Report to:	**East Sussex Health and Wellbeing Board**
Date of meeting:	**4 December 2018**
By:	**Safeguarding Adults Board Independent Chair**
Title:	**Safeguarding Adults Board Annual Report**
Purpose:	**To present the SAB Annual report as required by the Care Act 2014**

RECOMMENDATIONS

The Board is recommended to note the report

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1. Background

1.1. The Safeguarding Adults Board (SAB) Annual Report (Appendix 1) outlines the multi-agency safeguarding activity for vulnerable adults in East Sussex between April 2017 and March 2018.

2. Supporting information

Safeguarding Adults Reviews

2.1. Four safeguarding adults review (SAR) referrals were made in 2017 – 18. Of these referrals, one is being taken forward as a Serious Case Review by the Local Safeguarding Children's Board (LSCB), as the majority of the concerns occurred before the person turned eighteen years of age.

2.2. The second referral is still under consideration by the SAR sub-group as, at the time of this report, the case is still subject to a section 42 safeguarding enquiry by the local authority and a serious incident process by a health provider.

2.3. The third referral was for a woman with complex support needs who was found deceased in her room in a mental health inpatient unit, with her cause of death recorded as methadone toxicity. A serious incident investigation was completed by the health provider, and the case was subject to a coroner's inquest. A SAR was not required as all the appropriate learning points had been gained from the coroner's inquest and serious incident process.

2.4. The fourth referral, regarding a woman in her nineties who was living with family members when she died, followed concerns being raised over possible abuse and neglect. This is being taken forward as a discretionary SAR and learning from this will soon be available.

2.5. One SAR (Adult A) was published in 2017-18. This review evaluated multi-agency responses to the death of a man aged 64 (Adult A), from Kent, who was living in a care home with nursing in East Sussex, commissioned by NHS West Kent Clinical Commissioning Group. Adult A died as a result of systemic sepsis, infection of his legs, diabetes and cirrhosis. He was subject to a Deprivation of Liberty in his best interests as he was deemed to lack mental capacity to decide where to live. There were concerns of self-neglect as he often refused care and treatment.

2.6. Twenty three recommendations were accepted by the SAB following the review, in relation to placements, case co-ordination, mental capacity and mental health, safeguarding, advocacy, and disseminating learning. A joint action plan with the Kent & Medway SAB was put in place to ensure learning outcomes were achieved and to try to avoid similar cases occurring in the future. The recommendations and the action plan can be found online, along with the report.

Peer Challenge events

2.7. Peer challenge events were held in July 2017 and January 2018 following completion of a safeguarding self-audit tool by SAB agencies. These events involved a 'critical friend' approach where agencies were asked to provide more detailed explanation and evidence of their safeguarding practice, including policies, training and safer recruitment processes. Subsequent action plans are being monitored by the Performance, Quality & Audit sub-group.

Quality Assurance officer and Multi-agency audits

2.8. Recruitment of this fixed-term post was made on a shared basis between the East Sussex SAB and the Brighton & Hove SAB. The main purpose of this post is to focus on the implementation of learning from reviews and audits, and ensuring action plan improvements are made across agencies. Learning briefings have been developed following case audits focussing on Mental Capacity Assessments and Best Interests decisions, as well as Modern Slavery and Human Trafficking. The learning briefings can be accessed here.

Multi-agency training and safeguarding awareness campaigns

2.9. Multi-agency self-neglect training has continued throughout the last 12 months. Four sessions were held with a total of 63 attendees representing adult social care, health, police, ambulance service, probation and housing. Based on research commissioned by the Department of Health, the training centred on the perspective of the self-neglecting individual.

2.10. Throughout April and May 2017, staff members from the Safeguarding Development Team, alongside representatives from Trading Standards and Sussex Police, were involved in a campaign to raise awareness of financial abuse. A total of 70 contacts were made with members of the public and 174 with care staff, including personal assistants, staff employed by home care providers and care home / nursing home managers. The campaign was viewed by 12,787 people on Twitter and 13,665 on Facebook. Across both platforms, the campaign was shared or retweeted 212 times.

Service user involvement

2.11. An adult with care and support needs who has a personal experience of safeguarding has continued to play an active part in the Client and Carers Safeguarding Advisory Network, including assisting with the development of the Making Safeguarding Personal leaflet. A video is being developed to share their personal experience and will soon be available to share.

Advocacy support

2.12. Nationally, 73% of adults who lack capacity to make informed decisions about the enquiry receive support. In East Sussex, 96% receive support. This is the same proportion as reported in 2016 – 17, but a target of 100% remains in place.

3. Conclusion and reasons for recommendations

3.1. This report shows the continued effort of the Safeguarding Adults Board and partner agencies to work together to protect adults across East Sussex. The SAB will ensure learning from SARs and its multi-agency audit programme is shared and embedded into practice appropriately in the coming year.

3.2. The Board is recommended to note the Safeguarding Adults Board Annual Report.

GRAHAM BARTLETT
Safeguarding Adults Board Independent Chair