



East Sussex Safeguarding Adults Board Annual Report

April 2020 to March 2021



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Foreword by Graham Bartlett, East Sussex SAB Independent Chair



I have great pleasure in presenting this, my last annual report for the East Sussex Safeguarding Adults Board. I am standing down to pursue other challenges but am delighted to hand the reins over to a hugely experienced chair, Deborah Stuart Angus. I know Deborah will take the SAB from strength to strength.

To say this has been a challenging year would be a huge understatement. All of us have been affected by the COVID-19 pandemic and many people reading this will have contracted the virus, may have lost loved ones or had their lives changed forever. To those I extend my heartfelt sympathies and hope you can return to some form of normality soon.

To allow those working on the frontline the time and space, the SAB significantly reduced its work programme for most of the year especially those areas which would have drawn those the county relied upon from their critical roles. That said, we have made significant progress in developing our protocols, understanding the Safeguarding Adults Review process, adopting new and innovative ways of working and delivering our new three-year strategy. These developments have all been made with the new challenges very much in mind and will help partners to work better together to safeguard those who rely on us.

The Safeguarding Adults Review we published this year, Adult C, cut across so many safeguarding themes: domestic abuse, housing, substance misuse, mental ill health and criminality that there was hardly a single agency untouched by its learning. Embedding this is a significant task but one the Board and its members will rise to.

Learning from SARs is probably the best legacy we can provide to those who have died. That is why we should be very proud of the new Adult Death Protocol which was developed this year following the completion of the Adult B SAR in 2019 – 20. This will vastly improve how agencies respond to deaths where abuse or neglect are suspected. It is already making a difference and is being considered for adoption nationally.

I'd like to finish by thanking everyone who has made my tenure as SAB chair such a privilege. Their support and engagement has made all the difference, not only to me but crucially to those who rely on our shared safeguarding system. This is even more critical during this pandemic and, to those who have stepped up to the plate and made such a difference in these difficult times, a very special thank you.

A handwritten signature in black ink, appearing to read 'G Bartlett'.

Graham Bartlett

Independent Chair, East Sussex Safeguarding Adults Board

Comments by Healthwatch



In what has been an extremely challenging year for everyone, it has been very reassuring from a community perspective to know the East Sussex Safeguarding Adults Board and its subgroups have continued to deliver their functions and responsibilities, albeit with many adjustments required in response to the unprecedented demands caused by the coronavirus pandemic.

As one of the subgroups of the Board, the Safeguarding Community Network paused our meetings and delayed some aspects of our work programme during the height of the pandemic. However, in my role as chair, I continued to attend virtual Board meetings when these were reinstated and helped shape their agendas as a Healthwatch representative and on behalf of the community. I was also keen to ensure essential communications and connections were maintained throughout any periods of pause in activity. This included reassurance to the local community that all aspects of safeguarding was 'open for business' as usual, and anyone with concerns about an adult could raise these appropriately and receive a response.

Now, as restrictions are being lifted, plans are underway to reinstate the Safeguarding Community Network meetings, virtually at first and, when it is safe to do so, look at how we can meet again in community locations. Our work programme will also be reviewed to ensure any commitments made pre-pandemic are still relevant and can be delivered. This will include increasing representation at our network meetings by individuals and voluntary and community sector organisations, ensuring the Board has a robust communications strategy and that mechanisms are in place to share any learning from the pandemic that will assist the strategic direction of the Board as it agrees its priorities for the future.

We look forward to reconnecting with our network members as well as welcoming new ones in the year ahead.

Elizabeth Mackie

Volunteer & Community Liaison Manager, Healthwatch East Sussex

Our role and purpose

The East Sussex Safeguarding Adults Board (SAB) is a multi-agency statutory partnership which provides leadership and strategic oversight of adult safeguarding work across East Sussex. The Board brings together partner agencies who have a responsibility for adult safeguarding, and comprises core membership of statutory partners from East Sussex County Council (ESCC), NHS East Sussex Clinical Commissioning Group (CCG) and Sussex Police. Additional members from a range of organisations, including community and voluntary agencies and lay members, are represented on the Board to reflect that safeguarding activity and interventions can only be effective where there is collaboration and shared commitment. A full list of the partners of the East Sussex SAB is given at Appendix 1.

The work of the SAB is underpinned by the Care Act 2014, which sets out that we are required to:

- Develop and publish a [Strategic Plan](#) setting out how we will meet our objectives and how our partner agencies will contribute to this.
- Publish an annual report detailing how effective our work has been.
- Arrange for Safeguarding Adults Reviews (SARs) to be undertaken when the criteria under section 44 of the Care Act are considered to have been met.

The East Sussex SAB is led by Independent Chair, Graham Bartlett, and supported by a SAB Development Manager, a shared Quality Assurance and Learning Development Officer post and a part-time Administrator. The Board meets four times a year and is supported by a range of subgroups which are crucial in ensuring that the priorities set out in the Strategic Plan are delivered. Each subgroup has a work plan which details the areas of focus for the financial year, and is regularly updated with specific actions and timescales. These subgroups ensure that the work of the Board really makes a difference to local safeguarding practice, and to the outcomes adults and their carers wish to achieve. A diagram outlining our Board structure can be found at Appendix 2.

Our vision

Our vision is for all agencies to work together and effectively build resilience and empower communities in responding to abuse, neglect and exploitation, and to widely promote the message that safeguarding is everybody's business in that:

- Abuse is not tolerated.
- People know what to do if abuse happens.
- People and organisations are proactive in working together to respond effectively to abuse.

Our purpose

It is important to note that the SAB is not involved in operational practice. Rather, our overarching purpose is to ensure that agencies work in partnership to deliver joined-up services that safeguard adults with care and support needs from abuse, neglect and exploitation. We do this by:

- Gaining assurance that local safeguarding arrangements are in place as defined by the Care Act and its statutory guidance.
- Working collaboratively to prevent abuse and neglect, where possible.
- Ensuring partner agencies are effective when abuse and neglect has occurred, and give timely and proportionate responses.
- Gaining assurance that the principles of Making Safeguarding Personal (MSP) are central to safeguarding, and practice is person-centred and outcome-focused.
- Striving for continuous improvement in safeguarding practice, and supporting partner agencies to embed learning from local and national SARs, other learning reviews and multi-agency audits.

Partnership working

The SAB has formal links with a number of other strategic partnerships in East Sussex, including the East Sussex Safeguarding Children Partnership, Safer Communities Partnership, Children and Young People's Trust, the East Sussex Domestic and Sexual Violence and Abuse Management Oversight Group and the Health and Wellbeing Board. In addition, the Board maintains links with a number of Sussex-wide and national networks and forums including:

- National Network for Chairs of SABs.
- National SAB Managers Network.
- South East Regional SAB Network.
- Sussex Anti-Slavery Network.

The Board works closely with the neighbouring Brighton & Hove and West Sussex SABs, and many of our policies and procedures are adopted on a pan-Sussex basis.

Our strategic priorities



1: Accountability and leadership

To ensure the SAB provides strategic leadership to embed the principles of safeguarding, and contribute to the prevention of abuse and neglect.

2: Policies and procedures

To have assurance that multi-agency safeguarding policies and procedures are regularly reviewed and reflect up to date legal frameworks, policy and guidance, and that these are easily accessible and used effectively by frontline staff.



3: Performance, quality and audit, and organisational learning

To ensure learning from reviews is effectively embedded into practice and to facilitate organisational change across agencies.

4: Prevention, engagement and Making Safeguarding Personal

To ensure adults, carers and the local community as well as professionals shape the work of the SAB and safeguarding responses.



5: Integration, and training and workforce development

To ensure the workforce is equipped to support adults appropriately where abuse and neglect are suspected.

SAB budget

The SAB budget is pooled and our partner agencies contribute to the running of the Board, not just financially but for example by offering to chair meetings and co-deliver training.

Income for 2020 – 2021

East Sussex County Council	£68,900
NHS East Sussex Clinical Commissioning Group	£30,000
Sussex Police	£12,000
East Sussex Healthcare NHS Trust	£10,000
East Sussex Fire and Rescue Service	£5,500
Carry forward and third-party income	£7,433
Total	£133,833

In comparison to the 2019 – 20 budget, partner agencies contributed the same, with the exception of ESCC who increased their contribution by £2,100 to cover staff pay increases of 2.5%.

Expenditure for 2020 – 2021

SAB Independent Chair	£13,726
SAB Development Manager	£61,108
Quality Assurance and Learning Development Officer	£29,875
SAB Administrator	£12,955
Policy and procedures	£722
SAB website and associated training costs	£6,258
Software licence for SAR chronologies	£596
Total	£125,240

The impact of the coronavirus pandemic on SAB activity has led to some areas of proposed expenditure being amended from earlier projections. Over 2020 – 21 there was no financial expenditure on training, learning events and SAR activity. However, there were some one-off costs for the re-design of the SAB website and staff training in respect of this. The Board will carry forward £8,593 from 2020 – 21 into the 2021 – 22 budget.

Response to coronavirus

The coronavirus pandemic led to unprecedented challenges and put adult safeguarding in a position of greater importance than ever before. Over the past year the SAB has regularly sought assurance from our partner agencies about responses to COVID-19, and undertaken work to ensure services have been, and continue to be, supported to respond to emerging safeguarding themes.

Within East Sussex, as in many other parts of the country, during the pandemic there were concerns regarding the increased difficulty in identifying safeguarding issues due to reduced face-to-face contact. This was particularly in relation to domestic violence and abuse, self-neglect and the impact on those in caring roles. Additional areas of concern have included:

- The challenges of carrying out safeguarding enquiries remotely.
- The implementation of DNARs (Do Not Attempt Resuscitation) without following the Mental Capacity Act process in full and ensuring appropriate consultation with individuals and their families.
- A significant increase in calls to domestic abuse helplines including an increase in people with suicidal ideation and mental health concerns.
- The ongoing impact of social isolation on people's mental health, and the impact of the pandemic on the wellbeing of the health and social care workforce.
- New and emerging risks for people with care and support needs, such as scams about COVID-19 testing and vaccines, and coronavirus fraud.

The SAB suspended the majority of Board and subgroup meetings during the first and second waves of the pandemic to support frontline services to focus on operational demands. The Board also restricted its work in relation to SAR activity, although the SAR subgroup continued to meet virtually on a monthly basis. During 2020 – 21, there was a rise in SAR referrals. This was due in part to the impact of COVID-19, both in creating challenges for services and in a notable increase in concerns about mental health and suicide.

Alongside the challenges outlined above, the pandemic also brought opportunities for new ways of working. The first wave of the pandemic saw successful interventions and innovations, including the housing of those sleeping on the streets in East Sussex and the growth of community hubs, who have reached out to many isolated people providing practical and emotional support.

Over the past year, all SAB meetings and multi-agency training have been held remotely and we have seen an increase in engagement given the efficiencies that virtual meetings create.

The SAB contributed to the work of the Sussex Resilience Forum's Vulnerable People Cell. This met weekly during the height of the first wave to identify gaps and issues in the support available for vulnerable people, and to co-ordinate responses locally and across Sussex. Another welcome development was the increased participation of SAB managers in national networks, such as the National Board Managers Network and the NHS Safeguarding Adults National Network (SANN). These forums have supported more effective sharing of information about emerging safeguarding themes and learning from SARs, as well as providing a platform for a panel of speakers from a range of national leadership positions.

In the coming year, the SAB will continue to evaluate the ongoing impact of COVID-19 on safeguarding activity, and monitor recovery measures to ensure that learning is shared around the challenges and opportunities that this period has created and to consider the longer-term impact of the pandemic.

Key achievements 2020 – 21

Accountability and leadership:

- Work has begun across the three Sussex SABs to plan for the 2021 self-assessment programme and peer challenge / support event. A revised self-assessment tool has been devised which is more proportionate and allows for partners to provide more qualitative responses to support rigorous peer challenge.
- Contributions from the SAB Development Day, held in February 2020, informed the objectives and priorities for the new [Strategic Plan 2021 – 2024](#), which was launched at the beginning of April 2021.
- The SAB has continued to support the modern slavery agenda. This has included reviewing and adapting the training programme for virtual delivery, and working with the East Sussex Safer Communities Partnership to produce the first e-newsletter targeted at the Single Point of Contact (SPOC) network – staff who have enhanced knowledge and skill in this area. In October 2020, ESCC leaders marked Anti-Slavery Day by signing the Modern Slavery Pledge, which underlines the council's commitment to end modern slavery and human trafficking.
- The Safeguarding Development Team (SDT) in Adult Social Care and Health has led on work to review and evaluate the Financial Abuse Strategy. The evaluation highlighted that understanding of what constitutes high risk financial abuse differs amongst practitioners, there are gaps in ensuring all relevant agencies are involved in financial abuse cases, and there is a need for greater awareness of the interface between financial abuse and coercion and control. Further work is planned in 2021 to review and update the financial abuse guidance.
- The SAB has established links with the Rough Sleepers Initiative, and co-produced an article in the September 2020 edition of our [SAB newsletter](#) to raise awareness of the complexities of chronic homelessness and rough sleepers. The Operational Practice Subgroup receives updates from the Sussex Strategic Homelessness Group to maintain oversight of work in this area.

Policies and procedures:

- The Sussex Policy and Procedures Review Group has proposed a number of updates to the procedures, including coercion and control in domestic abuse, transitional safeguarding, Prevent, working with people in positions of trust and

causing other agencies to carry out safeguarding enquiries. The updates to the procedures will be implemented later in 2021.

- The three Sussex SABs have developed a number of pan-Sussex protocols, and the [Information Sharing Guide and Protocol](#) and the [Sussex SAR Protocol](#) were both launched in August 2020. The Board has also supported work to raise awareness of the SAR eligibility criteria through the development of a [SAR Referral Learning Briefing](#).
- The [Adult B SAR](#), published in East Sussex in February 2020, made a recommendation that the Board should review existing arrangements to investigate the deaths of vulnerable adults, where abuse or neglect by a third party is suspected or known. In response to this, the East Sussex SAB and Sussex Police led on developing the [Sussex Adult Death Protocol](#), which was launched in November 2020. The protocol, adopted across all three Sussex SABs, provides a mechanism to ensure a rapid coordinated multi-agency response to unexpected adult deaths. The protocol has received national attention and will be adopted in a number of other police forces across the country and will also be considered by the National Police Chiefs Council later in 2021 for national implementation.
- [Making Safeguarding Personal \(MSP\) guidance](#) was published to assist practitioners and providers to understand how to apply MSP effectively in safeguarding situations. The guidance also sets out resolution mechanisms for when someone cannot be seen alone and there is a concern they may be experiencing undue influence or coercion.

Performance, quality and audit, and organisational learning:

- 2020 – 21 has been extremely busy in terms of SAR activity, with the publication of the [Adult C SAR](#) in December 2020, work to deliver on recommendations from SAR action plans and an increased number of SAR referrals. The SAR Subgroup has strengthened arrangements to share learning across review processes with its meetings receiving updates on Domestic Homicide Reviews (DHRs) and from the Learning Disabilities Mortality Review (LeDeR) Programme. During 2021 – 22, it is planned that the SAR Subgroup will also start to receive updates on the outcomes of Drug Related Death reviews. The SAB also received the findings from the first [national analysis of SARs](#) and work will start over the next year to support and embed its learning.
- The Performance, Quality and Audit Subgroup has continued to develop and monitor the SAB multi-agency safeguarding data set, and has further enhanced the contributions from partner agencies. Through the National SAB Managers Network, the Quality Assurance and Learning Development Officer contributed to a working group to consider mechanisms to strengthen SAB data sets.

- Work has continued to monitor the effectiveness and impact of the self-neglect procedures on frontline practice. Following the SAB's involvement in a research project led by the University of Sussex in 2018 – 19 on [organisational learning from SARs in self-neglect](#), the SAB carried out an online workforce survey on self-neglect in November 2020. The results evidenced good attendance at relevant training and that overall practitioners are confident in responding to self-neglect cases. The responses indicated some gaps in knowledge regarding available legal options when working with those experiencing self-neglect, and the challenges for practitioners when working with a person who may find it difficult to engage with support. A combined action plan has been developed to bring together the findings from the research project and survey. Progress of this will continue to be monitored over 2021.
- Further to an audit undertaken in 2019 in relation to young people at risk of exploitation, a working group has been established to review transitions between children's and adults' services. The project has identified gaps in information sharing, provision and services for those young adults who may not have specific care and support needs, but who experience continuing risks and needs regarding child criminal and sexual exploitation. The group is working on a proposal to strengthen pathways across services which will be presented to the SAB and East Sussex Safeguarding Children Partnership in 2021.
- The SAB has published a number of [learning briefings](#) during 2020 – 21 regarding our SARs, multi-agency audits, and to raise awareness of specific areas of practice, such as [professional curiosity](#). We have ensured these are disseminated more broadly across partner organisations and shared with neighbouring SABs.

Prevention, engagement and Making Safeguarding Personal:

- The SAB has continued to use social media to communicate to both professionals and the public, sharing posts, supporting partner and national campaigns and offering general guidance. We have significantly increased our Twitter followers over the past year.
- In August 2020, the East Sussex SAB launched its new [website](#), with improved accessibility and easier navigation.
- The SAB has produced quarterly [e-newsletters](#) during 2020 – 21 to share news about the work of the Board, learning from SARs and audits, and adult safeguarding information. By promoting the newsletters through social media and targeted contact with agencies, we have reached a wider audience of professionals and members of the public.

- A new [Making Safeguarding Personal leaflet](#) was published in September 2020. This includes content on the importance of practitioners being able to have direct personal contact with adults where there are concerns about safety and risk. An [easy read version of this leaflet](#) was also produced in conjunction with East Sussex County Council's Learning Disability Partnership.
- The SAB has continued work towards increasing feedback from adults and carers on their experience of safeguarding interventions. The Safeguarding Development Team has updated questionnaire templates and is offering different options for adults to share their views to ensure the process is accessible to everyone. Further work is planned over 2021 – 22 to explore the role that Healthwatch and other partner agencies can play in supporting mechanisms to increase feedback rates and offer creative ways for people to engage in this process.

Integration, and training and workforce development:

- With the outbreak of the coronavirus pandemic in March 2020, all SAB multi-agency face-to-face training was put on hold. However, the Training and Workforce Development Subgroup has used creative ways to engage with the workforce to deliver training and reflective workshops, and over the past year set up several working groups to review the options for delivering our multi-agency training programme remotely via webinars or MS Teams. Further details are provided under 'Our training and development'.
- A recommendation from the [Adult B SAR](#) was to hold a conference to highlight key areas of learning, including professional curiosity, trauma-informed practice, and mental capacity and inherent jurisdiction. A safeguarding conference, hosted jointly with Brighton & Hove SAB, was scheduled to take place in March 2021. However, the impact of the pandemic in the first few months of the year, meant that this was postponed until May 2021. The conference brings together learning from multi-agency reviews across Sussex and nationally, including Domestic Homicide Reviews and Child Safeguarding Practice Reviews as well as SARs. The event will be supported by a range of colleagues from partner agencies with the aim of increasing knowledge and awareness of these emerging areas of adult safeguarding.

Our priorities 2021 – 22

In April 2021, the East Sussex SAB published its [Strategic Plan for 2021 – 24](#). Over the last 12 months many areas of SAB work have needed to adapt because of the ongoing impact of, and response to, COVID-19. This is reflected in the Business Plan for 2021 – 22, which will ensure that the impact of coronavirus upon services continues to be evaluated, and learning shared.

The key priority areas for the SAB for 2021 – 22 are:

- Embedding the Mental Capacity Act in practice.
- Safeguarding transitions for young people at risk.
- Working with multiple complex needs.

Some of our specific objectives over the course of this next year include:

- Support and embed the learning from the SAR National Analysis, including developing core standards for SAR reports.
- Receive assurance on the implementation of the Domestic Violence and Abuse Strategy from April 2021, and how this informs recommissioning and developments in specialist domestic violence services.
- Develop a multi-agency risk management framework to enhance partnership working when supporting adults with multiple complex needs.
- Ensure compliance with the Liberty Protection Safeguards (LPS) ahead of implementation in April 2022.
- Develop workforce awareness of the importance of understanding trauma within the context of safeguarding, and ensure this is embedded within safeguarding training.
- Develop a communication and engagement strategy to ensure greater adult and carer representation within the SAB.
- Develop multi-agency guidance and toolkits to support safeguarding practice in a range of areas. This will include a modern slavery toolkit, the financial abuse strategy and domestic abuse toolkit.
- Establish a bi-annual subgroup chairs' meeting with the aim of strengthening links and communication across the SAB's subgroups, and opportunities for peer support and reciprocal challenge.

Our training and development

SAB multi-agency training programme

As practitioners are dealing with increasingly complex and challenging safeguarding cases, the benefits of multi-agency training are significant, and create opportunities for increased collaboration and partnership, along with improved understanding of different roles and responsibilities.

Delivery of multi-agency training has inevitably been impacted by COVID-19. However, we have worked with colleagues from the Training and Workforce Development Subgroup and the East Sussex Safeguarding Children Partnership to review the content of courses and adapt them for virtual training events.

Our training programme is linked to our priorities, and over this last year has included the following workshops:

- Modern slavery and human trafficking.
- Adopting a whole family approach to domestic abuse and promoting safety.
- Mental Capacity Act 2005: A multi-agency approach to complex cases.
- Self-neglect.
- Coercion and control.

Adult Social Care and Health (ASCH) runs additional safeguarding training, including e-learning and virtual awareness and refresher courses. All our courses can be booked via the [East Sussex Learning Portal](#), and are available to SAB partner agencies and provider services in East Sussex.

The SAB and ASCH safeguarding training programme remains popular and, in this financial year, over 300 representatives from 15 different agencies have accessed the training. Given the limitations caused by the pandemic, this reiterates the importance of having the opportunity to share experiences and learn from others.

Our learning

Safeguarding Adults Reviews (SARs)

SABs have a statutory duty under the Care Act 2014 to undertake Safeguarding Adults Reviews (SARs). This is when:

- An adult dies as a result of abuse or neglect (including death by suicide), whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.
- An adult is still alive but has experienced serious abuse or neglect, and there is concern that partner agencies could have worked more effectively to protect the adult.

SABs can undertake reviews in any other circumstance where an adult has care and support needs.

The purpose of a SAR is set out in the [Sussex SAR Protocol](#), namely to look at the ways professionals and agencies work together to determine what might have been done differently that could have prevented harm or death. It is not an enquiry into how a person died, nor is it to apportion blame; but to learn from such situations, and to ensure that any learning is applied to future cases to reduce the likelihood of similar harm occurring again.

SAR referrals in 2020 – 21

During 2020 – 21, the East Sussex SAB received eight new referrals for SARs. Three other cases were raised for informal discussion outside of the SAR Subgroup meetings. These did not progress to formal referrals as it became clear the criteria were not met.

A range of issues was presented in these referrals:

- People with multiple complex needs and the associated impact of trauma from childhood into adulthood.
- Poor mental health, including self-harm, known suicide risks, depression and anxiety.
- Domestic and sexual violence and abuse, including coercion and control.
- Self-neglect.
- Neglect and organisational abuse.

- Substance misuse.
- Homelessness and the provision of temporary accommodation.
- The impact of having had children removed into care and / or being care leavers.
- People who had difficulty engaging with services and support.
- Deaths caused by suicide, or accidental or intentional death from drug overdoses.
- The impact of COVID-19 on service delivery and people's mental health and well-being.

Of the eight referrals received:

- Two were deemed not to meet the criteria for a SAR.
- Four other cases also did not meet the statutory criteria, but it was felt that there was multi-agency learning to be taken forward and a thematic review will be undertaken.
- One case progressed to a statutory SAR.
- Further information is being gathered in relation to the most recent referral, but discussions on the case thus far indicate that it will progress to a SAR.

These reviews are in the process of being commissioned and will be progressed over 2021 – 22, and summaries will be included in next year's annual report.

Whilst no new SARs were started this year, work progressed on the SARs commissioned in 2018 – 19. This included progressing the recommendations within the [Adult B SAR action plan](#), and concluding the Adult C SAR, which is summarised below.

The SAR Subgroup continues to have oversight of one case given concerns about ongoing organisational abuse.

SAR – Adult C

This SAR examined the circumstances leading up to the death of a 41-year-old woman, Adult C, who died from a drug overdose in December 2017.

Adult C experienced a complex interplay of different factors. She was involved in a volatile and violent relationship from 2015, and suffered significant levels of domestic

violence and coercive control. This was particularly severe during the last 12 months of her life, the period this review focused on. She experienced periods of homelessness, struggled with mental health issues and alcohol and drug dependency which, at times, resulted in her becoming involved in criminal behaviour. Adult C's relationships were impacted by domestic abuse, and she had alternative care arrangements in place for her two children.

The review found a lack of readily accessible accommodation for women with a combination of needs related to chronic trauma, drug and alcohol abuse, homelessness and domestic violence and abuse. It also found that services were not joined-up or tailored to the needs of women like Adult C.

The review, which examined the agencies involved in Adult C's case, also identified barriers to collating third party information relating to patterns of domestic violence and abuse which meant police only responded reactively to individual incidents.

Although recognising that short term prison sentences are unavoidable in some cases, the report highlighted the disruption these cause to the progress people may be making with the support of community teams, leaving women more vulnerable on their release.

The SAB has accepted the findings, produced a formal response to the review and developed an action plan to address the learning and support improvements to services.

The [full report, action plan and learning briefing](#) for the Adult C SAR can be found on the East Sussex SAB website.

Multi-agency safeguarding audit – self-neglect

During 2020 – 21, the SAB conducted an audit of cases involving multi-agency responses to self-neglect. The purpose of this audit was to assess the effectiveness of the self-neglect procedures (which are included in the Sussex Safeguarding Adults Policy and Procedures), the extent to which these are embedded in practice and how effectively agencies work together to support adults who are experiencing self-neglect.

The audit group comprised representatives from Adult Social Care and Health (ASCH), Sussex Police, East Sussex NHS Clinical Commissioning Group (CCG), Sussex Partnership NHS Foundation Trust (SPFT), East Sussex Healthcare NHS Trust (ESHT), Children's Services, East Sussex Fire and Rescue Service (ESFRS), STEPS and Southdown Housing.

The audit identified a number of strengths and examples of good practice as well as some areas for improvement.

What is working well?

- Robust initial response to, and risk assessment of, the presenting safeguarding concerns and evidence that actions taken were effective in reducing risks.
- Use of multi-agency meetings to co-ordinate a response, and support effective communication and information sharing.
- Many cases reflected a Making Safeguarding Personal approach, including professional curiosity, a trauma-informed approach and working creatively to overcome the challenges of non-engagement in person-centred ways.
- There was appropriate consideration of use of the Mental Capacity Act, and recognition of the need to be clear about a person's mental capacity when assessing risks and decisions in relation to self-neglect.
- Good knowledge and application of the self-neglect procedures, although this was not consistent across all cases.

What can we improve?

- Greater consistency in recognising self-neglect as a category of abuse under the Care Act, and that the self-neglect procedures must be followed in all cases whether a safeguarding enquiry is triggered or not.
- Raising awareness of the SAB Resolution Protocol and avenues available to challenge decisions in relation to safeguarding responses or outcomes of mental capacity assessments.
- Ensuring all relevant agencies are involved in responses to self-neglect cases, and contribute to, and share responsibility for, decisions about managing risks.
- The importance of recognising the impact of self-neglect on a person's family and wider support network, and ensuring a 'Think Family' approach.

An action plan is in place to address the areas for development, and this will be taken forward during 2021, with progress being monitored through the PQA Subgroup.

A [learning briefing](#) summarising the outcomes from this audit has also been published.

Learning from complaints

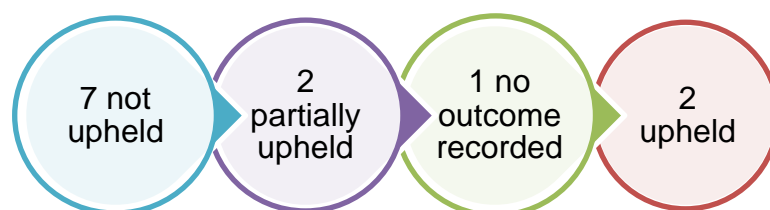
All complaints about our safeguarding processes are taken seriously, as they help us to learn and improve how we do things in the future.

The total number of complaints recorded for Adult Social Care and Health (ASCH) for 2020 – 21 was **255**. Of these, **12** related directly to safeguarding, this is **5%** of the total complaints received. This compares to **21** complaints received in relation to safeguarding in 2019 – 20.

In addition to these **12** complaints, there were **7** other complaints that had another primary classification but appeared to also have a safeguarding element.

Out of a total of **160** MP / Councillor enquiries in 2020 – 21, **6** involved safeguarding.

The outcomes of the **12** complaints received relating to safeguarding can be broken down as shown in this diagram:

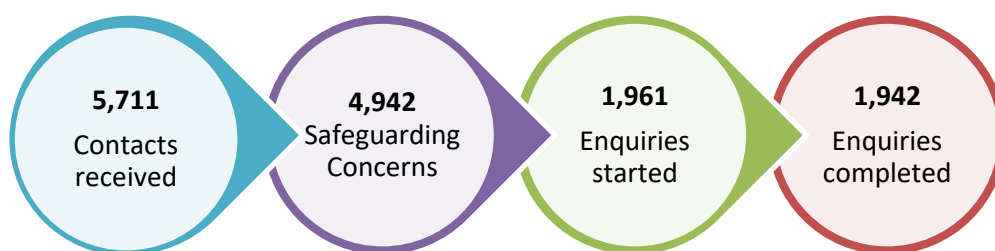
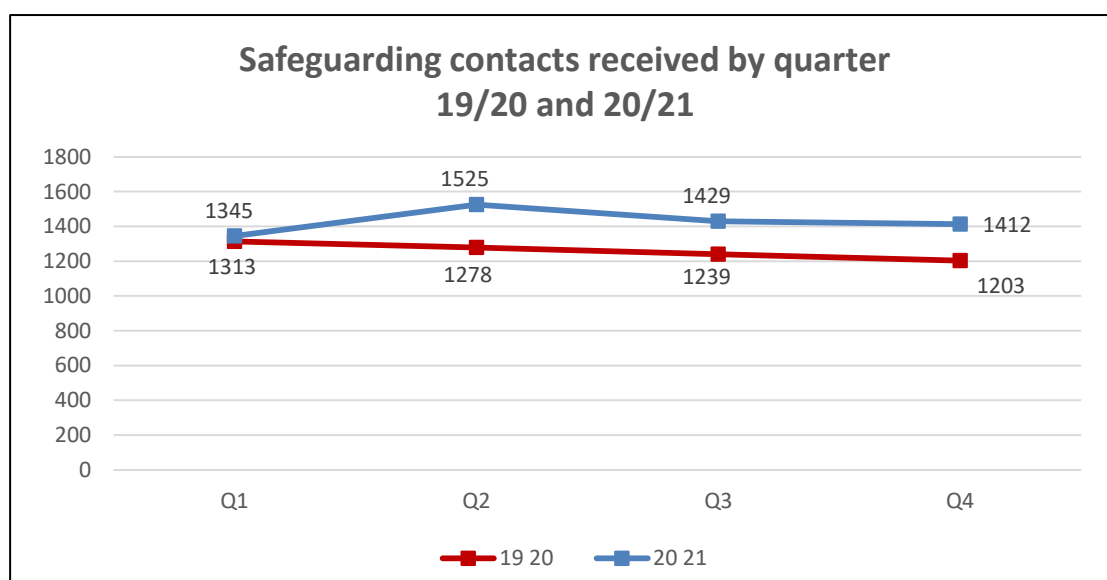


Our data

The Care Act 2014 sets out our statutory duties and responsibilities for safeguarding adults including the requirement to undertake enquiries under section 42 of the Act. Below is a summary of key safeguarding activity during 2020 – 21 for both concerns raised and enquiries undertaken by Adult Social Care and Health (ASCH) in East Sussex County Council.

Analysing safeguarding data

The number of safeguarding contacts has increased from **5,033** in 2019 – 20 to **5,711** in 2020 – 21, a change of 13.5%.

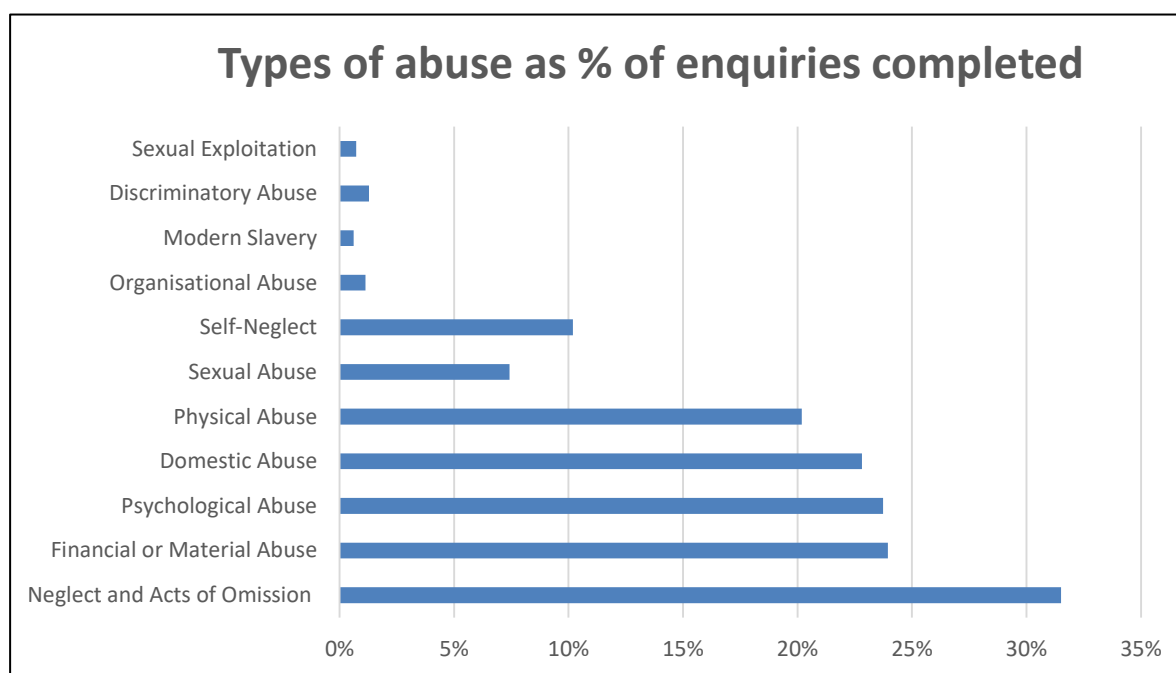


Of the total contacts received in 2020 – 21, **4,942 (86%)** were considered safeguarding concerns. The number of enquiries completed has decreased by **2.8%** when compared to 2019 – 20 (decreasing from **1,998** to **1,942**).

Note The figure for completed enquiries is not a proportion of the figure given for enquiries started as some completed enquiries would result from concerns received prior to 2020 – 21.

Initial analysis of the rate of conversion from safeguarding concerns to enquiries indicates that further work may be required to improve the recording of safeguarding activity to ensure all enquiries are captured. This work will be taken forward over the coming year. Additionally, and in line with the national picture, the number of safeguarding concerns raised during the initial weeks of the first COVID-19 lockdown was lower in comparison to the rest of the year, with numbers returning to and then exceeding expected levels in June 2020.

Types of abuse



In 2019 – 20, the most common form of abuse reported was neglect followed by financial and psychological abuse. In 2020 – 21, neglect is still the most common type of abuse with **31.5%** of all enquiries undertaken comprising, at least in part, neglect.

Financial abuse is still the second most common form of abuse reported, followed by psychological abuse, accounting for **23.9%** and **23.7%** respectively of the enquiries completed. The rate for concerns raised in relation to financial abuse has remained at a similar level to 2019 – 20 when this accounted for **25.4%** of the enquiries completed.

Note The total types of abuse will exceed the total completed enquiries as some enquiries involve multiple types of abuse.

It is not possible to compare this data with national figures until the NHS Digital Safeguarding Adults Collection is published at the end of 2021.

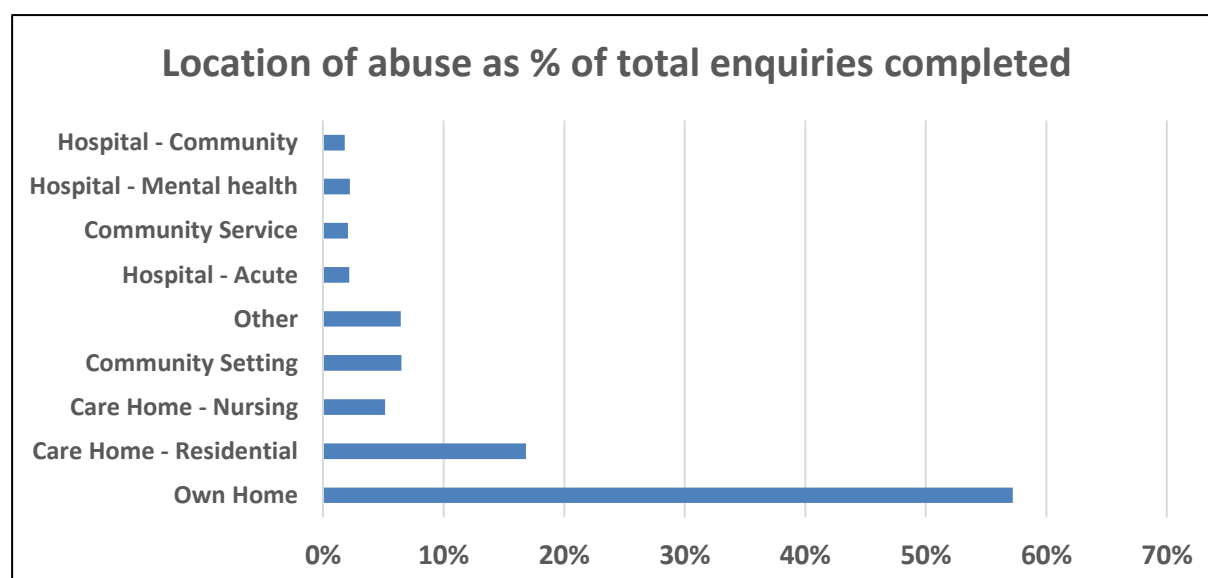
In terms of notable changes in the proportion of abuse types, the most significant differences since 2019 – 20 are:

- A 4% decrease in cases of neglect from 36% to 32%.
- A 4% increase in domestic abuse from 19% to 23%.
- A 2% increase in physical abuse from 18% to 20%.
- A 3% increase in self-neglect from 7% to 10%.

This continues to evidence that supportive measures for these areas of abuse are required to help work with people to manage the risk posed to them by others.

East Sussex has a much older population profile than the rest of the country with 26% of the population being aged 65 plus¹. This means that there is an increased number of people who have, or will develop, care and support needs.

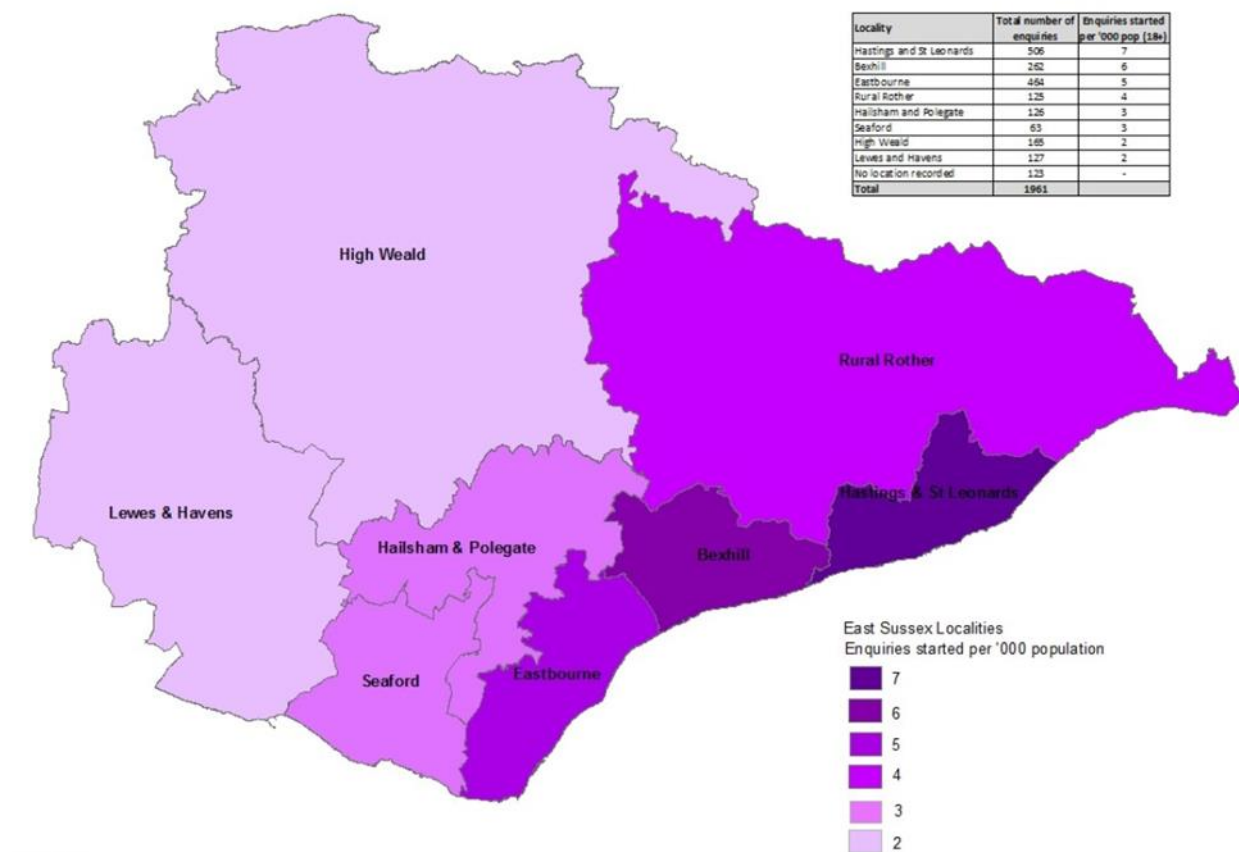
Locations of abuse



As in previous years, the most common reported location of abuse is in the adult at risk's own home (**57%**). This is an increase from **53%** in 2019 – 20. The second most common location continues to be care homes, accounting for **22%**. This is a decrease from **26%** in 2019 – 20.

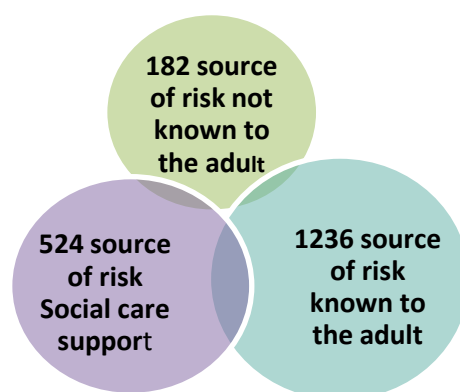
Abuse in residential homes has remained the same at **17%** of all reported abuse whilst all hospital settings have decreased by **1%** compared to 2019 – 20.

¹ Data extracted from East Sussex in Figures, June 2020



Source of risk

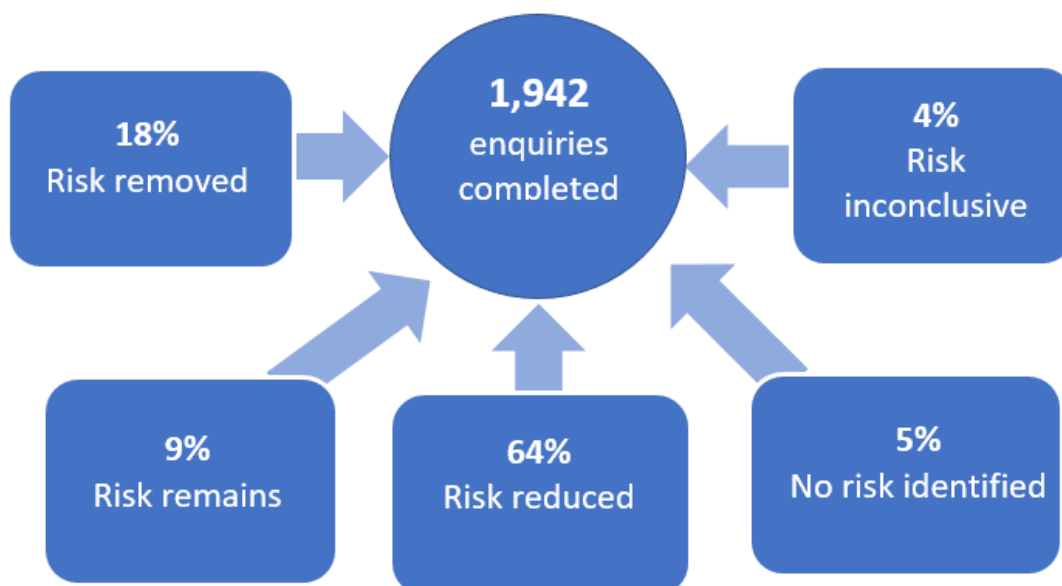
Of the 1,942 enquiries completed in this financial year, the source of risk was known to the adult in **64%** of those enquiries (this is up from **61%** in 2019 – 20). In **51%** of these, the source of the risk was either the adult's partner or another family member.



In **9%** of cases, the source of risk was not known to the adult (up from **8%** in 2019 – 20) and in the remaining **27%** of cases, the source of risk was social care staff, a decrease from **31%** in the previous year.

Impact on risk

In 2020 – 21, in **87%** of enquiries there was an identified risk to the adult and action was taken. In **91%** of these cases, the risk was either reduced or removed completely. This is an increase from **90%** in 2019 – 20.



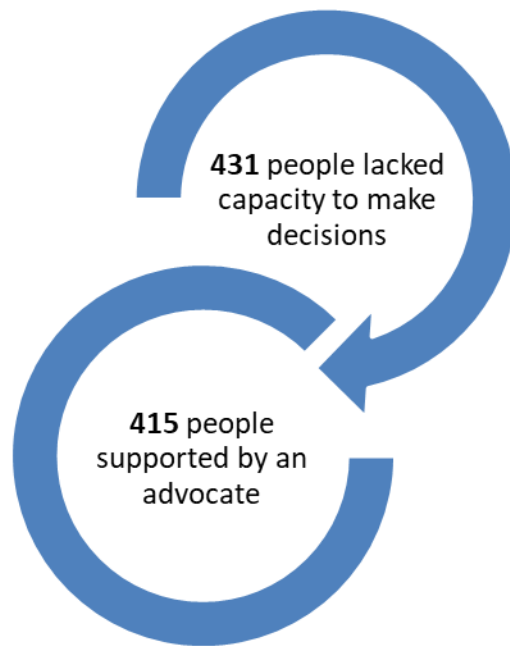
It should be acknowledged that it is unlikely that risk will be reduced or removed in 100% of cases, as people may exercise choice and control over the steps taken by authorities to mitigate the risk. A challenging aspect of safeguarding work is ensuring that the wishes of adults with capacity are respected when this results in risks remaining.

Of completed safeguarding enquiries in which a risk was identified, the proportion of cases where risk remains has decreased from **10%** to **9%**.

Support for adults at risk who lack capacity to make informed decisions

Making Safeguarding Personal is a key focus for the Board. We want people to express their wishes wherever possible and for safeguarding work to support their desired outcomes. This approach requires appropriate support for those who may lack the mental capacity to make safeguarding decisions for themselves. Support can be provided informally, for example by a family member or friend, or through advocacy services. In East Sussex, the advocacy service in 2020 – 21 was provided by POhWER.

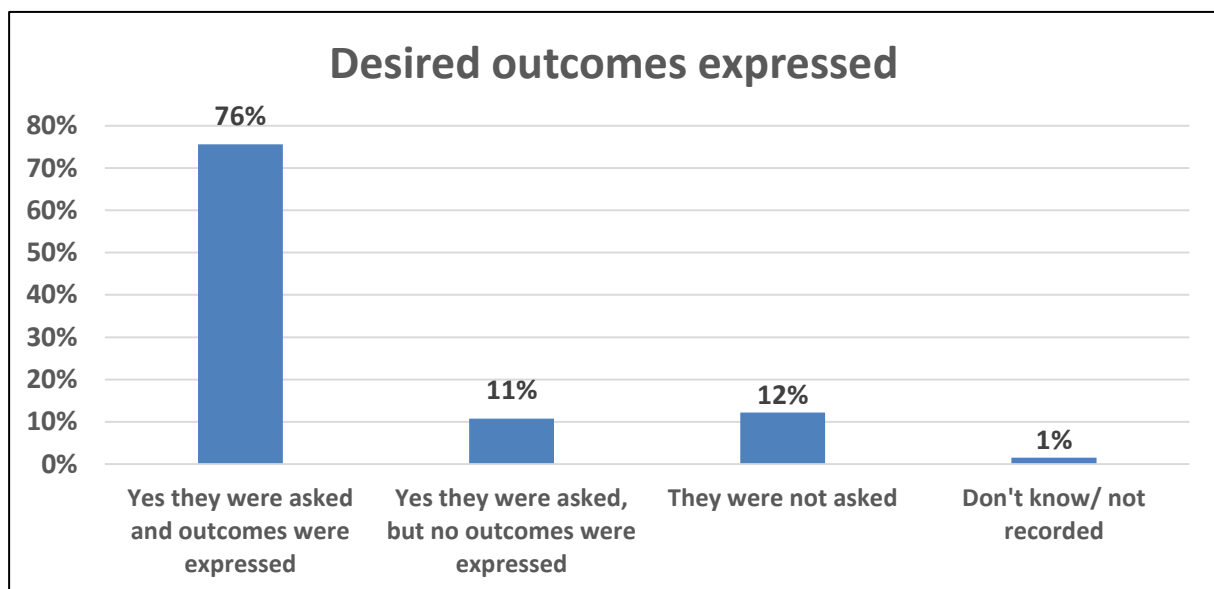
In East Sussex, **96.3%** of all adults who lacked capacity received support during safeguarding enquiries, either by family or friends or via a referral to POhWER for advocacy support. This is a slight increase from **93.9%** in 2019 – 20.



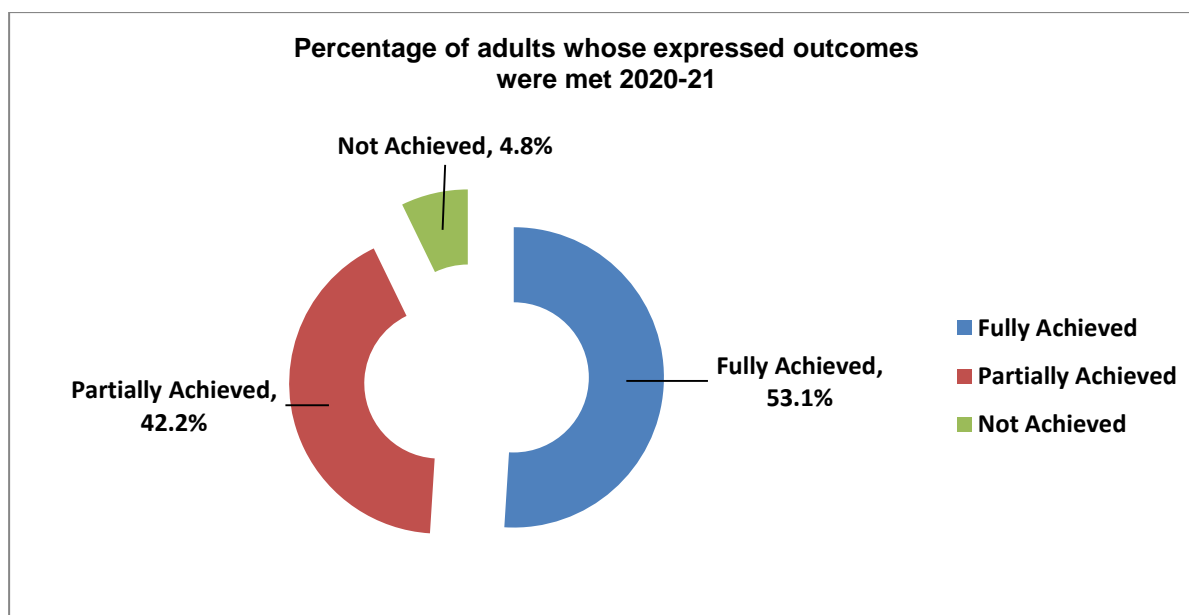
Outcomes achieved through safeguarding

In 2020 – 21, **86%** of adults were asked about their desired outcomes, a slight decrease on **87%** in 2019 – 20.

A review of completed cases where outcomes were not asked, found that these were all cases where the adult lacked capacity to make decisions in relation to the enquiry.



In 2020 – 21, where the person asked for specific outcomes, those outcomes were either fully or partially met in **95%** of cases. This is an increase from **93%** in 2019 – 20.



There will always be cases where outcomes are not achieved, for example, where desired outcomes are beyond the remit and control of the enquiry, or where the situation has changed from the initial desired outcomes that were recorded.

Safeguarding updates and data from partner agencies

Updates, including relevant data, for 2020 – 21 from some of the SAB partner agencies are provided below.

NHS East Sussex Clinical Commissioning Group (CCG)

Adult safeguarding data dashboard

Over the past year, the CCG has developed an adult safeguarding data dashboard to focus resources and provide assurance. In response to the high number of statutory reviews across Sussex in 2020 – 21, the Sussex CCGs Safeguarding Team launched a new statutory review tracker to enable greater oversight of all active 'health' action plans for Safeguarding Adults Reviews (SARs) and Domestic Homicide Reviews (DHRs). This extends far wider than CCG-specific actions and includes open actions for all health providers, and allows the Designated Nurses within the CCGs to closely track progress and support NHS Provider colleagues to implement the required practice improvements.

Specialist staffing

At the beginning of March 2021, interviews were held to recruit to eight vacant named GP for safeguarding roles. These recruitments allow for greater GP involvement in future SAB partnership working.

A new Deputy Designated Nurse for transitional safeguarding was recruited in November 2020. This role is one of the first of its kind within the CCGs, and will be key in driving forward developments in relation to transition and trauma-informed care on a regional and national level.

Domestic abuse

The domestic abuse portfolio within the CCG continues to work within a 'Think Family' approach, with a priority for the year being to embed this into practice.

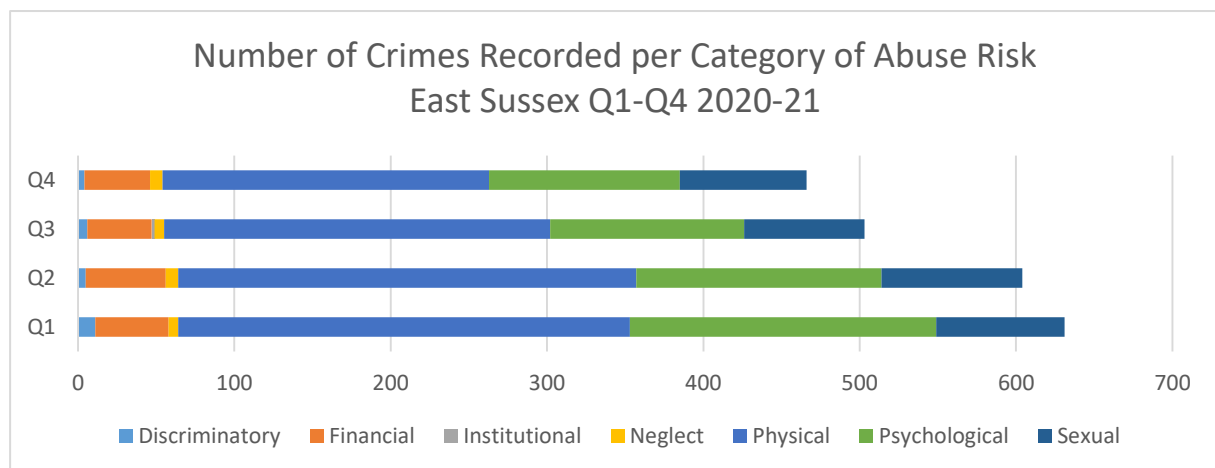
In recognition of the significant challenges that COVID-19 has presented for services supporting those experiencing domestic abuse, the CCG Safeguarding Team developed resources for providers and primary care to ensure domestic abuse was taken into consideration during virtual consultations and to ensure that the increased risks were taken into account during lockdown.

A pathway has been developed to ensure primary care is aware of adults and children registered at their practices who are referred into Multi-agency Risk Assessment Conferences (MARAC). This ensures that primary care practices can be

aware of these high-risk adults and families experiencing domestic abuse, and develop appropriate risk reduction plans and contribute information to MARAC to help inform safety planning.

Sussex Police

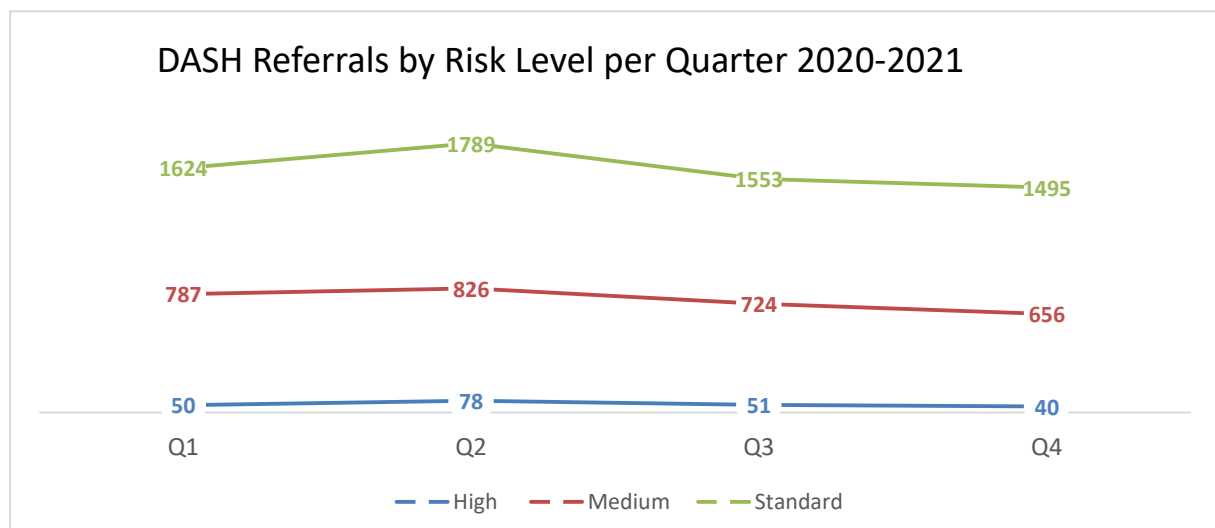
The following chart shows the number of reported crimes per category of abuse in each quarter. The overall number of crimes was lower in quarter three and quarter four, which is in line with the tendency for crime rates to be lower in the autumn and winter months. The ratio of the different abuse types for recorded crimes in each quarter has remained roughly stable through the year.



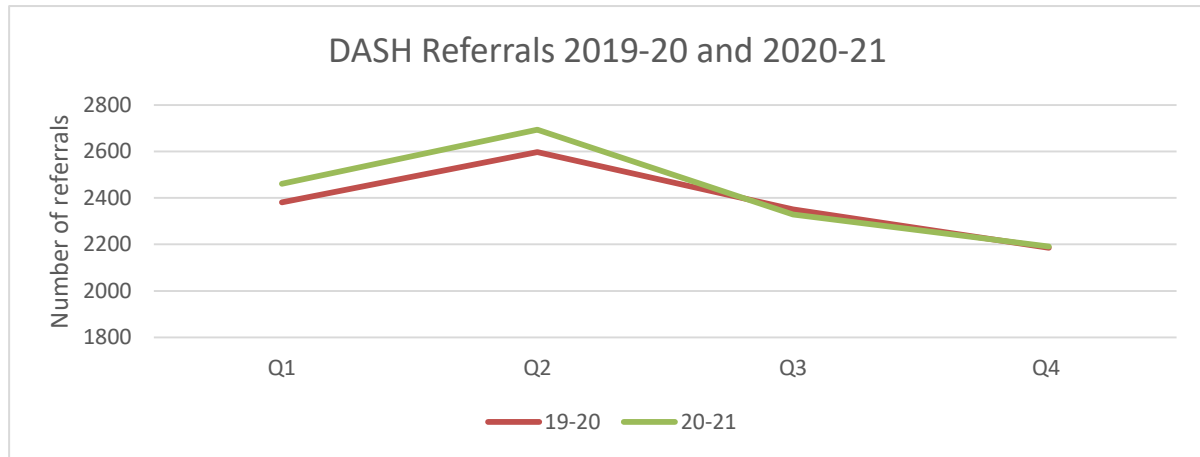
Domestic abuse, stalking and harassment (DASH) referrals

Domestic abuse incidents are subject to a risk assessment using a DASH checklist. Sussex Police Safeguarding Investigations Unit (SIU) refers all cases of domestic abuse involving an adult with care and support needs to ASCH. This checklist provides information on whether the risk to an individual is high, medium, or standard.

The chart below shows the number of DASH referrals made by Sussex Police to ASCH by risk level, for each quarter in 2020 – 21.



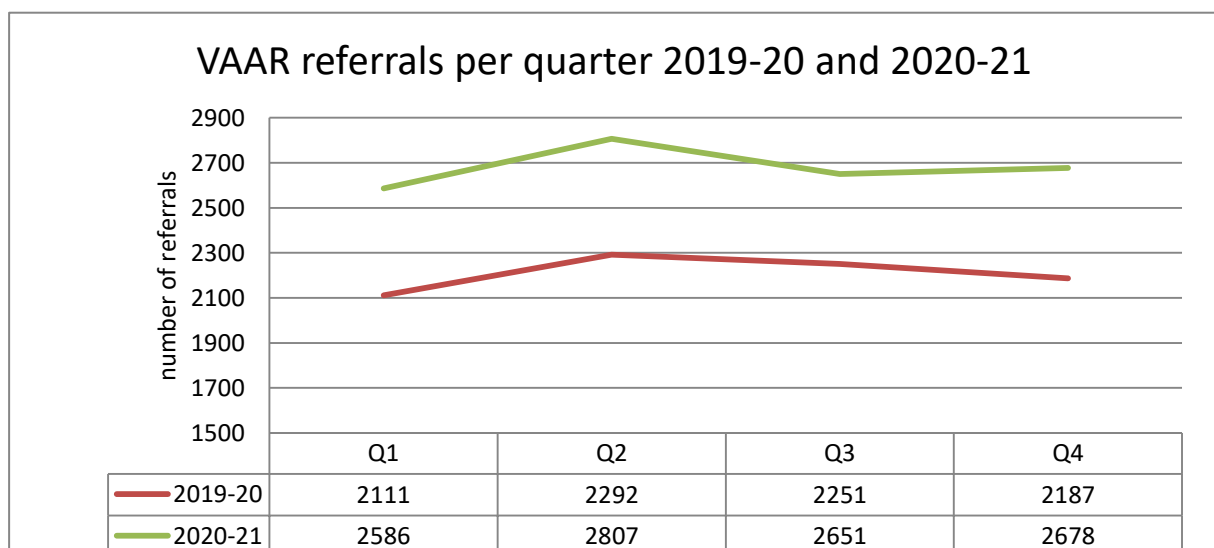
The number of standard level risk referrals increased in quarter two and then dropped back to the same level as in quarter one. Overall, for quarter one to quarter four there is a small, 1.6%, increase in the total number of DASH referrals compared to the data for the previous year. The lower levels of DASH referrals in quarter three and quarter four follow a wider pattern of reduced crime rates in the autumn and winter months.



Vulnerable adult at risk (VAAR) referrals

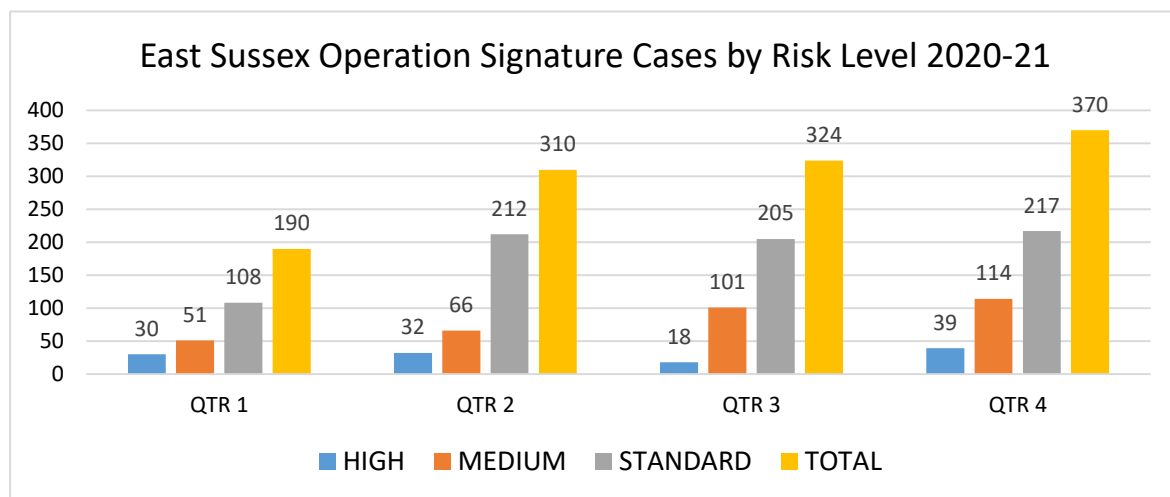
Sussex Police submits VAAR referrals to ASCH in relation to safeguarding adults concerns they identify. The chart below shows the number of VAAR referrals made by Sussex Police each quarter for the year 2020 – 21. The data shows there was a spike in the number of VAAR referrals in quarter two as lockdown restrictions were eased, and an overall increase in the total number of VAAR referrals of 21% in comparison to the data for the previous year.

Sussex Police responded proactively during COVID-19 by working with front line officers to upskill their ability to identify abuse and neglect, and refer vulnerable adults to ASCH by means of a VAAR. This included additional training such as the 'Adult at Risk' course and bespoke training packages for the Sussex Adult Death Protocol.



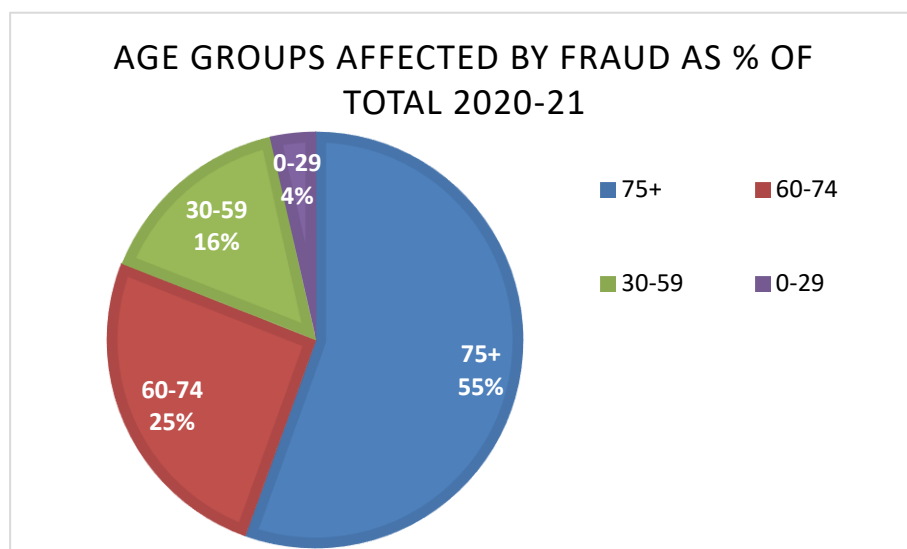
Operation Signature

There has been a 52% increase in reported cases of vulnerable victims of fraud, compared to last year. A disproportionate rise in romance fraud, false investment opportunities and doorstep criminals has been attributed to the COVID-19 pandemic. The number of cases in quarter one is low compared to the other quarters, and approximately half the number for quarter four. This is partly explained by lockdown restrictions reducing opportunities for doorstep crime, and because romance fraud cases, which rose in 2020 – 21, typically involve a period of grooming before the fraudster demands money and the case is then reported and recorded.



Two specialist Operation Signature case workers have supported 1,194 victims of fraud in East Sussex during 2020 – 21. Support has been provided by officers and case workers over the telephone when face-to-face visits were not possible because of the coronavirus pandemic. The total loss to vulnerable victims of fraud in 2020 – 2021 is £6.87 million, with the average loss, where recorded, being £15.48 thousand per victim, which is an increase on the previous year.

Courier fraud, telephone scams, doorstep crime and dating and romance are the top four most common types of fraud, with people most usually being contacted by telephone or in person on the doorstep.



In East Sussex, 80% of cases were people over the age of 60. The number of victims over 75 years old has dropped by 9% compared to the previous year, and the number of victims in the 30 to 59 year-old age range has increased by 7%.

There has been a wide range of scams exploiting the COVID-19 situation in 2020 – 21. The loneliness and isolation of victims, and financial worry and uncertainty people have felt, have been exploited with romance and investment fraud significantly higher than in the previous year. Vulnerable people have been targeted with fraudulent emails purporting to sell and / or offering face masks and COVID-19 relief funds, and vaccine and testing related frauds. There has also been a rise in frauds relating to vouchers or rebates, including vehicle tax refund and government tax rebate, and Her Majesty's Revenue and Customs (HMRC) telephone scams. The elderly and vulnerable are more likely to be victimised by the HMRC scam, and on-line shopping fraud continues to rise.

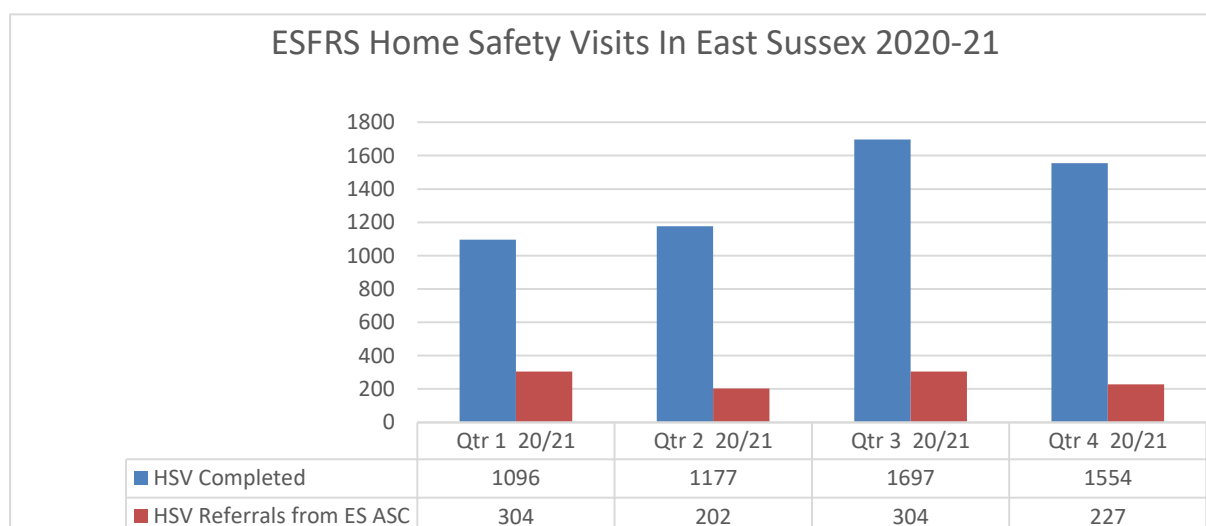
Sussex Police priorities for 2021 – 22

Sussex Police has identified the following priority areas for the coming year:

- Domestic violence and abuse.
- Coming out of lockdown and hidden harm being reported.
- Ensuring the Sussex Adult Death Protocol is embedded fully across the force.
- Transitional safeguarding, and 18 to 24 year-old care leaver support.

East Sussex Fire and Rescue Service (ESFRS)

The chart below shows the number of home safety visits (HSVs) conducted by ESFRS in the last four quarters, including the number of visits conducted following referrals from ASCH. These visits are one element of the ESFRS targeted prevention work providing support to the most vulnerable members of the community who may be more at risk of having a fire in their home.



The number of HSVs completed in quarters one and two of 2020 – 21 was 37% lower than for the same period in the previous year. Referrals for HSVs from a wide range of sources significantly dropped during the COVID-19 pandemic. As the restrictions eased the number of referrals and completed HSVs increased.

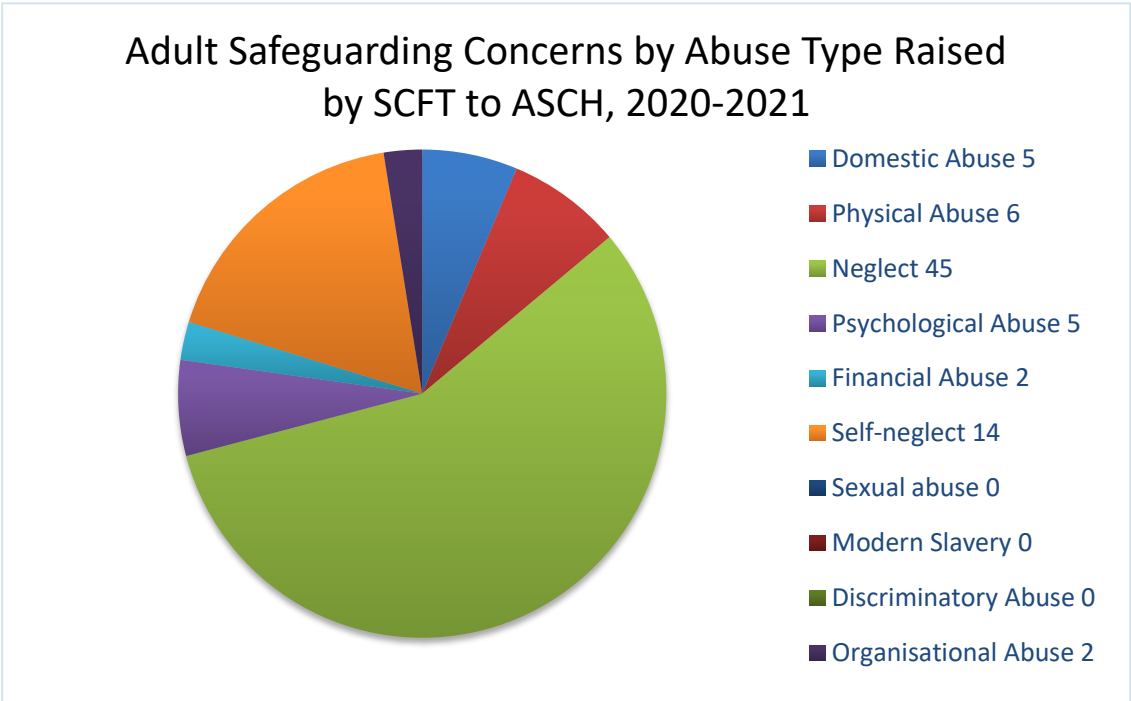
When undertaking HSVs, ESFRS often identifies safeguarding concerns, which they report to ASCH via a ‘Coming to Notice’ (CTN) form. During 2020 – 21 there was a total of 302 CTNs raised relating to a range of safeguarding and care and support issues, including self-neglect and hoarding, anti-social behaviour and mental health concerns.

Sussex Community NHS Foundation Trust (SCFT)

SCFT is the main provider of community NHS health and care across the High Weald, Lewes and Havens areas of East Sussex, helping people to plan, manage and adapt to changes in their health, to prevent avoidable admission to hospital and to minimise hospital stays.

In 2020 – 21, SCFT raised 79 safeguarding concerns, this is 20% less than in the previous year. The number of concerns raised for neglect, self-neglect, domestic abuse and financial abuse are all lower than for the previous year. The number of concerns raised for physical abuse and psychological abuse are small but an increase on the previous year.

The reduction in concerns raised is explained, in part, by the impact of the COVID-19 guidelines, and restrictions on visits to patients’ homes, care homes, out-patient clinics, minor injury clinics and urgent treatment centre settings.

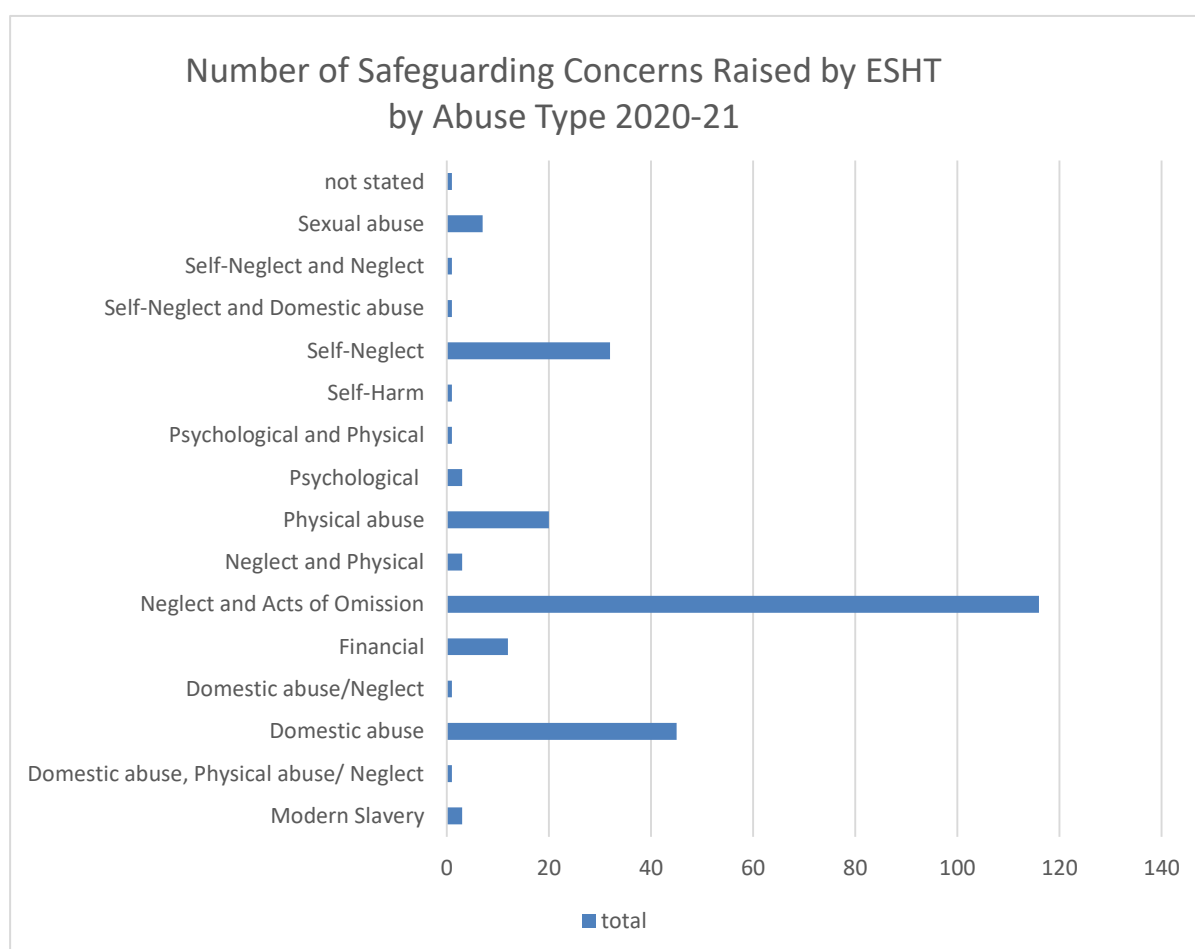


The most common type of abuse raised by SCFT as a safeguarding concern was neglect, and this is also reflected in SCFT advice line data. Self-neglect is the second most common abuse type reported by SCFT as a safeguarding concern. The SCFT Safeguarding Team has developed a specific self-neglect and hoarding intranet page, which is accessible to all staff, and contains supportive information and local and national reference links.

During 2020 – 21, the safeguarding team monitored data on concerns raised for COVID-19 themes and trends. Information sharing and partnership working with Sussex Clinical Commissioning Group Safeguarding Team ensured that both care home settings and domiciliary environments received timely and effective care delivery support.

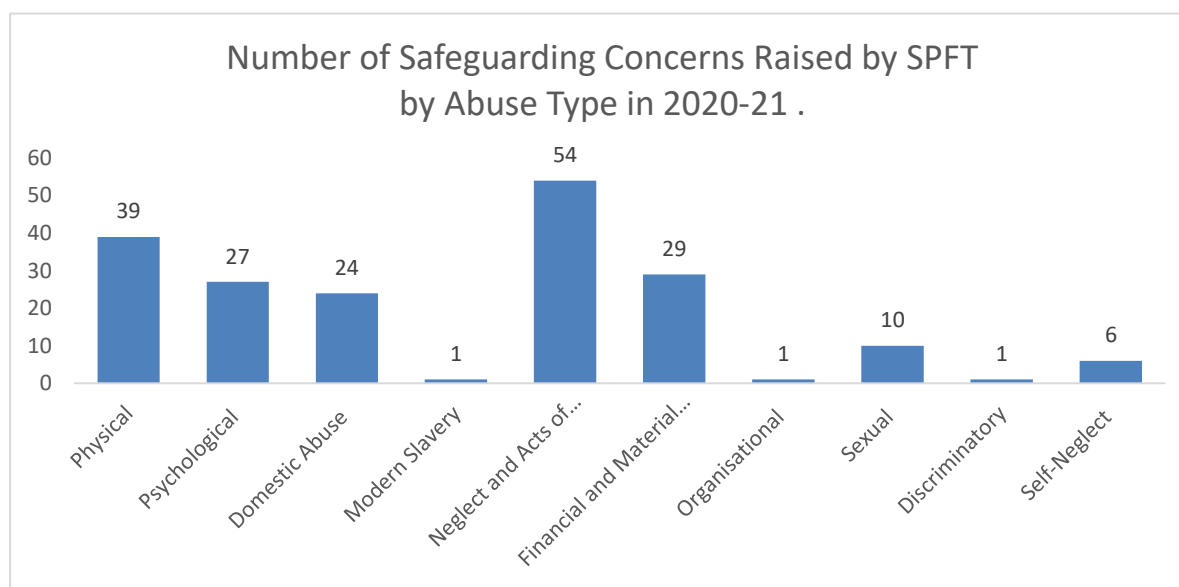
East Sussex Healthcare NHS Trust (ESHT)

ESHT raised 248 safeguarding concerns in 2020 – 21. The complexity of concerns raised has increased with people more likely to be experiencing more than one type of abuse. This is reflected in the chart below which, in some cases, shows a combination of abuse types. Neglect remains, as last year, the most commonly reported abuse type, followed by domestic abuse and self-neglect.



Sussex Partnership NHS Foundation Trust (SPFT)

The following chart shows the number of safeguarding concerns raised by SPFT, by abuse type, in 2020 – 21. Neglect and then physical abuse were the most prevalent types of abuse in safeguarding concerns raised by SPFT over the last year. There has been a 21% reduction in the overall number of safeguarding concerns raised by SPFT in 2020 – 21 compared with 2019 – 20. This can be explained in part by the fact that during the COVID-19 pandemic SPFT were seeing fewer clients face-to-face.



South East Coast NHS Ambulance Service (SECamb)

SECamb experienced a sizeable increase in safeguarding referrals, ie. 40 – 50%, during 2020 – 21 compared to 2019 – 20. This possibly reflects the fact that SECamb remained one of the services still accessing people's homes during the pandemic. There was a 32% increase in the number of safeguarding concerns raised by SECamb to ASCH in the first half of 2020 – 21. The first six months of the COVID-19 pandemic during 2020 – 21 saw a 40% rise in concerns for patient's mental health including a 100% rise in low level parental mental health. Additionally, there was a 25% rise in referrals for people at risk of, or having suffered, domestic abuse, compared to the first half of 2019 – 20.

During the pandemic, the SECamb Safeguarding Team produced a suite of resources to support staff who may have come across people experiencing domestic abuse or heightened parental mental health.

Raising a safeguarding concern

No one should have to live with abuse or neglect – it is always wrong, whatever the circumstances.

Anybody can raise a safeguarding concern for themselves or another person. Do not assume that someone else is doing something about the situation.

You can report a concern in the following ways:

Phone: 0345 60 80 191 (8am to 8pm 7 days a week, including bank holidays)

Email: [Health and Social Care Connect](#)

Online: Via the form on the [East Sussex County Council website](#)

Contact the police on 101 or in an emergency 999

Find out more in our [safeguarding leaflet](#) and [easy read version safeguarding leaflet](#).

Appendix 1 – Board membership

Partners of the East Sussex SAB are:

- East Sussex Adult Social Care & Health (ASCH)
- NHS East Sussex Clinical Commissioning Group (CCG)
- Sussex Police
- Care for the Carers
- Care Quality Commission (CQC)
- Change, Grow, Live (CGL)
- District and borough council representation
- East Sussex Fire and Rescue Service (ESFRS)
- East Sussex Healthcare NHS Trust (ESHT)
- East Sussex Safeguarding Children Partnership (ESSCP)
- Healthwatch
- HMP Lewes
- Homecare representatives
- Kent, Surrey, Sussex Community Rehabilitation Company (KSS CRC)
- Lay members
- National Probation Service (NPS)
- NHS England
- Registered Care Association (RCA)
- South East Coast Ambulance Service NHS Foundation Trust (SECAmb)
- Sussex Community NHS Foundation Trust (SCFT)
- Sussex Partnership NHS Foundation Trust (SPFT)
- Trading Standards
- Voluntary and community sector representation

Appendix 2 – Board structure

