Adult Social Care Training Team. These sessions have been attended by 79 participants

Self-Neglect
Following the publication of the new self neglect guidance and procedures, the training team delivered 25 one hour brief bite sessions to a total of 232 staff from Assessment & Care Management and Directly Provided Services teams across the county. Additionally, we delivered the first of four multi-agency training days for managers, attended by 24 staff representing adult social care, police, housing providers and health.

Appendix 3