East Sussex Safeguarding Adults Board

East Sussex Safeguarding Adults Board

Annual Report

April 2017 to March 2018

"Our vision is for all agencies to work together effectively to enable the citizens of East Sussex to live free from abuse and neglect, and to promote widely the message that safeguarding is everybody's business"

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Foreword

Welcome to the East Sussex Safeguarding Adults Board Annual Report 2017 – 18.

The Safeguarding Adults Board (SAB) oversees work to protect vulnerable people, and ensures that we have safeguarding arrangements that are working well and improving.

This year saw the publication of our first Safeguarding Adults Review (SAR), since the introduction of the Care Act 2014. The findings of this review are outlined in the report, and the SAB has worked tirelessly to ensure the learning it provides is embedded in services to improve outcomes for those in need.

To assist embedding of learning, the SAB recruited a Quality Assurance & Learning Development Officer, shared with the Brighton & Hove SAB, and held a conference focussed on key issues from the SAR, namely self-neglect and mental capacity. The SAB has refreshed its strategic plan for the next three years, and all partner agencies of the SAB are committed to this for the effective safeguarding of adults in East Sussex.

We hope you find this report interesting and are assured of the commitment of the East Sussex SAB to continual improvement and decisive action when things go wrong.

Graham Bartlett
Independent Chair, East Sussex Safeguarding Adults Board

Comments from Healthwatch East Sussex

I have continued in my role as Chair of the Clients and Carers Safeguarding Advisory Network, and have been encouraged by the progress made in 2017 – 18. This includes development of a Making Safeguarding Personal leaflet aimed at those who are experiencing a safeguarding enquiry, as well as plans for development of a video of an adult's own safeguarding story. This will be available in 2018 – 19 and we hope it will encourage others to speak up earlier where they may need a safeguarding intervention.

I have been involved again this year in the recruitment process for an additional lay member for the SAB, and am pleased that the SAB continues its commitment to seek the views of adults, carers and partner agencies in renewing its strategic plan.

It is also encouraging to see the priority the SAB has given to talking to local people and communities around safeguarding in the community (everyone's responsibility), by joining Healthwatch East Sussex engagement activities. This is a great example of working collaboratively on shared priorities which again Healthwatch would like to see continued in 2018 – 19.

Looking forward, I am also delighted to see a refresh of how the SAB hears directly from people with care and support needs who experience the safeguarding process to influence the strategic direction of the Board.

Healthwatch will continue to seek the views of those who use care and support services, and will ensure partner agencies are held to account within SAB activities where required.

Elizabeth Mackie
Volunteer & Community Liaison Manager, Healthwatch East Sussex

Executive summary

This annual report outlines safeguarding activity and performance in East Sussex between April 2017 and March 2018, as well as some of the main developments that have taken place to prevent abuse from occurring.

Highlights contained in the report are as follows:

Priority 1.1: Ensure the effectiveness and transparency of the Safeguarding Adults Board to oversee and lead adult safeguarding and the prevention of abuse

- Peer challenge events were introduced following completion of a safeguarding self-audit tool by SAB member agencies, and were held in July 2017 and January 2018.

- 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. Action plans for future improvements are being monitored by the Performance, Quality & Audit sub-group.

Priority 2.1: Ensure Section 42 safeguarding arrangements are in place under the Care Act, with appropriate feedback and review arrangements

- An updated version of the Sussex Safeguarding Adults Policy and Procedures has recently been launched and is available online. The purpose of the rewrite was to reduce repetition, and incorporate policy and legal updates as well as learning from safeguarding adult reviews, audits and developments in practice.

- Four safeguarding adult 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 it was agreed the LSCB is best placed to undertake the review as the majority of the concerns occurred before the person turned eighteen years of age.

  A 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.

  A third referral was for a woman with complex support needs, including alcohol and substance misuse, mental health problems and long periods of homelessness. She 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. The SAR sub-group was of the view that a SAR was not required because there was not a concern that partner agencies could have worked more effectively to protect the adult, and all the appropriate learning points had been gained from the coroner's inquest and serious incident process.

The fourth referral, regarding a woman in her nineties who was living with family members when she died and concerns have been raised over possible abuse and neglect, is being taken forward as a discretionary SAR and learning from this will be reported later in the year.

- One SAR 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.

  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. In addition, learning briefings regarding the review and the interface between self-neglect and safeguarding have been developed, and can be accessed at the same online location at the following address:

  https://www.eastsussexsab.org.uk/safeguarding-adult-reviews-2/

Priority 3.1: Focus on personalising and integrating safeguarding responses, and measure safeguarding outcomes that bring safety and people's wishes together

- The number of safeguarding contacts has gone up from 4,222 in 2016 – 17 to 5,551 in 2017 – 18. Of the total contacts received in 2017 - 18, 4,467 (81%) were considered safeguarding concerns

- The number of enquiries completed appears to have decreased significantly since 2016 – 17 (decreasing from 4,222 to 1,450). This is because of a change in the way safeguarding activity is recorded following lessons learned in the previous year. Previously, all safeguarding concerns were recorded as enquiries and these enquiries were managed in proportion with

the degree of risk associated with each concern raised. Now concerns and enquiries are recorded separately.

- In 2016 – 17, the most common form of abuse reported was neglect followed by physical and then emotional abuse. In 2017 – 18, neglect is still the most common type of abuse with 49% of all enquiries undertaken comprising, at least in part, neglect. Physical and emotional abuse remain the second and third most common forms of abuse accounting for 29% and 26% respectively. The proportion of cases involving emotional abuse continues to increase. This is because there is greater acknowledgement that abuse such as physical abuse and financial abuse can often have an emotional or psychological impact which is also being reported.

  The most significant proportional differences since 2016 – 17 are a 2% increase in emotional abuse from 16% to 18%, and a 1% decrease in sexual abuse from 5% to 4%.

- As in previous years, the most common reported location of abuse is in the adult at risk's own home (32%). This is a drop from 37% in 2016 – 17. The second most common location continues to be residential care homes, accounting for 30%. This is an increase from 23% in 2016 – 17. Reported abuse in nursing homes has reduced from 18% to 13% whilst cases in mental health hospitals have increased from 1% to 5% of all cases.

Priority 4.1: Allow the voice of clients, carers, and the local community to be heard in safeguarding policy and practice

- In 2017 – 18, in 89% of enquiries there was an identified risk to the adult and action was taken. In 91% of cases the risk was either reduced or removed completely. This is a slight increase from 90% in 2016 – 17. It should be acknowledged that it is unlikely that risk will be reduced or removed in 100% of cases, as individuals may exercise choice and control over the steps taken by authorities to mitigate the risk. The proportion of cases where risk remains has dropped significantly from 10% to 5%.

- 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.

Priority 4.2: Ensure that people are aware of safeguarding and know what to do if they have a concern

- 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 was 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.

Priority 5.1: Ensure that all people involved in safeguarding have the appropriate skills, knowledge and competencies

- Operational officers in Sussex Police have received training from the force lead for vulnerability and stalking. This has been complemented by a comprehensive communications strategy, both internally and externally under the #ThisIsVulnerability work. Specialist domestic abuse training has been delivered to all operational staff in partnership with the domestic abuse charity, Safe Lives.

- Additional updates from SAB partners, including key safeguarding initiatives and progress on priorities, are included in Appendix 2 of this annual report.

- 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.

Priority 5.2: Ensure clear links exist between partnership boards with accountability arrangements documented and understood to avoid duplication of workstreams

- Regular meetings take place between representatives of the SAB, LSCB, Safer Communities Partnership and Children and Young People's Trust, reflecting the Partnership protocol that was developed in 2016 – 17.

- Through the implementation of this protocol, it was agreed in 2017 – 18 that the Safer Communities Partnership would provide the lead strategic oversight for the modern slavery agenda, with the SAB supporting by way of undertaking a multi-agency audit and ensuring the updated Sussex Safeguarding Adults Policy and Procedures include more detailed and up-to-date information regarding this type of abuse.

- A formal review of the Partnership protocol has been postponed and will take place in 2018 – 19.

Conclusion

In presenting the progress made against our key priorities for 2017 – 18, this annual report has shown the continued effort of all partner agencies to work together to safeguard adults from abuse and neglect.

We have published the findings of our first safeguarding adults review (SAR) under the Care Act 2014, and we are confident that the action plan developed with the Kent & Medway SAB will ensure that the recommendations are translated into real change.

Embedding organisational change following reviews and audits continues to be a challenge for all safeguarding adults boards. So, we welcome the opportunity to participate in a research project taking place in 2018 – 19. Working alongside the University of Sussex and six other SABs, we will be looking into how to achieve organisational change.

Our recently updated strategic plan for 2018 – 2021 provides full details of our future plans that have been highlighted at the end of each section in this report. These plans will ensure adults with care and support needs are safeguarded from abuse and neglect as effectively as possible.

Glossary of key terms

Safeguarding concern A 'safeguarding concern' is when someone has reasonable cause to suspect that an adult with care and support needs, who is unable to protect themselves because of those needs, is experiencing or is at risk of abuse or neglect.

Three key tests in the Care Act The three key tests relate to adults covered by these safeguarding procedures.

Safeguarding duties apply to any adult who meets the three key tests, namely:

- has needs for care and support (whether or not the local authority is meeting any of those needs), and
- is experiencing, or is at risk of, abuse or neglect, and
- as a result of those care and support needs is unable to protect themselves from the risk or experience of abuse or neglect.

Once the local authority has reasonable cause to believe an adult meets these tests, the Section 42 duty to undertake a safeguarding enquiry is triggered. However, the local authority may still decide to undertake an enquiry where the three tests in the Care Act are not met

Note Carers are also covered by these procedures where they meet the three tests set out above.

Safeguarding enquiry The action taken or instigated by the local authority in response to a concern that abuse or neglect may be taking place.

An enquiry can range from a conversation with the adult to a more formal multi-agency plan or course of action.

A safeguarding enquiry starts when the initial information gathering has established that all three of the Section 42 criteria are met or, where the criteria are not met, the decision has been made that it is necessary and proportionate to respond as a safeguarding enquiry (ie. 'other safeguarding enquiry').

Section 42 enquiry Those enquiries where the adult meets **all** of the Section 42 criteria ie. the three key tests.

The local authority must make, or cause other agencies or organisations to make, enquiries when the Section 42 duty is triggered.

Other safeguarding enquiry Enquiries where an adult does not meet all of the Section 42 criteria but the local authority has the power under the Care Act to undertake an enquiry where it considers it necessary and proportionate to do so.

Safeguarding Adults Board (SAB) Safeguarding Adults Boards (SABs) are multi-agency partnerships that are committed to the effective safeguarding of adults in their local area.

A vital aspect of the work of a SAB is to ensure information is available to the public, staff working in partner agencies, adults with care and support needs, and informal carers.

The Care Act 2014 sets out the core purpose of a SAB as ensuring that local safeguarding arrangements are effective and take account of the views of the local community. In setting out to achieve this, it must:

- Publish an annual report outlining its work and the findings of any Safeguarding Adults Reviews. The report must be available to member organisations and the public.
- Publish a strategic plan each financial year with key objectives, consulting with Healthwatch and developed with local community involvement. The SAB must also take account of the views of people who use care and support services, their families and carer representatives.
- Undertake any Safeguarding Adults Reviews (SARs).

Safeguarding Adults Review (SAR) Safeguarding Adults Boards must arrange a SAR when an adult in its area has experienced, or dies as a result of, serious abuse or neglect (known or suspected), and there is concern that partner agencies could have worked more effectively together. The aim of the SAR is to identify and implement learning from this.

Making Safeguarding Personal (MSP) A 'Making Safeguarding Personal' approach means safeguarding responses should be person-led and outcome-focused.

The person should be engaged in a conversation about how best to respond to their safeguarding situation in a way that enhances their involvement, choice and control as well as improving their quality of life, well-being and safety.

Our vision

> Our vision is for all agencies to work together effectively to enable the citizens of East Sussex to live free from abuse and neglect, and to promote widely the message that safeguarding is everybody's business.

To achieve this vision, the Board will:

- Actively promote collaboration and commitment between organisations.
- Work together on prevention strategies.
- Listen to the voice of adults with care and support needs and carers to deliver positive outcomes.

The East Sussex SAB is committed to the principles of Making Safeguarding Personal ie. to listen to what the adult or their representative would like to achieve, and by ensuring the most appropriate support is available.

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 raise a concern in the following ways:

Phone: 0345 60 80 191 (8am to 8pm 7 days a week inc. bank holidays)
Email: Health and Social Care Connect
Text: 07797 878 111
Contact the Police on 101 or in an emergency 999

Find out more from our safeguarding leaflet.

Progress on 2017 – 18 priorities

1.1 Ensure the effectiveness and transparency of the SAB to oversee and lead adult safeguarding and the prevention of abuse

SAB budget

The SAB budget for 2017 – 18 consisted of financial contributions from the core partners of the SAB, namely Adult Social Care & Health (ASC&H), Sussex Police and the Clinical Commissioning Groups (CCGs). East Sussex Healthcare NHS Trust (ESHT), East Sussex Fire and Rescue Service (ESFRS), Sussex Community NHS Foundation Trust (SCFT) and the National Probation Service, also contributed financially to the working of the Board.

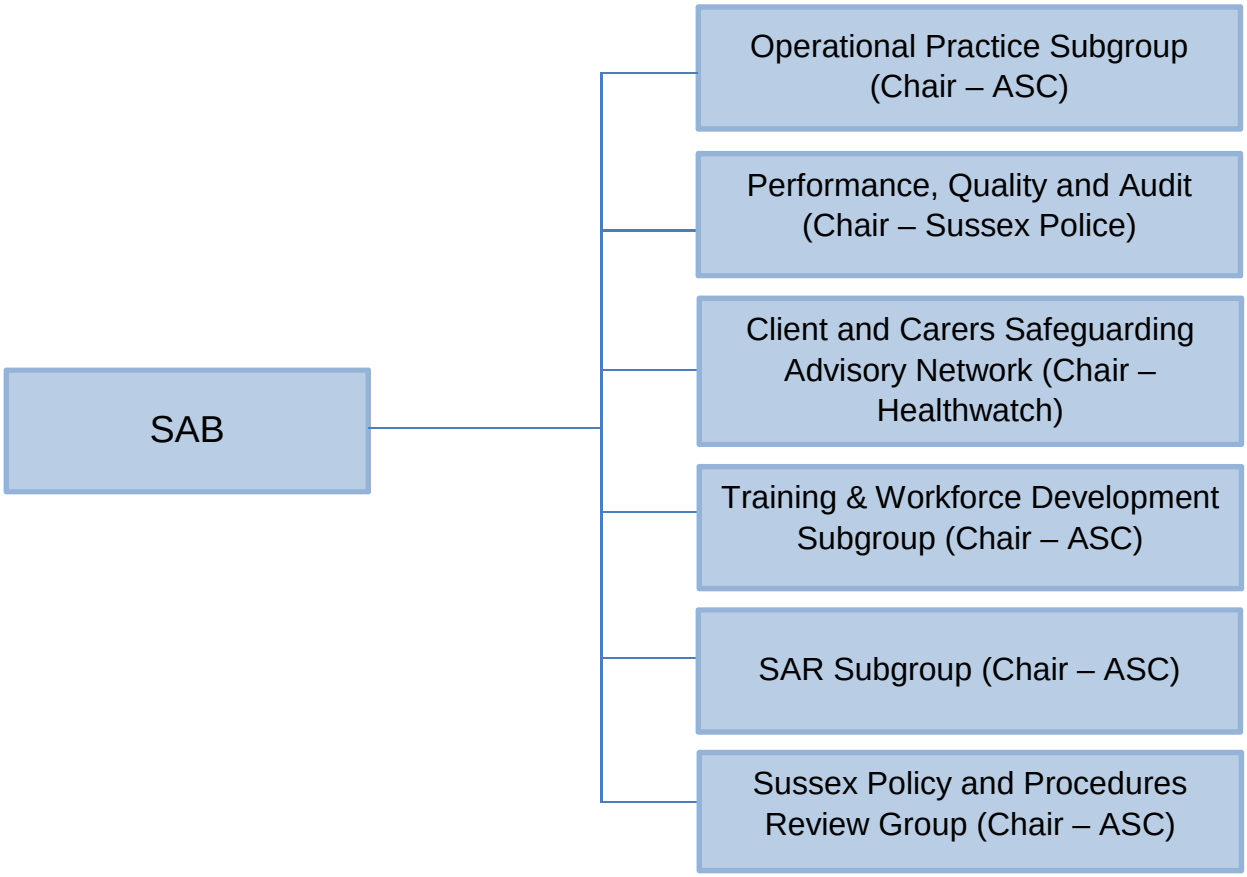
The following areas were identified for the budget to support the SAB in what is required of it under the Care Act, and to inform future business planning:

- Independent Chair
- SAB Development Manager
- SAB Administrator (0.5 FTE)
- Quality Assurance & Learning Development Officer (0.6 FTE)
- Multi-agency training and safeguarding promotions / awareness
- Safeguarding policy and procedures
- SAB website
- Safeguarding adult reviews

Please see Appendix 1 for more details on the end of year budget.

Governance and structure of the SAB

The descriptions below provide information on the role and make up of the SAB's sub-groups and workstreams.



Operational Practice Sub-group This group co-ordinates local safeguarding work, and ensures the priorities of the SAB are put into place operationally. Currently, its particular focus is to ensure an outcomes-focused approach is embedded in safeguarding practice, as well as ensuring advocacy provision will meet the Care Act duties.

Performance, Quality & Audit Sub-group This group establishes effective systems for monitoring, reporting and evaluating performance across agencies, and links annual reporting to improvement planning. The group highlights staffing groups or service areas that require further awareness or training.

Multi-agency Training & Workforce Development Sub-group This group is responsible for delivering the objectives of the training strategy 2015 – 18, and overseeing training opportunities in key safeguarding matters affecting a number of agencies. Currently, the group is focused on developing multi-agency self-neglect training.

Sussex Policy and Procedures Review Group This consists of the statutory partners of the SABs across Sussex, with the purpose of reviewing and updating the safeguarding procedures in line with any policy and legal updates.

Clients & Carers Safeguarding Advisory Network This network enables two-way communication and exchange of information between the SAB and clients and carers to improve safeguarding experiences and inform policy development.

The network has expanded its membership to include organisations that support and represent people with disabilities, mental ill health and learning disabilities, together with older adults and carers.

Safeguarding Adult Review (SAR) Sub-group This consists of the statutory partners of the East Sussex SAB, and meets monthly with the purpose of considering cases that may require a safeguarding adult review, and makes a recommendation to the SAB Chair.

Peer challenge events

Peer challenge events were introduced following completion of a safeguarding self-audit tool by SAB member agencies, and were held in July 2017 and January 2018.

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. Action plans for future improvements are being monitored regularly by the PQA sub-group.

Quality Assurance & Learning Development Officer

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, and they can be accessed here.

Named GP for Adult Safeguarding

The Clinical Commissioning Groups recruited a Named GP for Adult Safeguarding in 2017 – 18.

The Named GP offers advice and support regarding safeguarding concerns arising in primary care, as well as delivering training. She is also a member of the Safeguarding Adults Review Sub-group.

Peer review

An action plan has been developed to address areas for improvement highlighted by the South East ADASS Peer Review of adult safeguarding in East Sussex, undertaken in March 2018.

Recommendations to address the areas for improvement have been identified, and comprise the core elements of the action plan.

The action plan will be implemented on a phased basis over 9 – 12 months, and will not require additional annual investment nor the creation of new posts.

Future plans

- Review the impact of the Quality Assurance & Learning Development Officer post, to consider future plans for this post.
- The East Sussex SAB will take part in a research project, alongside eight other SABs, with the University of Sussex, to investigate how existing research and review findings can more effectively be implemented through organisational learning.

2.1 Ensure Section 42 safeguarding arrangements are in place under the Care Act, with appropriate feedback and review arrangements

Care Act 2014 duties

An updated version of the Sussex Safeguarding Adults Policy and Procedures has recently been launched and is available online.

The purpose of the rewrite was to reduce repetition, incorporate policy and legal updates as well as learning from safeguarding adult reviews, audits and developments in practice.

The principles, legal requirements and guidance under the Care Act and the Care and Support Statutory Guidance remain the same.

The policy and procedures provide an overarching framework to ensure a proportionate, timely and professional approach is taken, and that adult safeguarding is co-ordinated across all relevant agencies and organisations.

The definition of adults within the Care Act which the Board seeks to protect is any person aged 18 years or over who:

- has needs for care and support (whether or not the local authority is meeting any of those needs), and
- is experiencing, or at risk of, abuse or neglect, and
- as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of, abuse or neglect.

These three criteria are referred to as the 'three key tests'.

The Care Act places statutory duties on SABs as follows:

- It **must** publish a strategic plan for each year that sets out how it will meet its objectives. In developing this plan the SAB **must** consult Healthwatch and the local community.
- It **must** publish an annual report.
- It **must** develop policies and procedures, promote multi-agency training and develop preventative strategies.
- It **must** conduct any safeguarding adult reviews.

Fire safety and prevention

Multi-agency activity to reduce the risk of fire-related harm in the community is closely monitored. A data sharing agreement between East Sussex Fire and Rescue Service and ASC was implemented in October 2014 to support the strategy to reduce the number of fire deaths, fire injuries and fires in domestic dwellings. The effectiveness of this agreement continues to be monitored. Since April 2017, approximately 1,480 clients have received, or have a confirmed appointment to receive, a home safety visit as a specific result of the agreement.

Safeguarding adult reviews

Safeguarding Adults Boards have a statutory duty under the Care Act to undertake safeguarding adult reviews (SARs) – formerly known as serious case reviews. This is when:

- An adult dies as a result of abuse or neglect, 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.

Four 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 it was agreed the LSCB is best placed to undertake the review as the majority of the concerns occurred before the person turned eighteen years of age.

A 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.

A third referral was for a woman with complex support needs, including alcohol and substance misuse, mental health problems and long periods of homelessness. She 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. After considering information provided by the agencies involved, the SAR sub-group was of the view that most agencies had engaged and communicated with each other in providing support to the adult, so there was not a concern that partner agencies could have worked more effectively to protect the adult to a level that would require a SAR. Learning points from the coroner's inquest and from the serious incident process were taken forward and a decision

was reached that there would not be any further learning or value to be achieved by undertaking a SAR.

However, given the complexities of this case, public health professionals and substance misuse commissioners are considering whether any clearer systems or guidance are required for professionals to support people with similar needs to this adult. The SAR sub-group will be kept informed of this action.

The fourth referral, regarding a woman in her nineties who was living with family members when she died and concerns have been raised over possible abuse and neglect, is being taken forward as a discretionary SAR and learning from this will be reported later in the year.

SAR – Adult A

One referral was made in 2016 – 17, and the review was published in October 2017.

The 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 (CCG). Adult A died as a result of systemic sepsis, infection of his legs, diabetes and cirrhosis. He was subject to a Deprivation of Liberty (DoL) 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.

The SAR was led by independent reviewers who examined the following areas:

1. How care placements were organised and reviewed.
2. How health and social care professionals worked together across geographical borders.
3. How Adult A was engaged with.
4. How mental capacity and deprivation of liberty were assessed.
5. How the interface between the Mental Capacity Act (MCA) and the Mental Health Act (MHA) was understood and applied by professionals.
6. How care and treatment plans were agreed and followed.

The review found that the adult's continual refusal of care and treatment was respected by professionals, despite the fact he had been deemed to lack capacity to make decisions about his own wellbeing. The review called for agencies to work more closely together to share information and expertise, and to improve knowledge among professionals of the legislation which governs when interventions can be made against the wishes of those who are deemed to lack capacity to make informed decisions themselves. The review also found there had

been a lack of strong leadership in co-ordinating the adult's care by the commissioner of the service, and a lack of knowledge around safeguarding and legal matters by the commissioners and the nursing home provider.

The review demonstrates how crucial it is for all agencies to work closer together, sharing expertise to plan and deliver the best possible services to meet people's care and support needs.

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. In addition, learning briefings regarding the review and the interface between self-neglect and safeguarding have been developed, and can be accessed at the same online location at the following address:

https://www.eastsussexsab.org.uk/safeguarding-adult-reviews-2/

Multi-agency safeguarding audits 2017 – 18

Best interests decisions

One of the recommendations from the safeguarding adults review (Adult A, outlined above), was that the SAB should conduct an audit of cases to evaluate the outcomes of Mental Capacity Act (MCA) best interests decision-making, with particular reference to assessing multi-agency involvement and clarity about leadership responsibility.

This audit was undertaken by representatives of Adult Social Care & Health (ASC&H), Sussex Partnership NHS Foundation Trust (SPFT), East Sussex Healthcare Trust (ESHT), East Sussex Clinical Commissioning Groups (CCGs), South East Coast Ambulance NHS Foundation Trust (SECAmb), and Sussex Police.

What is working well?

- In some cases, professionals demonstrated a good understanding of the decision-specific nature of mental capacity assessments and the importance of providing additional support where necessary.

- In one case, support was provided by a specialist Learning Disability Nurse which assisted the process considerably.

- There were good examples where other professionals and family members were consulted when best interests decisions were made, and there were good examples of inter-agency working and communication (although this was not evident in every case).

What can we improve?

- Awareness of the decision-specific nature of mental capacity assessments.
- The way disagreements in relation to mental capacity assessments are resolved.
- Record-keeping and information sharing in relation to mental capacity assessments and best interests decisions.

In light of these development areas, the SAB has agreed the following actions will be implemented in 2018 – 19:

- Development of a multi-agency MCA policy and procedure, which will include a review and resolution mechanism in relation to disputed mental capacity assessments.
- Development of multi-agency MCA training, to complement existing single agency training.
- A learning briefing highlighting the findings of the audit will be shared amongst frontline staff

Modern slavery and human trafficking

This multi-agency audit was undertaken by the East Sussex SAB, on behalf of the Sussex Modern Slavery Network, to assess whether the needs of adults with care and support needs, who are known or suspected to be victims of modern slavery, are appropriately addressed.

The audit was undertaken by representatives of ASC&H, the Safe in East Sussex team, SPFT, CCGs, ESHT, Sussex Police, and Change, Grow, Live (CGL).

A sample of four cases was audited. These involved suspected forced drug dealing, human trafficking, sexual exploitation and financial exploitation.

What is working well?

- In one case a safeguarding enquiry was undertaken despite the 'three key tests' not appearing to be met, given the level of concern and potential

vulnerability of the adult, with good professional curiosity being evidenced by staff.

- Appropriate information was shared between the police and ASC&H.
- Quick action was taken by Sussex Police to reduce risk in two of the cases in particular.

What can we improve?

- Awareness of the National Referral Mechanism (NRM) and duty to notify form (MS1).
- The provision of information available to staff and the public regarding modern slavery.
- Training available to frontline staff.

In light of these development areas, the SAB has agreed the following actions will be implemented in 2018 – 19:

- Development of a multi-agency tiered training approach for modern slavery and human trafficking.
- Clarity to be provided on the safeguarding pathway in cases involving modern slavery and human trafficking.
- A learning briefing highlighting the findings of the audit will be shared amongst frontline staff.

Note Further information on the initiatives undertaken regarding modern slavery in 2017 – 18 can be found on page 45 of this report.

Managing allegations against people in a position of trust

In line with Care Act 2014 requirements, a framework and process has been established for how allegations against people in positions of trust, working with adults with care and support needs, should be responded to, in order to promote an individual's suitability to work with adults. Responsibility for this lies with the ASC&H Local Authority Designated Officer (LADO).

The concerns managed have related to individuals who:

- Work with adults with care and support needs.

- Have behaved in ways that have harmed an adult or child.

- Have committed criminal offences against adults or children.

- Have behaved towards adults or children in a way that indicates they may pose a risk of harm.

The key behaviours that have required the LADO's involvement, at times working in partnership with the Children's Services LADO, are:

- Allegations and incidents of sexual assault or offences.

- Allegations and incidents of domestic violence.

- Allegations and incidents of inappropriate conduct outside of the workplace that may pose a risk to adults with care and support needs, and potential to bring their employer or their profession into disrepute.

- Involvement of Children's Services, in particular child protection enquiries relating to the child(ren) of a person employed or volunteering with adults with care and support needs.

- Misuse or inappropriate use of social media including WhatsApp, Twitter and KiK and, where appropriate, involvement from POLIT (Paedophile On-Line Investigation Team).

- Staff who are unsuitable to work in health and social care settings, and have been removed from their professional role and referred to their professional body, where appropriate. Thereby, the risk of abuse or misconduct has been reduced or eliminated.

- Proportionate information has been shared consistently by the LADO with employers, student bodies and voluntary organisations to enable personnel procedures to be invoked, or risk assessments and effective risk management to be undertaken.

- The LADO has ensured employers have clear safeguarding and personnel procedures in place, and are carrying out investigations accordingly. The ASC&H LADO and Children's Services LADO have worked jointly in collaboration with key partners to review and support the Sussex safeguarding adults policy and procedures.

- A protocol for managing allegations in respect of people in positions of trust has been developed for ESCC Adult Social Care & Health staff.

- A dataset is in place to record information which is GDPR compliant. This details the person of concern, their gender identification, type of abuse, professional role, type of employer, and actions taken.

- Strong links have been established with Children's Services colleagues, and regular meetings take place between both departments' LADOs. Links have also been forged with Brighton & Hove City Council ASC & Children's LADO to support cases involving geographical boundaries, and this is proving effective in practice. Links have also been established with the CCGs, ESHT and West Sussex ASC.

The SAB will continue to monitor the LADO's activity in 2018 – 19, and ensure there is clarity on the response to allegations about people in a position of trust.

Future plans

- 'Market test' the updated Sussex Safeguarding Adults Policy and Procedures with frontline staff.

- Development and launch of the multi-agency Mental Capacity Act policy and procedures.

- Update the multi-agency self-neglect guidance.

3.1 Focus on personalising and integrating safeguarding responses, and measure safeguarding outcomes that bring safety and people's wishes together

Domestic violence and abuse

The Portal continues to provide a single point of access for victims and survivors of domestic and sexual violence and abuse, to find advice and support in East Sussex and Brighton & Hove. Other commissioned services also provide support to victims of domestic violence and abuse across the county, including Refuge (which operates five refuges in East Sussex) and Home Works (which provides flexible and tailored support to prevent homelessness).

During 2017 – 18, new initiatives have been funded or delivered, including:

- Work in health care settings, with domestic violence and abuse specialists located in a local hospital and primary care settings (funded by the Hastings & Rother Clinical Commissioning Group).

- Reviewing domestic abuse training, and running a course for practitioners from Children's Services, Adult Social Care & Health, and other professionals. This is delivered, in partnership, by the Local Safeguarding Children's Board (LSCB), the SAB and Safer Communities Partnership to reflect the need to adopt the 'Whole Family' approach.

- Developing a coercive control training module in partnership with Sussex Police, the LSCB and the SAB.

- Marking the 16 Days of Action and securing White Ribbon Status, alongside a range of events and activities hosted by district and borough Community Safety Partnerships. Locally, the Eastbourne, Lewes, Wealden and Hastings district and borough councils have all secured White Ribbon status.

The Safer Communities Partnership has also continued work in the following areas:

- Delivering the Multi-Agency Risk Assessment Conference (MARAC) for the highest risk victims of domestic violence and abuse, with a focus on continuous improvement and ensuring that professionals can access training with the roll-out of courses on risk identification and referral.

- Delivering a Champions Network, to bring together practitioners from a range of agencies, and to further strengthen community and agency responses across the county.

- Delivering the Women's Aid 'Ask Me' scheme to create safe spaces in the local community to increase public awareness and promote opportunities for disclosure.

Change, Grow, Live (CGL@thePortal) has expanded their Health Independent Domestic Violence Advisor service to Eastbourne, Hailsham and Seaford, building on the Hastings and Rother pilot which took place in 2016 – 17. The service has been funded until 2019. CGL has also piloted a service based within Eastbourne and Hastings police to review repeat standard risk and hard-to-engage cases that are not being escalated, and are being viewed as individual incidents.

Financial abuse and scams

The East Sussex SAB identified a need for a financial abuse strategy to combat financial abuse of adults with care and support needs, in recognition that where there are other forms of abuse there is often likely to be financial abuse occurring too. Moreover, financial abuse is the most commonly reported type of abuse that people experience in later life. The aims of the strategy are to ensure:

- Activity is co-ordinated between partners of the SAB to prevent and respond to financial abuse.
- Clarity of the roles of partner agencies.
- Recognition of activities already taking place.
- Identification of any overlaps and joint working opportunities to reduce duplication.
- Improvements in the consistency of signposting, responses and messages to the public and adults with care and support needs.
- Identification of gaps and actions needed.

The full strategy can be accessed here.

Alongside this strategy, the Safer Communities Partnership has continued to develop responses for vulnerable victims of fraud, rogue trading and cyber-enabled crime.

Mass marketing mail scams are often targeted at vulnerable or disadvantaged consumers, and causes approximately £5 – 10 billion of detriment to UK consumers each year. Some victims even struggle to identify themselves as victims, and respond because it helps with feelings of loneliness.

Locally, effective links have been made between East Sussex Trading Standards Service, Sussex Police, the National Trading Standards (NTS) Scams Team, East Sussex Fire and Rescue Service, and Adult Social Care & Health.

The Scams Working Group has now evolved to a bi-annual networking and engagement event to provide a platform for all partners in the voluntary and statutory sectors to showcase their work against scams. To build upon the success of the working group, each networking and engagement event incorporates a facilitated forum to test practice, share operational procedures, share research and plan strategies.

The NTS Scams Team works across England and Wales, and engages with local authorities and partner agencies to identify and support victims of scams. As part of this, officers from the East Sussex Trading Standards Service visit scam victims identified by the NTS Scams Team, usually accompanied by an Age UK or Citizens Advice Bureau representative. The NTS Scams Team also runs the Friends Against Scams initiative which aims to increase the awareness of scams throughout the UK.

This is supported by the East Sussex Against Scams Partnership (ESASP) which is a partnership of organisations – businesses, charities, church groups, clubs, community enterprises, councils, societies, voluntary groups and other partners. Partners are committed to the ESASP Charter's three key aims which are:

- Raising awareness and de-stigmatising scams.
- Prevention and protection.
- Identification and recording.

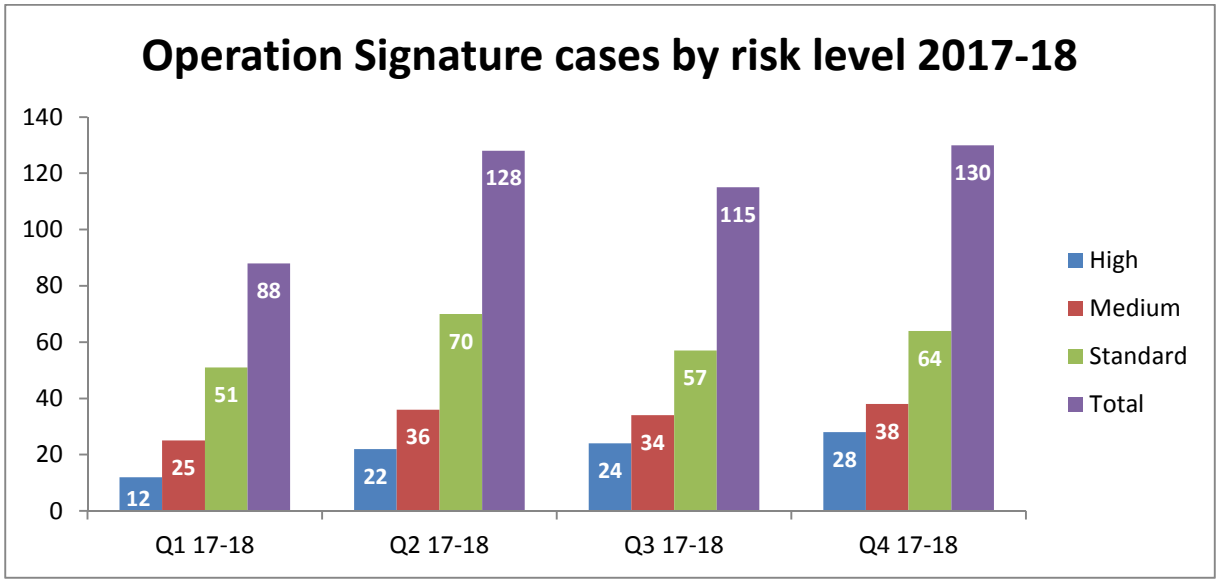
Over 80 partners have pledged their commitment to taking a stand against scams by signing up to the Charter, and the number continues to grow.

Future plans include:

- Increasing the number of Charter partners, and continuing to provide scams and fraud awareness raising activities to existing members such as the Sussex Armed Forces Network and Dementia Action Alliances.
- Continuing to strengthen communications with Charter partners; sharing key messages, providing newsletter articles and maximising social media output for Charter partners.
- Holding an annual networking and engagement event which will incorporate a facilitated forum to test practice, share operational procedures, share results of surveys and plan strategies.

Operation Signature

Operation Signature is the operational response of Sussex Police to scam mail fraud. It identifies and supports vulnerable, and often elderly, victims of this type of fraud within Sussex. The chart below shows the number of cases identified in East Sussex during 2017 – 18.



The Police and Crime Commissioner (PCC) funded two specialist caseworker posts, under Victim Support, to provide frontline support to vulnerable victims of fraud and prevent future victimisation. These posts have established clear pathways with other relevant support agencies, and began taking cases from Operation Signature in January 2017. The support provided has shown that the majority of victims are continually being targeted and affected by scam and nuisance phone calls, and an increase has been seen in romance frauds.

The PCC will continue to fund these posts for the next financial year, and the SAB will continue to monitor the impact this has.

Analysing safeguarding activity

5,551
Contacts received

1,413
Enquiries started

1,450
Enquiries completed

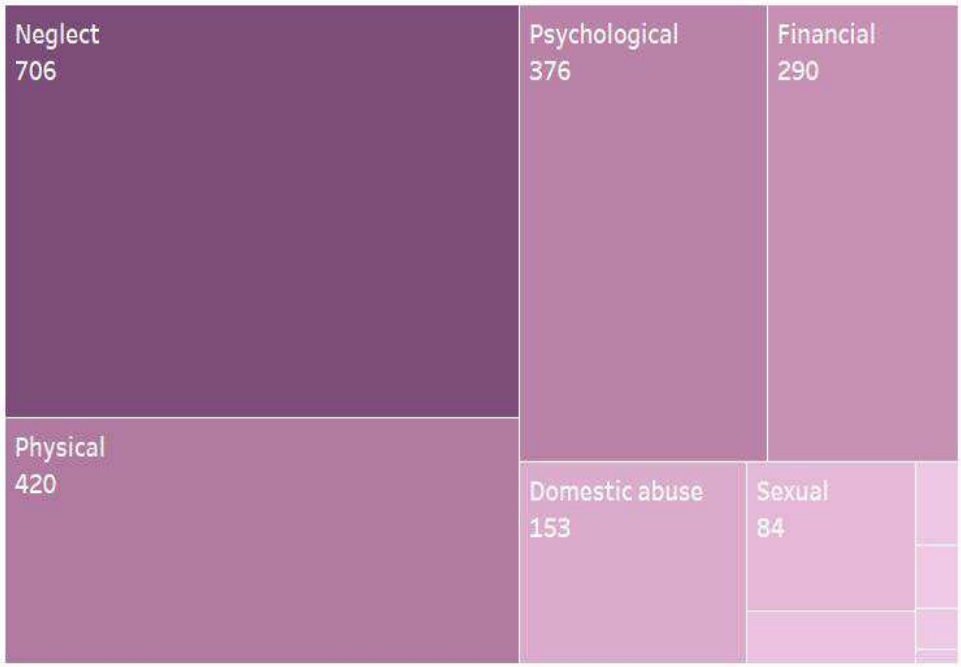
Note The figure for completed enquiries is not a proportion of the figure given for enquiries started as some completed enquiries would result from concerns

received prior to 2017 – 18 and correspondingly some enquiries started in 2017 – 18 would still be ongoing at the end of the financial year.

The number of safeguarding contacts has gone up from **4,222** in 2016 – 17 to **5,551** in 2017 – 18. Of the total contacts received in 2017 - 18, **4,467 (81%)** were considered safeguarding concerns.

The number of enquiries completed appears to have decreased significantly since 2016 – 17 (decreasing from **4,222** to **1,450**). This is because of a change in the way safeguarding activity is recorded following lessons learned in the previous year. Previously, all safeguarding concerns were recorded as enquiries and these enquiries were managed in proportion with the degree of risk associated with each concern raised. Now concerns and enquiries are recorded separately.

Types of abuse investigated in 2017 – 18



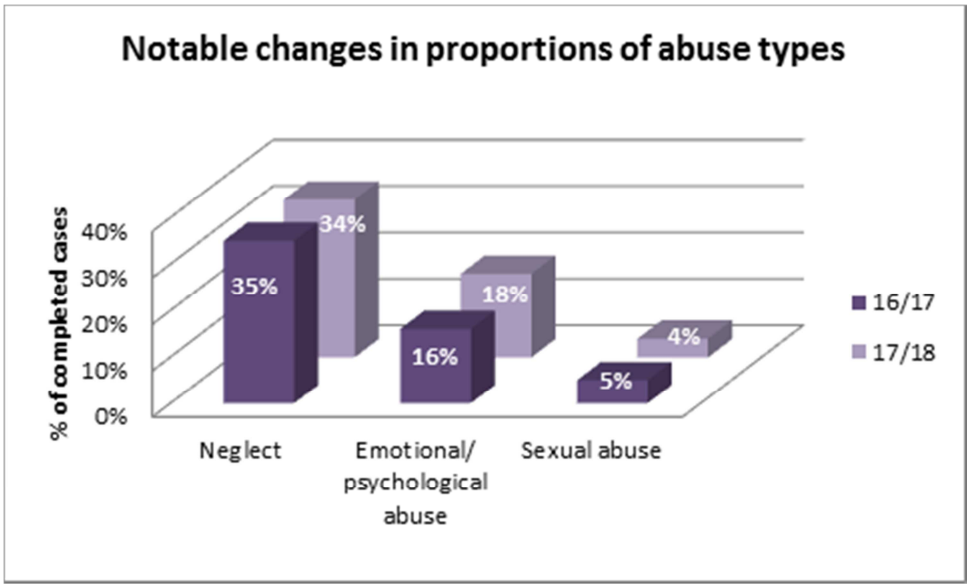
Type of abuse	
Neglect	706
Physical	420
Psychological	376
Financial	290
Domestic abuse	153
Sexual	84
Self-neglect	30
Discriminatory	12
Organisational	9
Sexual exploitation	6
Modern slavery	2

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

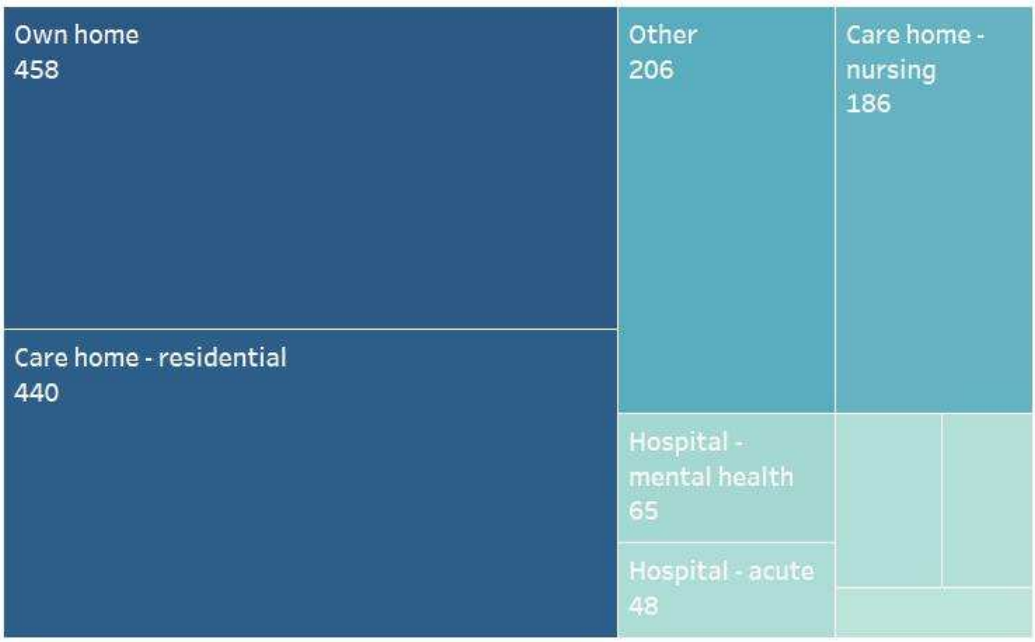
In 2016 – 17, the most common form of abuse reported was neglect followed by physical and then emotional abuse. In 2017 – 18, neglect is still the most common type of abuse with **49%** of all enquiries undertaken comprising, at least in part, neglect. Physical and emotional abuse remain the second and third most common forms of abuse accounting for **29%** and **26%** respectively. The proportion of cases involving emotional abuse continues to increase. This is because there is greater acknowledgement that abuse such as physical abuse and financial abuse can often have an emotional or psychological impact which is also being reported.

The most significant proportional differences since 2016 – 17 are:

- A 2% increase in emotional abuse from 16% to 18%.
- A 1% decrease in sexual abuse from 5% to 4%.



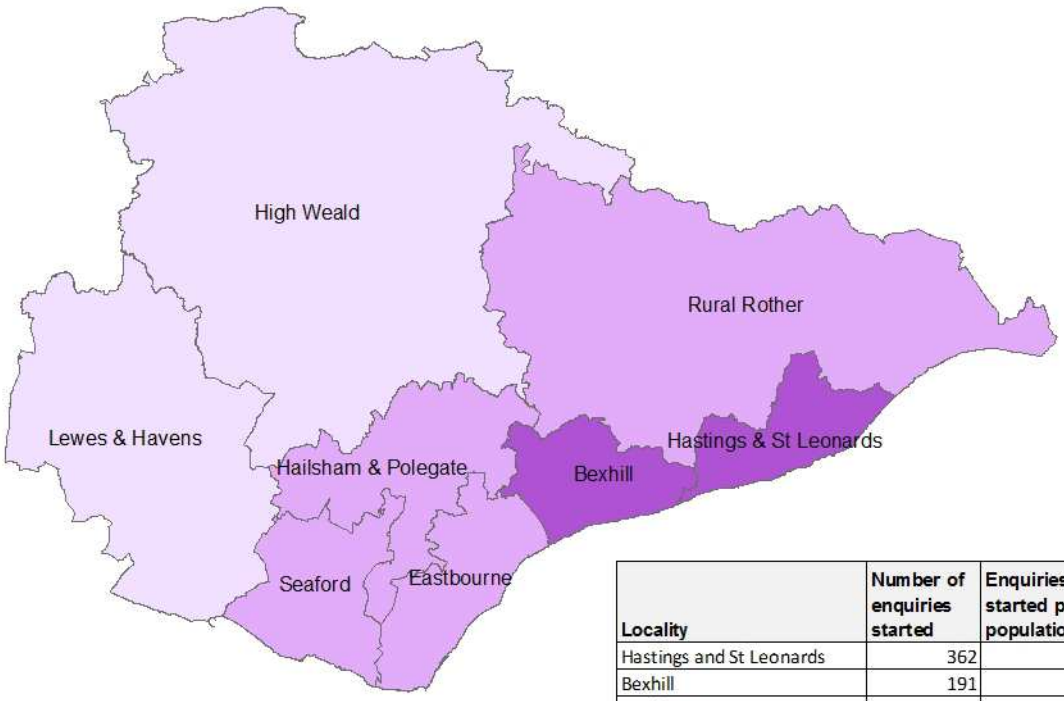
Locations of abuse



Location of abuse	
Own home	458
Care home - residential	440
Other	206
Care home - nursing	186
Hospital - mental health	65
Hospital - acute	48
Community service	43
Hospital - community	37
Community setting	23

As in previous years, the most common reported location of abuse is in the adult at risk's own home **(32%)**. This is a drop from **37%** in 2016 – 17. The second most common location continues to be residential care homes, accounting for **30%**. This is an increase from **23%** in 2016 – 17.

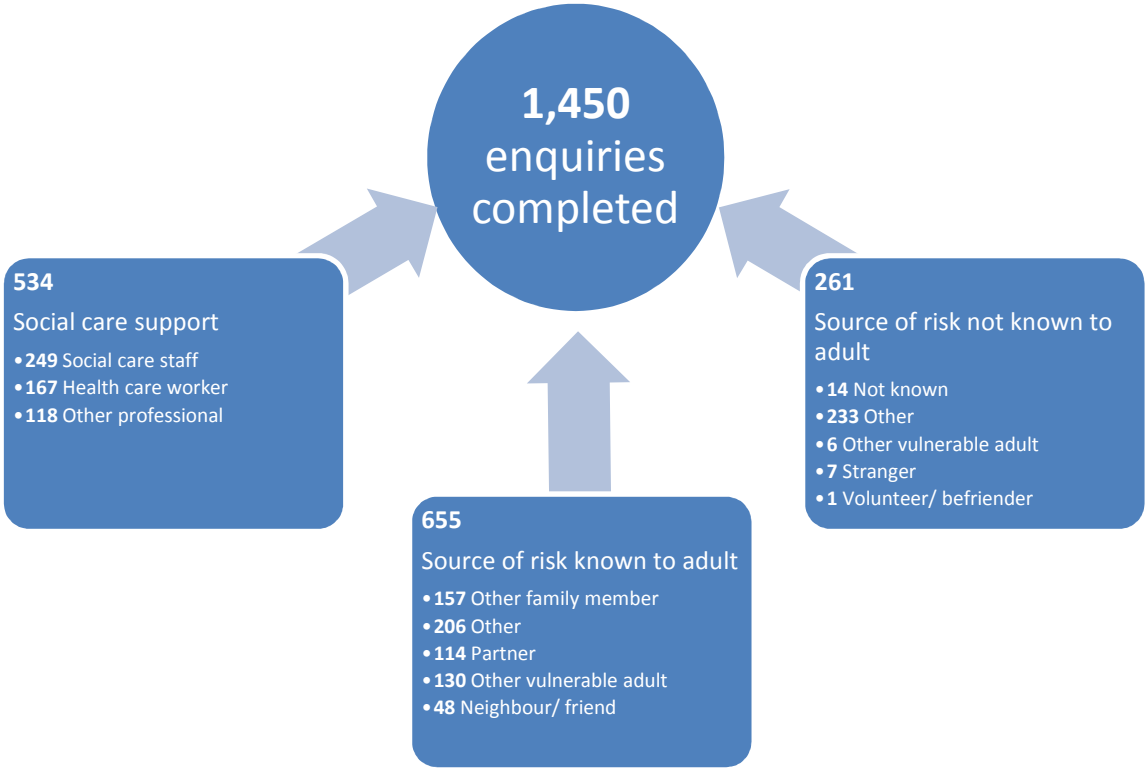
Reported abuse in nursing homes has reduced from **18%** to **13%** of all reported abuse whilst cases in mental health hospitals have increased from **1%** to **5%** of all cases.



East Sussex Localities
Enquiries started per '000 population
5
3
2

Locality	Number of enquiries started	Enquiries started per '000 population
Hastings and St Leonards	362	5
Bexhill	191	5
Eastbourne	305	3
Hailsham and Polegate	106	3
Rural Rother	82	3
Seaford	65	3
High Weald	136	2
Lewes and Havens	112	2
Out of county/ not recorded	54	-
Grand Total	**1413**	-

Source of risk



In **45%** of the enquiries completed, the source of risk was known to the adult (up from **39%** in 2016 – 17). In **18%** of cases, the source of risk was not known to the adult (down from **31%** in 2016 – 17) and in the remaining **37%** of cases the source of risk was social care staff, an increase from **30%** in the previous year. The main reason for this change is improvements in the recording of details relating to the source of risk so fewer cases are being recorded as 'not known to adult'.

4.1 Allow the voice of clients, carers, and the local community to be heard in safeguarding policy and practice

Quality assurance activity in Adult Social Care & Health

Quality assurance activity in Adult Social Care & Health (ASC&H) includes analysis of audits, and feedback from stakeholders and adults who have been involved in safeguarding enquiries.

Over the past 12 months the Safeguarding Development Team has been involved in developing a mechanism to promote greater opportunities for feedback from adults involved in safeguarding enquiries. This has been built directly into the safeguarding recording system used by ASC&H. It creates a means of evaluating individual's outcomes in line with Making Safeguarding Personal (MSP), and promotes an approach in which ASC&H as a whole moves towards ensuring that feedback from adults involved in safeguarding enquiries is gathered routinely as part of the enquiry itself.

Since this change was implemented, ASC&H has received a significant increase in feedback questionnaires from adults regarding their experiences of being involved in safeguarding enquiries, and this feedback has helped to promote learning and development in adult safeguarding. However, the number is still low and the SAB has included a priority in the strategic plan for 2018 – 2021 to increase feedback rates.

Between April 2017 and March 2018, the Safeguarding Development Team (SDT):

- Completed audits on **123** cases, consisting of responsive audits, threshold audits (to ensure clear distinctions are made between safeguarding concerns and cases which need to be taken into an enquiry), full case audits, audits of mental capacity assessments, and multi-agency modern slavery audits.

- Received feedback from **9** stakeholders via questionnaires.

- Received feedback from **14** adults regarding their experiences of the safeguarding enquiry from questionnaires and interviews.

From this quality assurance activity, the following strengths and areas for development were identified:

Strengths

- Effective, planned multi-agency partnership working.

- Enquiries reflect an appropriate weighing up of risks and protective factors.

- A Making Safeguarding Personal approach with regard for the welfare and safety of adults, and the outcomes they wish to achieve is central to enquiry activity.

Key areas for development

- Understanding of what constitutes a safeguarding concern, and consideration of the extent to which abuse or neglect is a contributory factor within that concern.

- To ensure feedback from adults is embedded within the safeguarding process, and that the adult's views are sought from the outset of the enquiry and reviewed throughout.

- To continue to improve practice in relation to applying the principles of the Mental Capacity Act, particularly regarding the need to evidence in mental capacity assessments that all practical steps have been taken to support people to maximise their decision making ability.

Brenda's story

Brenda lives in a residential care home. She developed needs for care and support after a severe stroke, resulting in physical disability and communication difficulties.

The care home manager raised a safeguarding concern after Brenda disclosed that she was worried her son had been taking money from her account. Brenda did not want to inform the police as she knew her son was experiencing financial difficulty and she had previously given him permission to access her account if he needed money.

Brenda was referred for Care Act advocacy in relation to the safeguarding enquiry. With support from the advocate she identified her desired outcomes as:

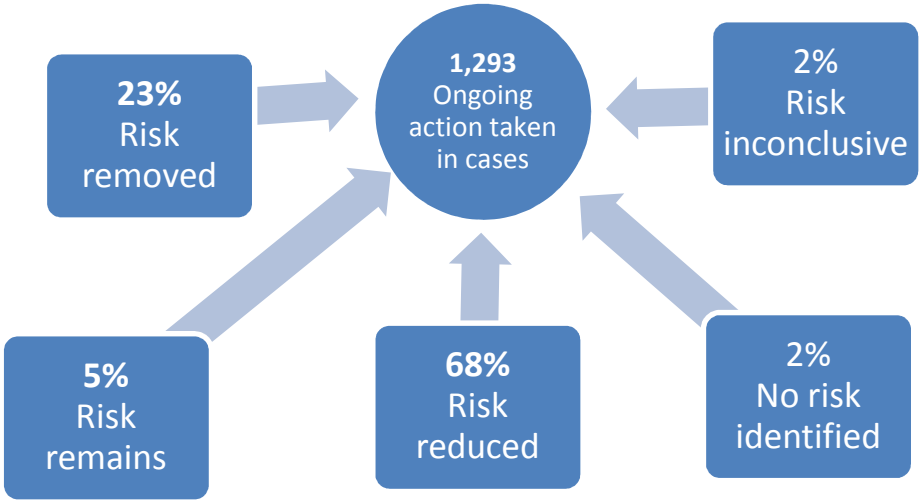
- Wanting her son to stop taking money from her account.
- Wanting to maintain her relationship with her son and for him to continue to visit her.
- Wanting to explore if another person could provide help in managing her finances.

Brenda was supported by her advocate to attend a safeguarding meeting, and the following safeguarding measures and outcomes were achieved:

- The local authority Client Affairs Team agreed to take responsibility for supporting Brenda with her finances.
- Brenda's son was offered support to access advice around maximising his benefits.
- Brenda was able to maintain her relationship with her son, and he acknowledged he should not have taken money from Brenda's account.

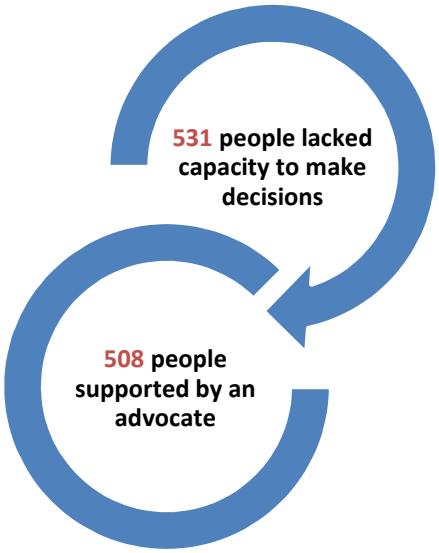
Analysis of outcome data

Impact on risk



In 2017 – 18, in **89%** of enquiries there was an identified risk to the adult and action was taken. In **91%** of cases the risk was either reduced or removed completely. This is a slight increase from **90%** in 2016 – 17. It should be acknowledged that it is unlikely that risk will be reduced or removed in 100% of cases, as individuals may exercise choice and control over the steps taken by authorities to mitigate the risk. The proportion of cases where risk remains has dropped significantly from **10%** to **5%**.

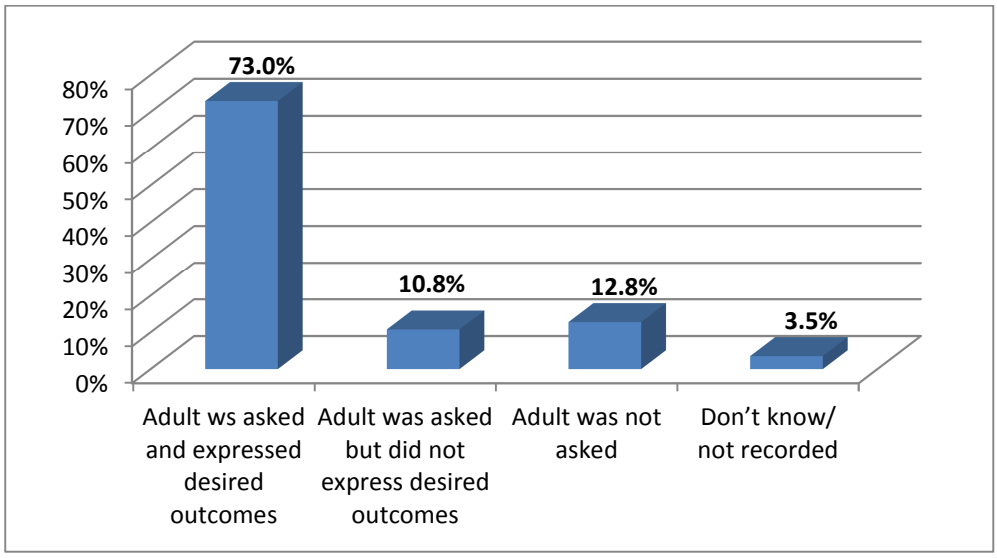
Support for adults at risk who lack capacity to make informed decisions



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.

Outcomes achieved through safeguarding

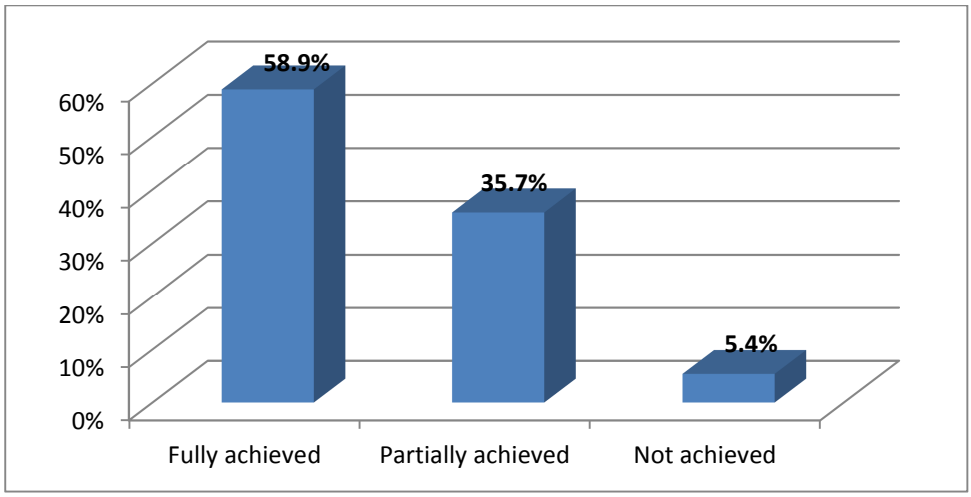
Number of adults who were asked for their desired outcomes:



In East Sussex, this is the first full year that this information has been available. **84%** of adults were asked about their desired outcomes in 2017 – 18. This is significantly higher than the figure of **67%**, of the local authorities that submitted data relating to this in 2016 – 17.

A review of 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.

Of those who identified outcomes, the proportion whose outcomes were met:



In East Sussex, this is the first full year that this information has been available. Of the local authorities that submitted data relating to this in 2016 – 17, **95%** reported that identified outcomes had been either fully or partially achieved, matching the local picture in 2017 – 18.

It is acknowledged that there will always be cases where outcomes will not have been achieved, for example, where desired outcomes are beyond the remit and

control of the enquiry or enquiry manager, or where the situation has changed from the initial desired outcomes that were recorded.

Learning from complaints

We take all complaints about our safeguarding processes seriously, as they help us to learn and improve how we do things in the future.

We aim to work with complainants in a mutually respectful way, and respond to concerns fairly and openly. Managers will generally look into any concerns that have not been considered within the enquiry, when the enquiry has been closed. This is to ensure the focus of the safeguarding enquiry is maintained appropriately.

Findings are informed by looking at whether we have followed our processes in the way that we would expect. This is done through discussions with complainants and practitioners, and looking at records. When things have gone wrong we want to put things right to avoid someone else having the same experience in the future.

Because of the nature of safeguarding, we can expect that some people will not agree with the decisions or the outcomes of our enquiries. We do, however, always try to explain the actions we have taken and resolve any ongoing issues, wherever possible.

The total number of complaints recorded for Adult Social Care & Health for 2017 – 18 was 433. Of these 20 related directly to safeguarding, this is **4.5%** of the total complaints received.

In addition to these 20 complaints, two MP / councillor enquiries were received. This represents **1.5%** of the total number of MP / councillor enquiries received in 2017 – 18, which was 150 enquiries.

This compares to 18 complaints and four MP / councillor enquiries in 2016 – 17.

The 20 complaints received can be broken down as follows:

Complaint outcome	
Not upheld	13
Partially upheld	6
Upheld	0
No outcome recorded – enquiry is ongoing	1
Total	**20**

These complaints were broken down into the following complaint sub-categories:

Complaint sub-categories	
Disputed outcome	7
Information	6
Manner / attitude / respect of staff	2
Placement	1
Policy	1
Quality	2
Responsiveness	1
Total	**20**

Key themes

Of the complaints received from clients or their representatives, key themes were about:

- Outcomes of safeguarding enquiries, including the actions agreed in the safeguarding plan.
- The safeguarding process, particularly around communication and support provided during safeguarding enquiries.
- Our decisions not to take concerns into safeguarding enquiries.

Some complaints were from former workers and care providers involved in enquiries, and they were concerned about:

- Communication and delays during safeguarding enquiries.
- Outcomes of safeguarding enquiries.

Learning and actions

We recorded learning at an individual, service and organisational level. Examples of learning and changes included:

Process and recording

- In response to delays in sending out minutes, improvements were made to the system for generating minutes.

- When information was recorded incorrectly, we apologised for the errors and amendments were made to correct and clarify the information. This has included addendums added to minutes.

Partnership working

- We have reviewed and improved how we confirm and clarify issues that have been raised through a different process, for example, this often applies to the relationship between the complaints and safeguarding process.

- We continue to reflect upon how safeguarding enquiries are conducted, and how we ensure collaborative relationships with partners and providers to achieve the outcomes wanted by clients.

Compliments

We received three compliments about the safeguarding process from clients and their representatives:

"I spoke at length with N this evening and she was very helpful and informative. I finally felt listened too and that the care needs of my father will now hopefully be addressed. It has been distressing to have to go to such lengths to get to this point, however, N has given me confidence that action will now be taken. My priority was to safeguard my father and obtain help and I feel like this has finally happened this afternoon. I would like to pass on my thanks for N's interaction with me today."

"Thank you to you and S for your advice and support over this past difficult period. It's appreciated."

"Just wanted to say a huge thank you for your support and dedication with W's case."

The Safeguarding Development Team received the following feedback from adults and their representatives:

Lay members

The role of lay members is to enable effective ties to be developed between the SAB and the local community, and to ensure the work of the SAB is transparent and accessible.

Lay members support the work of the Board by:

- Contributing to the development of strategies and plans to respond to and prevent abuse and neglect.
- Challenging the work of the SAB where required.
- Bringing an awareness and knowledge of the diverse communities and individuals living in East Sussex.

"I have now had the opportunity to support the Board in my role as lay member for another year, and have remained impressed by the strategic oversight of the Board in its role to ensure vulnerable adults are effectively safeguarded.

It is clear a good deal of learning develops from ongoing policy and practice reviews, and concise action plans are developed which attempt to ensure this learning impacts on the front-line of service provision.

There is still more work that can be done to monitor the impact of all implemented strategies to truly assess their efficacy and to measure their impact on the desired outcomes.

Additionally, it feels important to increase participation of the broader community, to ensure the Board's strategies truly reflect the community it is hoping to serve, to maximise the opportunity to develop proactive strategies to prevent abuse and to strengthen and develop the reactive strategies in responding to abuse. Furthermore, this would enable the Board to gain an insight into the effectiveness of the activities in practice, such that the Board's role is dynamic and responsive and wholly in touch with the practice 'on the ground'."

Board lay member, 2018

Making Safeguarding Personal (MSP) leaflet

This leaflet was developed by members of the Client and Carers Safeguarding Advisory Network, alongside the Safeguarding Development Team in ASC&H. It is available to give to all adults who are being supported through a safeguarding enquiry, to better inform them what they can expect within an MSP approach. This approach aims to ensure adults are involved and consulted while helping to keep them safe, and to have regular discussions about their desired outcomes.

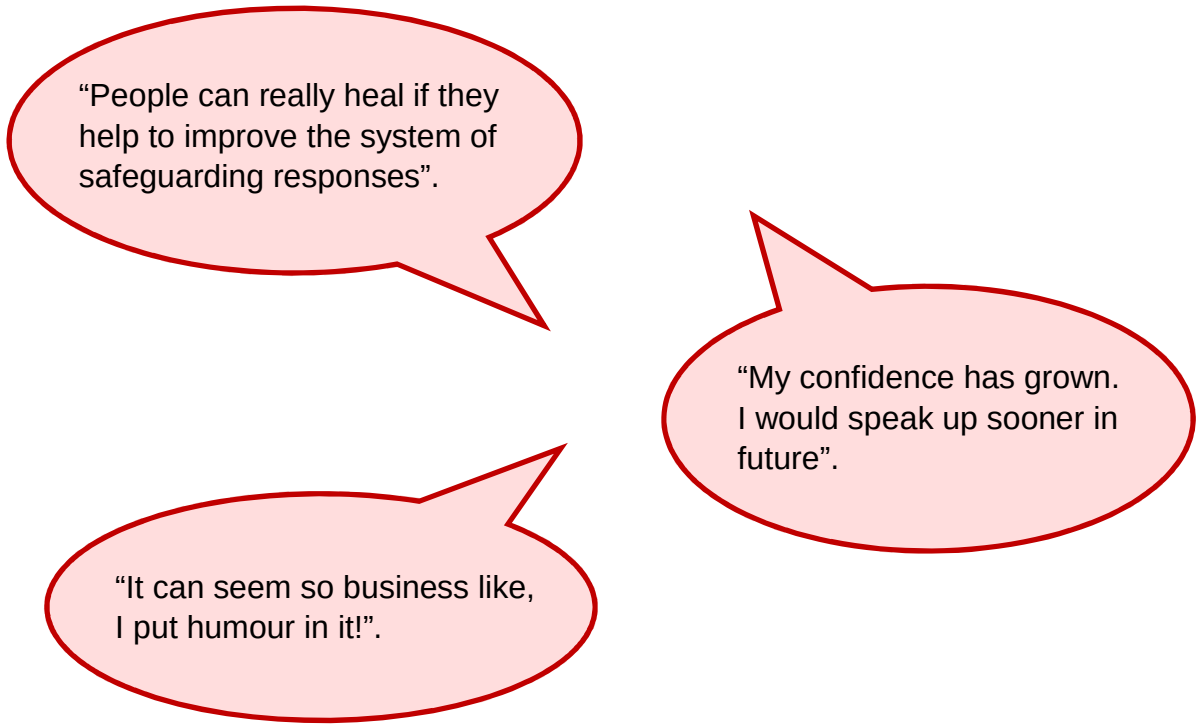
The leaflet can be accessed here.

Service user involvement

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. Future plans include the development of a video to share their personal experience.

The following quotes demonstrate the benefits of being involved in the work of the SAB, from their perspective:



Making Safeguarding Personal audit (Sussex Community NHS Foundation Trust)

The Adult Safeguarding team completes an audit of all requests to make enquiries received from the local authority to establish whether Making Safeguarding Personal (MSP) has been considered, and that the wishes and outcomes of patients and family / carers has been met.

- The 2015 – 2016 findings indicated that MSP was appropriately captured in 44% of enquiries. This could be as a result of the new Care Act adult safeguarding process.

- The 2016 – 2017 findings evidenced a positive increase, with MSP being appropriately captured in 68% of enquiries.

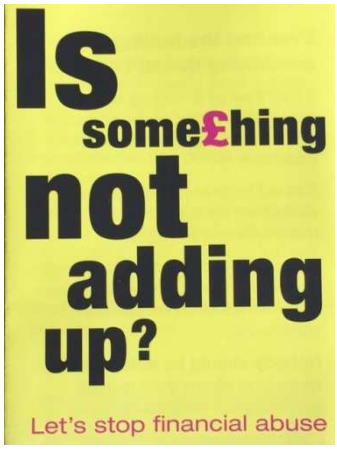
- The 2017 – 2018 findings again evidenced a positive increase, with MSP being captured in 74% of enquiries.

Going forward into 2018 – 2019, MSP is reported on quarterly, utilising the above annual data as our baseline to measure our success regarding:

- the quality and effectiveness of communication, and
- appropriately capturing MSP within the safeguarding adults process.

4.2 Ensure that people are aware of safeguarding and know what to do if they have a concern

Financial abuse campaign

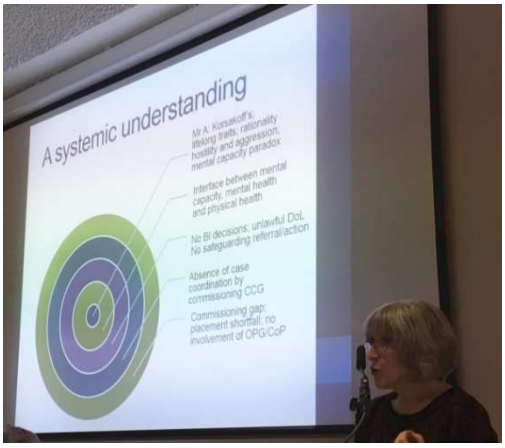


Throughout April and May 2017, staff members from the Safeguarding Development Team, alongside representatives from Trading Standards and Sussex Police, were involved in a campaign to raise awareness of financial abuse.

The campaign comprised a series of events, including presentations to home care providers and home care forums, and holding public stalls in day services. The campaign was also promoted through social media and via posters and leaflets distributed to libraries and health settings, including hospitals and health centres.

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.

Mental Capacity Act (MCA) and self-neglect event



Dr Suzy Braye

Andrew Parker, OPG

The MCA and self-neglect event was held at The View Hotel, Eastbourne, in April 2018. Attended by over 100 delegates from a range of agencies, the key note speech was delivered by Dr Suzy Braye, and followed by a presentation from the Office of the Public Guardian (OPG).

In response to the safeguarding adults review for Adult A and the recommendations ratified by the SAB, the event focussed on the following areas:

- Learning from local and national case reviews.
- Identifying the challenges when people are faced with clients showing signs of self-neglect. What is it they need to work through? What do they need to do, and who do they communicate with?
- Increasing understanding of the complexities of supporting and intervening with people who self-neglect, with particular emphasis on mental capacity.
- Increasing understanding of the legal remedies available to intervene in situations where people are assessed as lacking capacity, or where there is fluctuating capacity and / or differing professional opinions.
- Considering how to translate the learning into improving multi-disciplinary practice.

Feedback gained from delegates at this event will be considered in the update of the self-neglect guidance planned for launch in the autumn 2018.

Future plans

- Further develop use of social media by the SAB for increased community engagement.
- Monitor the impact of the financial abuse strategy across SAB partner agencies.
- Launch an updated safeguarding leaflet for the public alongside an updated Easy Read version.
- Produce an Easy Read version of the 'Making Safeguarding Personal' leaflet.

5.1 Ensure that all people involved in safeguarding have the appropriate skills, knowledge and competencies

Key training figures and initiatives

Adult Social Care & Health safeguarding training

April 2017 – March 2018

Course title	No. of courses
Safeguarding adults: basic awareness	11
Safeguarding adults and the law	3
Safeguarding and the Care Act	4
Safeguarding adults: refresher	20
Making safeguarding enquiries for Enquiry Managers / Officers	5
Safeguarding adults – train the trainer / Train the Trainer Forum	3
Using coaching skills to support an adult to identify their desired outcome	3
Mental Capacity Act 2005	22
Deprivation of Liberty Safeguards	12
Coercion, control and stalking	3
Bespoke courses	26

KWANGO safeguarding adults e-learning

April 2017 – March 2018

Organisation	Number of learners
ESCC	5,149
Hospitals and Clinical Commissioning Groups	1,201
Independent care sector	7,441

On 1st July 2018, KWANGO will be closing. Consequently, ESCC is developing its own e-learning modules on the following topics:

- Safeguarding awareness
- Mental Capacity Act and DoLS

These modules will be underpinned by the Care Act, and have a local flavour: referring to the Sussex Safeguarding Adults Policy and Procedures and the competency framework.

Three modules on domestic abuse have already been written and are available for all staff.

Multi-agency training

Self-neglect

We have continued to deliver this training throughout the last 12 months. In the four sessions there were 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. Feedback from the sessions highlighted learning and specifically how staff:

- Understand the importance of relationship building and the complexity of why individuals self-neglect.
- Understand that multi-agency meetings can be called by any of the professional agencies involved.
- Became aware of the underlying reasons for self-neglect and the thoughts of the individuals.
- Understand the importance of giving time and flexibility to individuals.
- Found it helpful to link current research to their own learning.

Priorities for 2018 – 2019

Modern slavery

In response to the increasing demand to raise awareness of staff about the types, prevalence and implications of modern slavery, we will be offering a multi-agency training pathway from October 2018. This is not designed to replace training already provided by individual organisations, but to enhance this and encourage a more collaborative response to tackle the issue.

Tier 1: Raising awareness This tier is for all staff. The Home Office modern slavery awareness booklet provides an up-to-date, easy-to-read resource setting out some of the key facts about modern slavery. To supplement this, Home Office research 'A typology of modern slavery offences in the UK' has broken down the broad categories of modern slavery into 17 distinct types of offence identified in the UK. This booklet will help to inform staff and increase understanding of the issues.

Tier 2: e-learning module This tier is aimed at staff requiring a bit more information and in-depth knowledge because of their role. The module explores:

- The 17 types of modern slavery (signs, symptoms, barriers to disclosure) in more detail.
- The global, national and local context.
- How to apply the learning to clients, carers and other people we may come into contact with in our day-to-day work.

Tier 3: Single Point of Contact (SPOC) training This tier is aimed at staff taking on the role of a SPOC. This face-to-face training is multi-disciplinary and will:

- Increase knowledge and understanding of legislation, policy and practice.
- Ensure an understanding of the role of the SPOC.
- Provide an opportunity to share experiences.
- Enable learning from others.
- Establish a network for peer support.

The SAB will continue to work with the Pan Sussex Modern Slavery Network in 2018 – 19. The network was established to bring together all the organisations across Sussex that are committed to tackling modern slavery, and establish effective pathways and responses to concerns raised regarding modern slavery.

Coercion and control

During 2017, Adult Social Care & Health piloted a course on coercion and control. Jointly facilitated with Sussex Police, the training explored:

- The legal context.
- How to identify coercion and control.
- Mental capacity, coercion and control.
- How to support victims to gather evidence effectively.

- How to ensure your personal safety.
- How to use the Risk Indicator Checklist for coercion and control.

We are now in a position to roll this out on a multi-agency basis, and will be promoting dates through SAB members later in 2018.

Key safeguarding initiatives and training figures from SAB partner agencies can be found in Appendix 2.

5.2 Ensure clear links exist between partnership boards with accountability arrangements documented and understood to avoid duplication of workstreams

Regular meetings take place between representatives of the SAB, LSCB, Safer Communities Partnership and Children and Young People's Trust, in accordance with the partnership protocol that was developed in 2016 – 17.

Through the implementation of this protocol, it was agreed in 2017 – 18 that the Safer Communities Partnership would provide the lead strategic oversight for the modern slavery agenda, with the SAB supporting by way of undertaking a multi-agency audit (detailed on page 16), and ensuring the updated Sussex Safeguarding Adults Policy and Procedures include more detailed and up-to-date information regarding this type of abuse.

A formal review of the partnership protocol has been postponed, and will take place in 2018 – 19.

Future plans

- Further development of multi-agency training opportunities including modern slavery, coercion and control and Mental Capacity Act.
- Establish robust referral pathways for concerns involving suspected modern slavery and human trafficking.
- Review of the partnership protocol.

Conclusion

In presenting the progress made against our key priorities for 2017 – 18, this annual report has shown the continued effort of all partner agencies to work together to safeguard adults from abuse and neglect.

We have published the findings of our first safeguarding adults review (SAR) under the Care Act 2014, and we are confident that the action plan developed with the Kent & Medway SAB will ensure that the recommendations are translated into real change. The full report and action plan can be accessed here.

Embedding organisational change following reviews and audits continues to be a challenge for all safeguarding adults boards. So, we welcome the opportunity to participate in a research project taking place in 2018 – 19. Working alongside the University of Sussex and six other SABs, we will be looking into how to achieve organisational change.

To ensure that all staff involved in safeguarding have the appropriate skills, we will continue to deliver multi-agency training courses in 2018 – 19. Our particular focus for next year will to be promote courses on modern slavery and human trafficking, and coercion and control.

We will also be evaluating the effectiveness amongst frontline staff of our newly launched safeguarding policy and procedures.

Our recently updated strategic plan for 2018 – 2021 provides full details of our future plans that have been highlighted at the end of each section in this report. These plans will ensure adults with care and support needs are safeguarded from abuse and neglect as effectively as possible.

Appendix 1 – SAB Budget 2017 – 18

Income		Expenditure (excluding VAT)	
East Sussex County Council	£71,000	SAB Development Manager	£61,750
Sussex Police	£20,000	SAB Administrator	£14,232
East Sussex Healthcare NHS Trust (ESHT)	£10,000	Quality Assurance & Learning Development Officer	£16,708
NHS Hastings and Rother Clinical Commissioning Group (CCG)	£5,000	Independent Chair	£8,999
NHS Eastbourne, Hailsham and Seaford CCG	£5,000	Multi-agency Training programme (inc. admin. and safeguarding promotional materials)	£3,171
NHS High Weald Lewes Havens CCG	£5,000	Policy and procedures	£667
East Sussex Fire and Rescue Service (ESFRS)	£5,000	SAB Website	£935
Sussex Community NHS Foundation Trust	£4,250	SARs / Multi-Agency Reviews (facilitator and venue costs)	£4,919
National Probation Service	£2,500		
Carry forward from 2016-17	£8,768		
Totals	**£136,518**		**£111,381**

Appendix 2 – Additional updates from SAB partners

Clinical Commissioning Groups (CCGs)

Progress on 2017 – 18 priorities

- **Awareness of Mental Capacity Act (MCA) / DoLS and application to practice**

  Workshops with a specialist MCA component have been held.

  Safeguarding adults review learning briefings have been disseminated.

  CCG work with provider organisations regarding MCA continues, and includes analysis of audit and assurance regarding actions to identify weakness in practice.

- **Continue to work with primary care colleagues to promote understanding of safeguarding issues including MCA, domestic violence and abuse, modern slavery, PREVENT and self-neglect**

  The Named GP for Adult Safeguarding has had an increased profile within the CCGs. This has helped to increase awareness of safeguarding issues in day-to-day practice.

  An MCA policy that can be adopted by primary care colleagues has been written and approved. It includes a flowchart and guide regarding mental capacity and best interest decision making.

  Domestic abuse awareness continues, and continuation and expansion of the domestic violence and abuse pilot to Eastbourne, Hailsham and Seaford and Hastings and Rother CCGs has been agreed.

- **Continue partnership working to improve the health and wellbeing of adults who may be at risk across East Sussex**

  The Designated Nurse has continued to work with ASC colleagues, and has an expanded role within the Training Sub-group to jointly develop and deliver training across East Sussex health and social care providers regarding modern slavery.

  The Designated Nurse has worked closely with ASC colleagues to provide an independent health opinion and overview of safeguarding concerns, and has participated in complex multi-agency self-neglect meetings regarding substance misusers.

  Information sharing meetings regarding care home quality concerns continue to act as a vehicle to intervene at an early stage to address issues that may have a negative impact on health and wellbeing.

- **Continue with the Transforming Care Programme**

  The CCGs continue to engage with health and social care colleagues to build upon the progress made to date and ensure that improvements in service provision for adults with a learning disability continue. Additionally, the CCGs continue to engage with the LeDeR programme, and ensure that any emerging themes are addressed and any lessons embedded into practice.

- **Ensure learning from safeguarding adult reviews and domestic homicide reviews is disseminated across health and social care**

  Briefings have been developed jointly with the SAB and disseminated across health and social care providers.

  Learning from both local and national reviews will continue to be incorporated into training and supervision sessions.

  Joint work will continue to ensure that lessons are embedded into, and have a positive impact upon, practice.

Throughout 2017 – 18, the CCGs have worked collaboratively and effectively with the SAB and partner agencies to ensure that there are effective safeguarding arrangements in place across health and social care.

The CCGs have continued to hold their provider organisations to account to ensure robust safeguarding arrangements are in place, providing both challenge and leadership as required.

With the progress towards Sustainability and Transformation Plans (STP) there will be significant challenges due to the complexity of commissioning arrangements and the changing landscape of health and social care. Designated professionals and safeguarding teams will need to be proactive and at the forefront of decision making to ensure the health and wellbeing of the populations they serve.

Adult safeguarding activity / initiatives

- The pilot promoting domestic violence awareness and referral routes has been extended to include Eastbourne, Hailsham and Seaford, and Hastings and Rother primary care practices.

- The Health Independent Domestic Violence Advisor (HIDVA) post at the Conquest Hospital has been re-commissioned for another year, funded via Healthy Hastings and Rother and the Office of the Police Crime Commissioner.

- The CCGs have continued to promote and raise the profile of adult safeguarding within primary care practices, with links being forged with

Safeguarding Leads, the Named GP for Adult Safeguarding and Designated Nurse.

- Face-to-face safeguarding training for primary care staff is now delivered either in-house at surgeries or when places are available at CCG monthly training sessions.

Priorities for 2018 – 19

- To continue to improve awareness of domestic abuse, and appropriate responses by health professionals.

- To continue to improve application of the MCA, and promote awareness of the Court of Protection and Office of the Public Guardian.

- To improve understanding of, and the response to, self-neglect.

- To increase awareness of modern slavery and human trafficking, and appropriate responses.

- To develop an STP safeguarding profile, including safeguarding awareness and accountability within commissioned services.

- To continue partnership prevention work.

Care for the Carers (CFTC)

Progress on 2017 – 18 priorities

- **Ongoing training and reflective practice with staff**
  Safeguarding has been a regular topic of reflective discussion, safeguarding training has been delivered, and staff have continued to recognise indicators of abuse and raise safeguarding concerns appropriately.

Adult safeguarding activity / initiatives

- Joint working protocols have been developed between CFTC and various agencies, including Age UK, Friends, Families and Travellers, British Red Cross, Homeworks, STEPS and Amaze. The protocols seek to ensure that carers get the support they need when they need it, thereby achieving positive impacts for people with care and support needs.

- CFTC has worked in partnership with ESHT to develop guidelines to involve carers in relation to carers' admission. This includes guidance for ESHT

staff to follow in relation to implementing emergency plans for adults with care and support needs when a carer is admitted to hospital.

- Twenty seven staff (100% of workforce) have completed safeguarding adults training, through either e-learning or more in-depth face-to-face training, in the last three years. Several staff have also attended other safeguarding related training, including Mental Capacity Act and Deprivation of Liberty Safeguards.

- In 2017 – 18, feedback from carers has been overwhelmingly positive about the impact of Care for the Carers' services on their lives. There has been a demonstrable improvement in carers' wellbeing, achieved by support and advice and counselling services.

Priorities for 2018 – 19

- Ongoing training and reflective practice with frontline staff.

Change, Grow, Live (CGL)

Adult safeguarding activity / initiatives

- CGL@thePortal holds a weekly Peer Support Group where information and identified needs and concerns are fed back to the Service Manager and Team Leaders. Our 'You said, we did' approach of responding to service user requests has resulted in the introduction of step-down services for our client group.

- East Sussex drug and alcohol recovery service (STAR) continues to contribute to Coroner's inquests, and to embed a process of learning across the service from investigations into deaths. This has led to a significant increase in our offer of naloxone pens resulting in 91.7% of eligible service users being offered a naloxone pen. In addition, more staff have completed suicide prevention training, and we have joined the East Sussex Suicide Prevention Group.

- In 2017 – 2018, CGL STAR established a 'dual diagnosis working together agreement' with SPFT mental health services in Hastings, and we are working to replicate this agreement in Eastbourne in 2018 – 2019. This aims to improve the experience of people who need to access both mental health services and substance misuse services by enabling them to get their needs met through a combined approach which is informed by the expertise of both services.

- 78% of STAR staff have completed safeguarding adults classroom training and 89% completed our e-learning package. All CGL@thePortal staff have completed safeguarding adults classroom and online training.

- Both CGL and STAR services have progressed recommendations from the domestic abuse audit undertaken by the SAB in 2016 – 17, including improving the quality of information shared at MARAC, by staff bringing all relevant information on research forms to these meetings (the audit had shown only the updated information had been brought for a multiple repeat victim).

Priorities for 2018 – 19

- To train staff within CGL STAR on newly implemented modules on our case records database for managing safeguarding concerns.

- To produce a 'Positions of Trust' policy.

- To produce and implement improved safeguarding governance guides for services.

- To review our safeguarding adults policy.

East Sussex Fire and Rescue Service (ESFRS)

Progress on 2017 – 18 priorities

- **Develop our safeguarding audit process to provide improved internal reporting**

  The Safeguarding Panel oversees the audit process which is undertaken on a quarterly basis with random selection from a number of safeguarding areas including adults, children and Firewise.

- **Embed modern slavery training**

  This is incorporated within the new Cylix on-line training course as well as a one-day advanced training course.

- **Embed training on the identification and classification of hoarding, and implement a multi-agency hoarding framework**

  The multi-agency hoarding framework has now been adopted by the East Sussex SAB and is available to all agencies.

Adult safeguarding activity / initiatives

- ESFRS has adopted a new safeguarding e-learning course, written specifically for Fire & Rescue Services. The training course is mandatory for all staff and community volunteers and is to be undertaken in April / May annually. The course includes child and vulnerable adult safeguarding, domestic abuse, modern slavery, PREVENT and female genital mutilation.

- All senior managers, staff and volunteers who are engaged in work or activities that bring them into direct contact with vulnerable people, such as the Education Team, will undertake a one-day safeguarding course on a bi-annual basis.

Priorities for 2018 – 19

- To ensure that our new on-line training course is undertaken by all staff and volunteers.

- To encourage greater uptake of reporting concerns through the 'coming to notice' reporting mechanism once safeguarding training has been widely rolled-out.

East Sussex Healthcare NHS Trust (ESHT)

Progress on 2017 – 18 priorities

- **Improve consistency in recording mental capacity by reviewing documentation, training and encouraging staff to access advocacy where appropriate**

  Last year's audit on mental capacity indicated that there were inconsistencies in the recording of mental capacity. A further audit has been undertaken and is due to be published in the summer.

  Mental Capacity Act (MCA) training has been reviewed and increased from a one-off training session to three yearly. The audit indicated that staff knowledge of the MCA was varied depending on their frequency of application. We have introduced on-line MCA and DoLS training so that it is more accessible to staff groups.

  The training review has enabled our Safeguarding Specialists to spend more time in clinical areas, supporting staff in the application of the MCA and undertaking DoLS assessments when required.

  More information regarding advocacy is available to staff and members of the public, and safeguarding training does now refer to the use of an advocate.

- **Take steps to ensure that information is available to adults and their families about safeguarding adults and who to contact if they have a concern, including access to the SAB website**

  Information about safeguarding, and who to contact where there is a concern, is now available to adults and their families on the ESHT website.

  The level 1 safeguarding leaflet and training materials are being updated, and the ESHT safeguarding intranet site is currently under review.

- **A review of the information available to ensure it is in a variety of formats for those with specific communication needs**

  ESHT will continue to review the information formats available, as well as promoting the use of the interpreter service.

Adult safeguarding activity / initiatives

- This year has seen an increase in the visibility of the Safeguarding Specialist Nurses both in the acute and community clinical areas in order to address some of the concerns raised, to provide greater safeguarding support, and for the learning from safeguarding enquiries to be shared with healthcare professionals.

- ESHT has reviewed its policy and procedures regarding allegations of abuse by staff. The management of allegations against ESHT staff for both adult and child safeguarding has been aligned into a single policy. This has enabled the Local Authority Designated Officer (LADO) to be included as well as ESHT Human Resources and the Safeguarding Specialists' role and responsibilities in regards to allegations to be more clearly defined.

- Feedback from training delivered by ESHT Safeguarding Specialists has been mainly good to excellent. Training is under review to ensure that it is current and fit for purpose.

Priorities for 2018 – 19

- To embed the revised governance arrangements for the operational and strategic safeguarding groups and safeguarding adults team.

- To continue to progress the work within the ESHT safeguarding annual work plans including highlighting any amber and red actions where more evidence of implementation is required for positive assurance.

- To continue to work towards the recommendations outlined in the Adult A Action Plan, specifically Recommendation 8.

- To continue to review safeguarding training, introduce level 3 safeguarding adults training, to include Self-neglect and Modern Slavery.

- Deliver PREVENT awareness training throughout the Trust, and address areas of low training compliance.

- To introduce structured safeguarding adults supervision for ESHT professionals working in areas where there is increased patient vulnerability.

- To maintain our engagement with the LeDeR programme for investigating and learning from deaths where the person had a learning disability.

Kent, Surrey, Sussex Community Rehabilitation Company (KSS CRC)

KSS CRC staff are responsible for identifying vulnerable adults with whom they work directly or indirectly. This may be adults supervised under statute or other adults in any service user's circle, including family and potential victims. At the start and throughout the service user's sentence, the Responsible Officer is required to identify key issues of vulnerability that relate to the service user's life, not only from a service user perspective, but in partnership with other key agencies including statutory, non-statutory and third sector. Identified risks are then managed with the service user and relevant agencies to reduce any identified concerns.

Progress on 2017 – 18 priorities

- **Ensure frontline staff have access to SAB training to consolidate prior learning and experience**

  Online safeguarding adults training and mental health training is mandatory for all staff.

- **Embed the updated Sussex safeguarding adults policy and procedures to ensure staff feel confident in managing safeguarding concerns**

  The policy has been revised to include assessing mental capacity, and re-launched across the organisation. There is a mandatory requirement for all policies to be discussed in supervision and team meetings.

- **Our Strategic Lead to review how serious case review, safeguarding adult review and serious further offence learning is shared across the organisation and incorporated at local team level**

  Specific actions are identified and allocated appropriately to individuals or included in a strategic implementation plan. Organisational learning will be pulled together by the Excellence and Effectiveness Manager and shared across operational teams.

Adult safeguarding activity / initiatives

- Articles on neglect, 'Making Safeguarding Personal' and stalking were placed within the KSS CRC staff magazine to raise awareness, aid identification and promote swift responses to concerns.

- Staff have been actively encouraged to attend specialist safeguarding training, and team discussions have been held on policies and procedures, which are fundamental in supporting early detection and intervention to prevent escalation of safeguarding concerns.

Priorities for 2018 – 19

- The Strategic Safeguarding Lead will be attending team meetings across the three counties to ascertain frontline practitioners' safeguarding needs i.e. are policies accessible and understandable, do they feel they are missing any type of training, is there any other way the Lead can support staff in fulfilling their statutory safeguarding duties?

- Review of safeguarding policies (including staff safeguarding policy) to include stalking behaviours.

- To continue to publish articles that raise staff awareness of a variety of safeguarding issues.

National Probation Service (NPS)

The NPS responsibilities include sentence planning, assessment, supervision, risk management, monitoring and enforcement of multi-agency public protection arrangements (MAPPA), and preparation of Crown and Magistrates Court assessments of convicted offenders.

The NPS provides a public protection service to children and adults, working in partnership with other agencies.

Adult safeguarding activity / initiatives

- Significant improvements in our risk assessments and subsequent risk management plans.

- Continued positive developments in our MAPPA practice and management of some of the most dangerous offenders in Sussex.

- Increased awareness of our staff of the NPS role in adult safeguarding, not only in terms of public protection but also in relation to the vulnerability of our service users.

- Our adult safeguarding policy has been updated and circulated to managers and staff.

- Learning from safeguarding adults reviews.

- Promotion of safeguarding awareness week.

- Adult safeguarding e-learning and class-based training has been provided for staff.

Priorities for 2018 – 19

- To fully implement our Safeguarding Practice Improvement Tool in all our risk management plans.

- To increase our partnership working and community presence, especially in relation to work with rough sleepers and the homeless.

- To promote reflective practice and peer learning in relation to safeguarding.

- To ensure that our Safeguarding Practice Improvement Tool drives up the quality of our risk management plans in direct relation to safeguarding actions as well as safeguarding objectives in sentence plans.

Sussex Community Foundation Trust (SCFT)

Progress on 2017 – 18 priorities

- **Ongoing audit of Making Safeguarding Personal**

  This is detailed on page 41 of this report.

- **Continue to monitor and develop advice line processes**

  445 staff contacts were made to the Adult Safeguarding Advice Line, which included detailed mental capacity and DoLS advice and support. 89% of contacts where advice was provided led to a safeguarding concern being raised.

- **Develop further assurance and governance processes for Section 42 safeguarding enquiries and individual management reviews**

  In order to provide assurance that health-related S42 enquiry findings and actions have been taken forward internally to support trust-wide learning, the Adult Safeguarding Team has worked in partnership with the Heads of Nursing and Governance to provide a process for taking actions forward. A monthly narrative of all current safeguarding enquiry / summary of involvement / individual management review / SAR work is shared with Area Directors and the Heads of Nursing and Governance, and there is now core attendance by Adult Safeguarding at locality Harm Free Care Meetings to share and learn from findings and actions.

Adult safeguarding activity / initiatives

- The updated 'Safeguarding adults: Roles and competencies for health care staff – Intercollegiate Document' is expected to require enhanced knowledge. Accordingly, in 2017 – 2018, our current level 3 adult safeguarding training cohort was extended to Band 6 and above Nursing and Allied Health Professionals (AHP) frontline staff who support adult care delivery. This staff group was chosen because they line manage and support all clinical care delivery by frontline staff.

Priorities for 2018 – 19

- Rolling internal audit of Making Safeguarding Personal.

- To continue to capture data via advice line contacts that evidences the care and support that SCFT delivers to patients to protect them from harm or abuse.

- Following the provision of level 3 adult safeguarding training to Band 6 and above Nursing and AHP adult services frontline staff, we propose to open up level 3 training to all bands of Nursing and AHP staff (Bands 3 – 7) working in frontline clinical care so that level 3 training becomes 'business as usual' within adult services.

  To support staff to achieve level 3 adult safeguarding training, the Adult Safeguarding Team will provide training across the Trust on a bi-monthly basis. In addition to this, there are alternative methods of training: e-learning, workbook completion, and attending external events such as pan-Sussex Safeguarding Adults Board conferences. The aim of alternative methods of accessing level 3 training is to reduce the need for staff to travel to venues which may increase time spent away from frontline care delivery.

South East Coast Ambulance Service NHS Foundation Trust (SECAmb)

Adult safeguarding activity / initiatives

- Level 3 safeguarding adults face-to-face training was delivered to 100% of operational managers, 999 and 111 call centre clinical staff.

- PREVENT training was delivered to 85% of staff across the Trust.

- Mental Capacity Act e-learning training was delivered to 94% of staff across the Trust.

- There was an 8% increase in referral activity across the whole Trust.

- A comprehensive review of how allegations are managed across the whole Trust was undertaken. This looked back at all disciplinary cases over the preceding two years to identify gaps. Improved links between HR and safeguarding have now been established to ensure there is safeguarding oversight in all cases which might have a potential safeguarding element.

- Quality Assurance Visits undertaken across the whole Trust have included safeguarding, asking staff to share their experiences both around keeping patients safe, and how supported and safe they feel within the organisation.

- Infographic posters have been developed. Each month a poster detailing referral activity, reporting themes and a case study focussing on lessons learnt is produced and distributed to all Trust locations. Case studies may be based on a complaint, safeguarding enquiry, published serious case review / safeguarding adults review etc.

Priorities for 2018 – 19

- Continue to embed the links between HR and safeguarding.

- Continue to engage with the culture change work being undertaken within the Trust to ensure that the vulnerabilities of both staff and patients are considered and appropriate support is offered.

- To deliver training to all patient-facing staff regarding harmful behaviours with a focus on coercive and controlling behaviours and staff groups who may be at increased risk.

- Develop bespoke training for HR and staff support (i.e. Wellbeing Hub and union representatives).

- Increase capacity within the safeguarding department to improve staff support within the Trust. This includes a plan to have a named safeguarding link in each operational unit and the recruitment of a dedicated Freedom to Speak-up Guardian with a supporting locality network.

Sussex Partnership NHS Foundation Trust (SPFT)

Progress on 2017 – 18 priorities

- **Planned improvements to the clinical record system with regard to the recording of safeguarding activity including the development of a specific safeguarding flag**

  A safeguarding flag has been developed and implemented.

- **Improvements to data collection and reporting to ensure data is both more accessible and more accurate**

  Data collection has improved and we are now reporting on a wider data set.

- **Development of new safeguarding team enabling greater emphasis on advice, scrutiny and training for staff**

  The new team is in place.

- **Ensuring learning from safeguarding adults reviews (SARs) and other reviews is prioritised and undertaken**

  Learning from SARs has been prioritised with a trust-wide focus on all relevant SARs.

- **Review of safeguarding adults policy and development of specific PREVENT strategy**

  Our safeguarding adults policy has been revised and is currently awaiting ratification. A PREVENT policy has been developed and published.

- **Development of identified safeguarding leads in all care groups and areas**

  Strategic safeguarding leads for each local authority area have been identified. With the introduction of the safeguarding liaison practitioner role, we are working with all adult teams and placing leadership responsibility for safeguarding with team leaders and managers.

Adult safeguarding activities / initiatives

- SPFT seeks patient and carer feedback through the Sussex Experience Survey. In 2018 – 19, we are planning to undertake safeguarding

awareness sessions with patients in our inpatient units and this will open opportunities for feedback.

- The new post ‘safeguarding adults liaison practitioner' has responsibility for supporting and advising staff members and teams, raising awareness of safeguarding in the organisation, and providing training.

Priorities for 2018 – 19

- Improved and timely data reporting.
- Development of level 3 safeguarding adults face-to-face training.
- Compliance with NHS England requirements regarding PREVENT training.
- Raised awareness and improvements in practice – embedding safeguarding culture in everyday practice.
- To continue to provide governance and assurance through the local safeguarding management groups.
- To continue to play an active role as a member of Safeguarding Adults Boards in the promotion of safeguarding across Sussex.
- Improved learning and governance with regard to safeguarding adults reviews and domestic homicide reviews.

Sussex Police

Progress on 2017 – 18 priorities

- For the last year, Sussex Police has had a dedicated senior officer leading and developing the force’s approach to vulnerability, including stalking. Officers have received training to improve the identification of stalking, (which can often be reported as crimes such as harassment, criminal damage, or malicious communications). The force is also working with Veritas Justice to establish a specialist support service for people who are affected by stalking.
- Operation Signature has continued to develop as the force’s response to frauds perpetrated against vulnerable, often elderly, people. Our local Prevention Teams work with victims to implement safety plans to prevent further victimisation, whilst specialist officers in each Safeguarding Investigation Unit are available to assist in safeguarding those victims who are most vulnerable.

- Sussex Police has worked extensively with partners to tackle organised criminal networks, often known as County Lines. County Lines refers to cases where drug dealers, often from London, travel to towns outside of London. Characterised by violence, vulnerability and exploitation, they are known to exploit children by drawing them into drug dealing and other criminal activity, but they will also target vulnerable adults to take control of houses and flats from which to deal their drugs. This is known as Cuckooing. Operation Cuckoo has been developed in response to this kind of exploitation and now forms part of our established multi-agency response to County Lines drug dealing.

- Domestic Abuse Matters training has been delivered force-wide to all practitioners and supervisors, with approx. 2,500 staff receiving training. Domestic Abuse Matters highlights the vulnerabilities of adults and children who are exposed to domestic abuse.

  Sussex Police has over 200 domestic abuse mentors who act as champions on their teams to ensure the best service is given. The force has also pushed the use of Domestic Violence Protection Orders and the Domestic Violence Disclosure Scheme to help protect people

Adult safeguarding activity / initiatives

- Missing persons – initiatives to try to reduce repeat occurrences, in particular prevention interviews. Enabled by Police Transformation Project Funding, we will undertake prevention interviews during 2018 and report on the pilot by March 2019. This pilot applies to selected child and adult cases. If successful, consideration will be given to introducing this permanently.

- Our adult safeguarding policy has been reviewed, updated, and circulated across the organisation.

- We have continued to support the multi-agency work undertaken by the Safeguarding Adults Board, including chairing the Performance, Quality & Audit sub-group.

- Operational officers have received training from the force lead for vulnerability and stalking. This has been complemented by a comprehensive communications strategy, both internally and externally under the #ThisIsVulnerability work. Specialist domestic abuse training has been delivered to all operational staff in partnership with the domestic abuse charity, Safe Lives.

Priorities for 2018 – 19

- Sussex Police adult safeguarding improvement plan. This is an aspirational working plan and subject to change and revision.

- Development of Force Management Statements required by Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services, over four years. We are developing a consistent return regime that incorporates organisational governance, operational standards and performance. This information will be the benchmark for sharing with partners.

- Improving knowledge and awareness amongst officers and staff, specifically around adult safeguarding (under the Care Act and in accordance with the pan-Sussex procedures).

- Improving performance in relation to the completion of the Vulnerable Adult at Risk (VAAR) form. This will be done through the Combined Assessment of Risk Form (SCARF) review process which includes a review of the VAAR to ensure it remains fit for purpose. A workshop has taken place with further development around IT and communications. This will be formulated into a formal strategy this year.

- Improving knowledge and awareness of mental capacity. This will be achieved by teams completing online training.

Appendix 3 – Partners of the East Sussex SAB

Partners of the East Sussex Safeguarding Adults Board are:

- East Sussex Adult Social Care
- Hastings & Rother Clinical Commissioning Group, Eastbourne, Hailsham & Seaford Clinical Commissioning Group, High Weald Lewes Havens Clinical Commissioning Group
- Sussex Police
- Care For The Carers
- Change, Grow, Live (CGL)
- District and borough council representation
- East Sussex Fire and Rescue Service
- East Sussex Healthcare NHS Trust
- Healthwatch
- HMP Lewes
- Homecare representatives
- Kent, Surrey, Sussex Community Rehabilitation Company
- Lay members
- Local Safeguarding Children's Board
- National Probation Service
- NHS England
- Registered Care Association
- South East Coast Ambulance Service NHS Foundation Trust
- Sussex Community Foundation Trust
- Sussex Partnership NHS Foundation Trust
- Trading Standards
- Voluntary and Community Sector representation