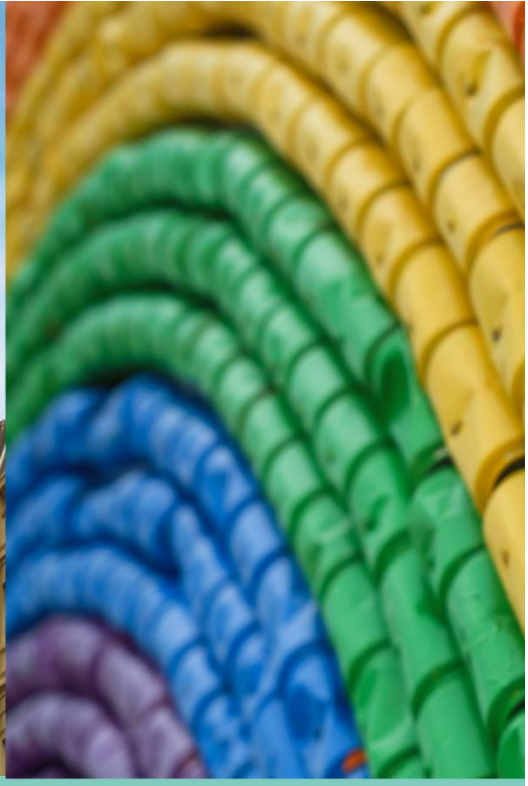




Brighton & Hove
SAB
Safeguarding
Adults Board

Brighton & Hove Safeguarding Adults Board Annual Report 2020-21



1. Contents

2. Foreword from our Independent Chair

I have great pleasure in presenting this, my last Annual Report for the Brighton and Hove Safeguarding Adults Board. I am standing down to pursue other challenges but am delighted to hand the reins over to a hugely experienced chair, who I know will take the SAB from strength to strength.

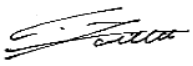
To say this has been a challenging year would be a huge understatement. All of us have been affected by the Covid 19 pandemic and many people reading this will have contracted the virus, may have lost loved ones or had their lives changed forever. To those I extend my heartfelt sympathies and hope you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

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

The Safeguarding Adults Review we published this year, 'Christopher', cut across many safeguarding themes including multi-agency communication and collaboration, whether the policies and procedures in place were sufficient and appropriately followed as well as consideration of the challenges around supporting people with multiple complex needs. Whilst this review was referred late, some of the issues remain and it's the Board's responsibility to ensure the lessons are learned.

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

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



Graham Bartlett

Independent Chair, Brighton and Hove Safeguarding Adults Board

3. Foreword from Healthwatch

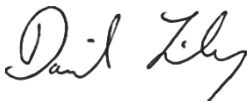
Healthwatch Brighton and Hove have worked closely with the B&H SAB over the last year. Dr Lester Coleman, our Evidence and Insight Manager is the Chair for the Safeguarding Adults Review (SAR) monthly meetings.

The core role of Healthwatch is to improve health and care services across our City. We have a particular focus on reaching out to vulnerable people and communities who do not have a strong voice. Last year we engaged with 1700 people with disabilities; 400 LGBTQ; and nearly 500 people from ethnic minority groups.

Hearing from vulnerable groups is also evident from a new service we have delivered since the Covid-19 pandemic – providing wellbeing checks for those people recently discharged from hospital. Our dedicated team of volunteers phone people usually within their first two weeks of discharge to offer support including signposting to other services. Having contacted 1700 people (up until March 31st, 2021), we do encounter people where a safeguarding concern is escalated to Adult Social Care. Safeguarding concerns may also be raised in our email information and signposting service (info@). Together with the Hospital Discharge project, we escalated 54 safeguarding concerns over the last year.

In Chairing the Safeguarding Adults Review, Healthwatch has witnessed several developments in the way reviews are assessed and undertaken. There is transparent guidance around whether a new case warrants a review; how learning can be shared from similar cases; useful summaries produced from the learning and recommendations from reviews; insights from across the region (primarily East Sussex, Kent and Surrey); and specific guidance provided to the independent reviewers. More recently, the SAR meetings have welcomed additional contributors to the meetings to discuss cases directly with the members of the Board.

The Brighton and Hove Safeguarding Adults Board continues to provide excellent leadership, coordination, and a focus for partnership to promote high standards of safety and quality in health and social care in our City



David Liley

CEO, Healthwatch Brighton & Hove

4. Our Purpose

The Brighton and Hove Safeguarding Adults Board (BHSAB) is a multi-agency statutory partnership which provides leadership and strategic oversight of adult safeguarding work across Brighton and Hove. The Board comprises organisations that have a role in adult safeguarding and the prevention of abuse and neglect within Brighton and Hove. This includes the three statutory partners: Brighton and Hove City Council, Sussex Police and the Sussex Clinical Commissioning Group, as well as a range of other community and voluntary agencies. The work of the BHSAB is underpinned by the Care Act 2014, which sets out that we are required to:

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

The Board's vision is that we will all work together to enable people in Brighton & Hove to live a life free from fear, harm and abuse and our three year strategic plan that was published in 2019, and updated annually since then, identified six priorities to support this vision becoming a reality.
The Board meets four times a year and is supported by four subgroups that take forward these six priorities through individual work plans that are regularly updated.

5. Our Strategic Priorities

Priority Area 1: Accountability, Assurance & Leadership

Ensure the SAB provides strategic leadership to embed the principles of safeguarding across agencies and contribute to the prevention of abuse and neglect.

Desired outcome: Confidence in Multi-agency safeguarding responses, people are safeguarded from abuse and neglect.

Priority Area 2: Policies, Strategies & Procedures

To be assured that multi-agency safeguarding strategies, policies and procedures are regularly reviewed to ensure currency, reflecting emerging legislation, policy and/or learning, and that these are easily accessible to frontline staff and used effectively

Desired outcome: Our partners work within a framework of policies and procedures that keep people safe.

Priority Area 3: Performance, Quality and Audit / Organisational Learning

Assure learning from SAB activity is effectively embedded into practice to facilitate organisation change across agencies, refocus quality assurance mechanisms, and better use safeguarding data to define SAB priority areas of business.

Desired outcome: Confidence that services are learning and improving in their safeguarding practice and adult safeguarding risk is better understood by the SAB and appropriately assessed by partners.

Priority Area 4: Prevention & Early Intervention

Ensure the SAB has a focus on prevention that clearly identifies how it will aim to reduce incidence of abuse and neglect (including self-neglect) in Brighton & Hove.

Desired outcome: Adults at risk are identified early and have their needs met promptly and effectively.

Priority Area 5: Engagement & Making Safeguarding Personal

Adults, carers, the local community and professionals assisting to shape the work of the SAB and safeguarding responses and safeguarding practice is client centred.

Desired outcome: Public safeguarding awareness is improved. Clients and professionals feel empowered for their voices to be heard in safeguarding practice and policy development.

Priority Area 6: Integration / Training and Workforce Development

Assure the workforce is equipped to support adults appropriately where abuse and neglect are suspected. This to include emerging local safeguarding challenges.

Desired outcome: Clients are supported by a skilled and competent workforce.

6. Board Membership and Structure

Partnership working is at the heart of adult safeguarding and alongside our three statutory partners and the community and voluntary sector organisations the BHSAB has links with a number of other strategic partnerships; these include the Brighton and Hove Safeguarding Children Partnership, the Safer Communities Partnership and the Health and Wellbeing Board.

Our Statutory Partners

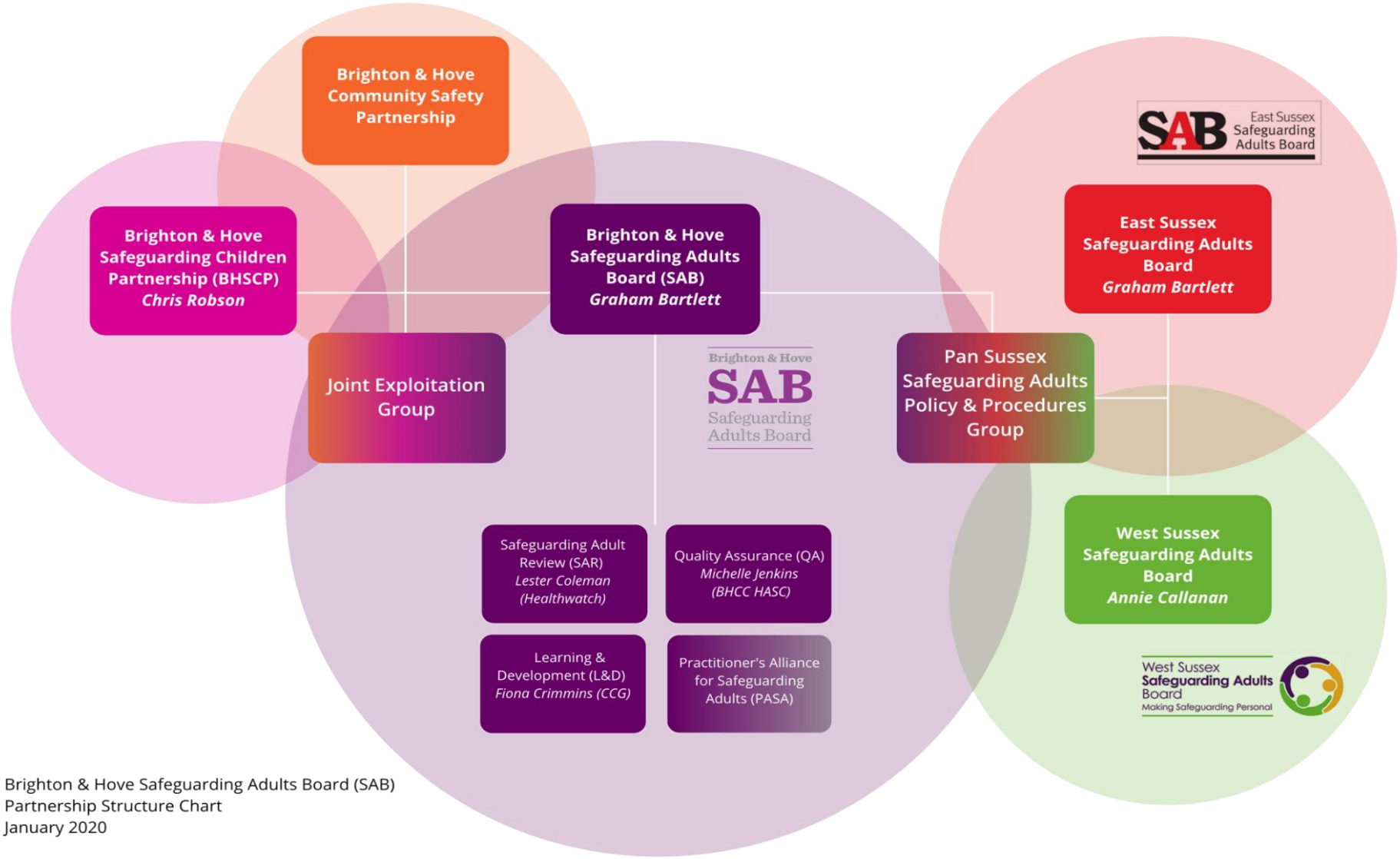
- **Brighton and Hove City Council**
- **Sussex Police**
- **Sussex Clinical Commissioning Group (CCG)**

The further partners of the Board are.

- **Brighton and Hove Safeguarding Children Partnership**
- **Brighton and Sussex University Hospitals (BSUH) Trust**
- **East Sussex Fire and Rescue Service (ESFRS)**
- **Brighton and Hove Healthwatch**
- **Kent, Surrey, Sussex Community Rehabilitation Company (KSS CRC)**
- **National Probation Service (NPS)**
  (from June 2021 the KSS CRC and NPS will become one service known as The Probation Service: Kent, Surrey and Sussex Region)
- **South East Coast Ambulance Service NHS Foundation Trust (SECAmb)**
- **Sussex Community NHS Foundation Trust (SCFT)**
- **Sussex Partnership NHS Foundation Trust (SPFT)**
- **Voluntary and Community Sector representation (represented by PASA)**

In addition, the Board maintains links with the following:

- **East Sussex Safeguarding Adults Board**
- **West Sussex Safeguarding Adults Board**
- **The National Network of Chairs of Safeguarding Adult Boards**
- **The Safeguarding Adults Board Manager Network**
- **Safeguarding Adults National Network**
- **Brighton and Hove Community Safety Partnership**
- **South East Regional Safeguarding Adult Board Network**



Brighton & Hove Safeguarding Adults Board (SAB)
Partnership Structure Chart
January 2020

7. Our Budget

The SAB budget is pooled, and our partner agencies contribute to the running of the board, not only financially, but by chairing or vice-chairing meetings, providing use of their buildings and facilities, or hosting learning events.

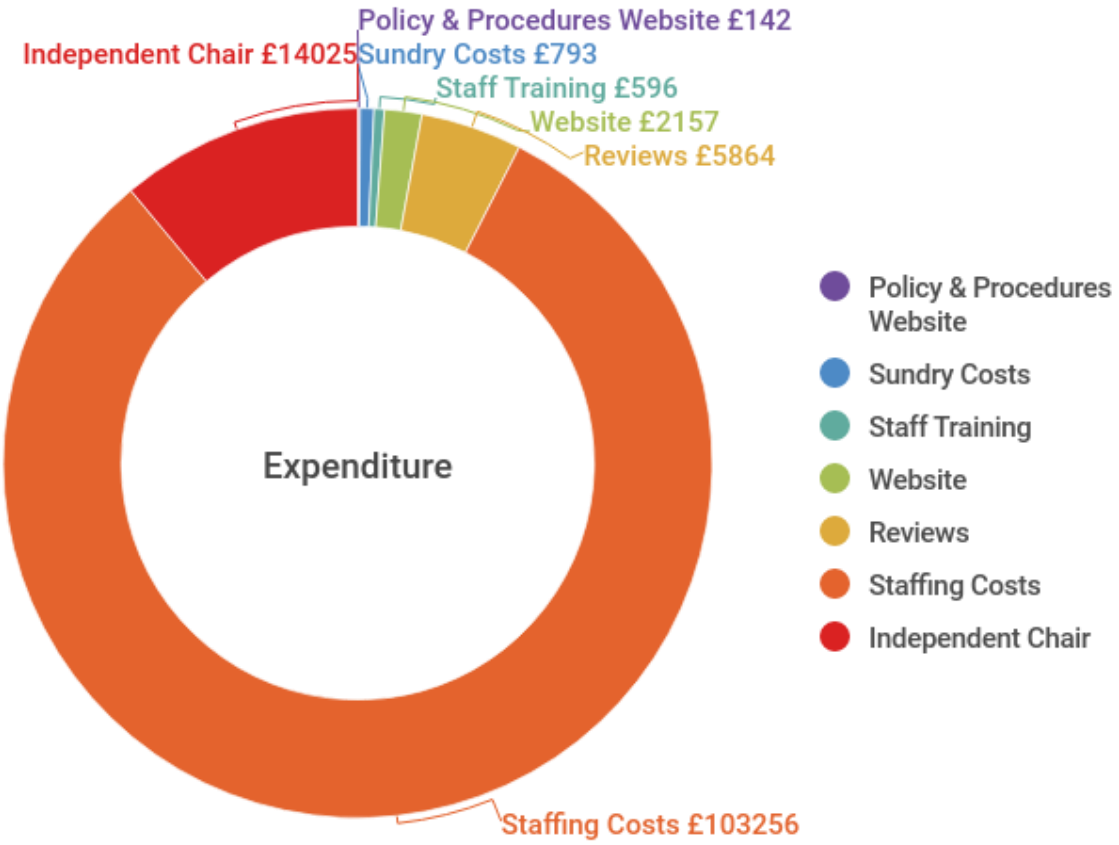
Income for 2020/21

Brighton & Hove City Council	£83,829
Sussex Police	£22,610
Brighton & Hove Clinical Commissioning Group	£26,600
Total	£133,030

The board carried forward some of the Brighton & Hove City Council and third-party income from the 2019/2020 budget into 2020/21, and some has again been carried forward into 2021/22. Contributions from the statutory partners increased from previous years, in line with the agreement to fund a full-time Business Manager position for the SAB.

Expenditure

Independent Chair	£14,025
Safeguarding Adult Reviews	£5,864
Staffing Total:	£103,256
Business Manager	*£60,355*
Administrator	*£22,590*
Quality Assurance	*£19,916*
Other	*£395*
B&H SAB Website	£2,157
Staff Training	£596
SAB Conference	£0
Sundry costs	£793
Sussex Safeguarding Adults Policy & Procedures Website, Annual Licence	£142
Recruitment Costs	£0
Total	£126,833



8. Coronavirus Response

The Coronavirus pandemic has led to unprecedented challenges for partner agencies and over the past year the SAB has regularly sought assurance in relation to the impact this has been having locally and to ensure services are supported to respond to emerging safeguarding themes.

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

- The challenges in carrying out safeguarding enquiries remotely.
- The implementation of DNARs (Do Not Attempt Resuscitation) without following the Mental Capacity Act process in full and ensuring appropriate consultation with the individuals and their families.

- A significant increase in calls to domestic abuse helplines including an increase in people experiencing suicidal ideation and mental health concerns.

- The ongoing impact of social isolation upon people's mental health and additionally the impact of the pandemic upon the wellbeing of the health and social care workforce.

- New and emerging risks for people with care and support needs, such as in relation to scams about Covid-19 testing and vaccines and Coronavirus fraud.

The Board took the decision to suspend the majority of SAB and subgroup meetings during the pandemic to enable frontline services to prioritise operational demands. The focus of Board work during these times was on meeting our statutory duties in relation to SAR activity, and our SAR subgroup continued to meet virtually on a monthly basis during which we saw a significant rise in the number of referrals received.

The pandemic has also brought opportunities for new ways of working. The first wave of the pandemic saw successful interventions and innovations, including the housing of those sleeping on the streets in Brighton and Hove and the development of an adult safeguarding hub by the local authority. Over the past year meetings and multi-agency training have been held remotely and we have seen an increase in engagement given the efficiencies that virtual meetings create. The SAB supported frontline operational services as well as contributing to the work of the Sussex Resilience Forum – a multi-agency partnership, which met weekly during the height of the first wave to identify gaps and issues within the support available for vulnerable people, and to coordinate responses locally and across Sussex. Another welcome development caused as a direct result of the pandemic was the increased participation of SAB managers in national networks, such as the National Board Managers Network and the NHS Safeguarding Adults National Network (SANN). These forums have supported more effective sharing of information about emerging safeguarding themes and learning from SARs as well as creating a platform to have a panel of speakers from a range of national leadership positions.

Over the course of the next year the SAB will continue to evaluate the ongoing impact of Covid-19 on safeguarding activity and monitor recovery measures to ensure that the learning is shared both in relation to the challenges and opportunities that this period has created and to consider the longer-term impact of the pandemic.

9. Our Achievements in 2020-21

Accountability, Assurance and Leadership

- This has been an extremely challenging year for everyone and in recognising the impact of this the BHSAB paused non-essential work to enable partners to focus on these challenges. However, throughout this time the BHSAB continued to meet our statutory duties and progress our strategic priorities, holding monthly virtual SAR subgroup meetings and quarterly board meetings. This has enabled local and national safeguarding challenges and emerging themes to be discussed as well as providing a forum for regular updates to be provided by partners.

- During 2020/21 the BHSAB has undertaken a multi-agency audit on non-engagement, which identified some areas of exemplary practice as well as learning in areas such as creative and flexible approaches, the importance of both planning and information sharing around risk management with all those involved in supporting individuals. Assurance work has also been undertaken with partner agencies in relation to the Coronavirus pandemic, seeking to learn lessons from what has occurred so that this can be shared with all partners and utilised in the event of further waves during 2021/22 or in the future.

- In ensuring that robust mechanisms are in place for partners to be held to account for their safeguarding practice the BHSAB has been working closely with our colleagues in East and West Sussex to develop a pan-Sussex Self-Assessment Tool and Peer Challenge Event to be undertaken in 2021/22. In recognising the pressures partners have been under, and continue to experience, the overall length of the tool has been reduced but the scope has been broadened in order to further explore areas such as commissioning, training and emerging themes. It has also been designed to gather much more detailed information from partners to support rigorous peer challenge.

- The request from local organisations identified in the previous Self-Assessment and Peer Challenge Event in 2019 for increased knowledge and awareness around managing safeguarding allegations against staff have been taken forward through an article in the newly launched BHSAB quarterly newsletter as well as PIPOT guidance developed and published on the BHSAB website.

- Whilst there have several Safeguarding Adults Reviews commissioned during 2020/21 budget activity continues to be carefully managed and discussed regularly with partners to ensure this is clear and transparent.

Policies, Strategies and Procedures

- In being assured that multi-agency safeguarding strategies, policies and procedures are regularly reviewed to ensure currency, reflecting emerging legislation, policy and/or learning the BHSAB has worked with partners and colleagues both locally and nationally at different levels. With many partner agencies working across Sussex the BHSAB recognises the need for a pan-Sussex approach wherever possible in order to ensure consistency and we have worked with our SAB colleagues in East and West Sussex, and partners, to develop and publish a joint SAR Protocol, an Information-Sharing Guide and Protocol as well as an Adult Death Protocol. These respond to issues that have been identified locally, such as the lack of knowledge and understanding around the SAR eligibility criteria and processes, doubt in relation to when information around safeguarding should be shared and co-ordinating multi-agency responses.

- Through the pan-Sussex Policy and Procedure subgroup, and in addition to the protocols mentioned above, several priority updates for the Sussex Adult Safeguarding Procedures have been agreed across the three local authority areas and are being worked on. These include Domestic Abuse, Causing Others to Enquire, PIPOT and Prevent, as well as protocols on themes that include Hoarding.

- At a national level the BHSAB has engaged with the SAB Manager network, the Independent Chair network and Safeguarding Adults (SANN) network in relation to themes such as the National SAR Analysis, ADASS and NICE safeguarding guidance and updates to ensure we are sighted and able to respond to ongoing developments. On a local level the BHSAB has supported COVID-19 resilience work, developed and strengthened relationships with partners such as the Sussex Resilience Forum, Safeguarding Children Partnership, Community Safety Partnership and the voluntary and community sector. We have developed our own guidance for agencies in relation to areas such as Prevent and PIPOT (People In a Position of Trust) and are also working to share learning from other areas going forward as we seek to continue to strengthen adult safeguarding networks and frameworks.

Performance, Quality and Audit/Organisational Learning

- This has been an extremely busy year for the BHSAB in respect of Safeguarding Adults Reviews (SARs), reflecting both increased pressures on agencies as well as an increased focus on raising knowledge and awareness of the SAR eligibility criteria and processes. There is a detailed section on Safeguarding Adults Reviews further on in this Annual Report but in summary these SARs have identified a number of areas of learning, which include the challenges of working with those who self-neglect, the need for increased knowledge and awareness of trauma-informed practice as well as the need for all services to be able to pro-actively respond to those who are homeless or transient. The BHSAB will be focusing on working with our partner organisations to develop action plans in order to take forward the recommendations made and to effectively disseminate the learning.

- There are three other Safeguarding Adults Reviews currently in progress, one of which was rapidly undertaken in a six-month period and has been signed off by board members and due to be published. A Thematic Learning Review and a desktop review are both also underway and we anticipate these being completed during the course of 2021/22. There has been a significant increase in the number of SAR referrals made to the BHSAB during 2020/21.

- Despite the pressures on agencies during the last twelve months the BHSAB has continued to gather multi-agency data on a quarterly basis to gain assurance around performance and to inform planning for future activities. The development of a HASC safeguarding data dashboard enables the BHSAB to receive up-to-date data supported data to be accessed regularly Learning briefings continue to be developed in response to audits and reviews that have been undertaken and we will also be continuing to do this going forward.

Prevention and Early Intervention

- The raising of public safeguarding awareness, including awareness of local safeguarding challenges, has been another area in which the BHSAB has made progress this year. During the early stages of the pandemic we contributed to awareness campaigns, alongside the Safeguarding Children Partnership, and this year and we have sought to raise our public profile through an increased social media presence on Twitter.

- We have continued to develop the Brighton and Hove Safeguarding Adults Board website, making this easier to navigate and with updates and new pan-Sussex protocols added. A resources section has been created for professionals with guidance on adult safeguarding themes such as Prevent and PIPOT with links to national resources. There are also links to training that practitioners can access to develop their knowledge around Modern Slavery and continuing to develop resources and to link to those from elsewhere through the relationships established with other SABs and other partnerships is an area we will continue to focus on going forward in supporting prevention and early intervention.

- The BHSAB has continued to receive data from our partners in relation to safeguarding activity, as well as data specifically in relation to the impact of Coronavirus. We worked with the local authority to support the development of a data dashboard and have maintained strong relationships with our partners, meeting regularly in a range of settings in order to ensure we remain sited on adult safeguarding developments.

Engagement and Making Safeguarding Personal

- Engagement and raising the profile of the BHSAB has been a key priority over the course of 2020/21 and this has been progressed through a number of means. In the first months of 2020/21 during the Coronavirus pandemic the BHSAB paused non-essential activities and undertook tasks directly to support partners, such as attending the local resilience forum and working with practitioners in health and social care services.

- Following on from this, engagement activities undertaken with statutory partners included presentations and meetings held with colleagues in Health and Adult Social Care (HASC) and Brighton and Sussex University Hospitals Trust (BSUH), the Brighton and Hove Safeguarding Children Partnership (BHSCP) and Community Safety Partnership (BHCSP). These joint working relationships were further progressed through the BHSAB joining the Exploitation subgroup and Modern Slavery steering group as well as on a pan-Sussex basis through the Policies and Procedures subgroup. Engagement has also taken place with the voluntary and community sector through the Practitioner Alliance for Safeguarding Adults (PASA) and developing relationships with a range of other professionals and agencies.

- Making Safeguarding Personal (MSP) is a priority of the BHSAB and has been taken forward through all of our activities over the last year. This has included seeking to involve others in all the reviews undertaken and where possible ensuring their views and outcomes are central to these processes. We have also ensured that evidencing MSP in practical terms, is a key feature of our audit activities and the learning that is disseminated.

- The BHSAB has launched a new quarterly newsletter and delivered two editions so far. These have included articles on the role of the SAB, news updates, Safeguarding Adults Reviews, the Safeguarding Conference and managing allegations against staff.

Integration/Training and Workforce Development

- This priority is one that has been impacted by the pandemic as whilst the BHSAB continued to undertake key activities, that included learning briefings from audits, the Learning and Development subgroup was paused for the majority of 2020/21. However, with the increase in SAR activity over the course of the year taking forward the learning from these will be a key priority in 2021/22 and following the publication of SAR Christopher a learning briefing has been shared in order to highlight learning from this review.

- Whilst a virtual joint Safeguarding Conference hosted by the BHSAB and our colleagues at the East Sussex SAB was scheduled to take place in March 2021 the impact of the pandemic on agencies in the early months of the year meant that a decision was made to delay this until May 2021. This conference has been developed to focus on learning from reviews with workshops on several common themes; trauma-informed practice, professional curiosity as well as mental capacity and inherent jurisdiction. These are being presented by a range of colleagues from partner agencies and it is hoped that it will raise knowledge and awareness of these emerging areas of adult safeguarding across the spectrum of both statutory and non-statutory organisations.

10. Our Learning in 2020-21

Due to the challenges presented by the coronavirus pandemic, that have already been discussed, it has not been possible to progress all of the challenges identified in the 2019-20 Annual Report. However, there has been significant development in some areas.

An updated pan-Sussex Safeguarding Adults Review (SAR) Protocol was published during 2020-21 as well as two further pan-Sussex SAB Protocols: an Information Sharing Guide and Protocol as well as an Adult Death Protocol. Work has continued on a pan-Sussex Hoarding framework and we are exploring the development of a number of other pan-Sussex protocols. Updates to the pan-Sussex Safeguarding Adult Policy and Procedures are also in progress and the BHSAB will continue to take a pan-Sussex approach towards adult safeguarding wherever possible.

The focus on engagement over 2020-21 has included developing strong relationships and working in partnership with the Violence, Vulnerability and Exploitation Co-ordinator and the Safeguarding Children Partnership. This has led to the BHSAB participating in work on Exploitation and Modern Slavery, both with our statutory partners and more widely, and this multi-agency working will continue. There has not been the opportunity to progress working with the Brighton Crime Reduction Partnership to examine how we can engage local businesses, but this remains an aim going forward.

There has been some scoping in relation to proportionally high rate of suicides in the city and that collaborative work was taking place with Public Health to explore how the BHSAB can have sight of this serious issue.

Learning from Safeguarding Adults Reviews

Under section 44 of the Care Act 2014 Safeguarding Adults Boards (SABs) have a statutory duty to commission a Safeguarding Adults Review (SAR) when an adult with care and support in its area dies; and the Board knows, or suspects the death was as a result of abuse or neglect and there is concern about how the SAB, its members or organisations worked together to safeguard and protect the adult.

A SAR is not undertaken to hold any organisation to account; is not a punitive process and is not to apportion blame. The purpose of a SAR is to promote effective learning and to prevent future deaths or serious harm occurring again. The aim is that it tackles barriers to good practice and lessons can be learned from the case, which can be applied in the future to prevent similar harm re-occurring.

Whilst approaches to undertaking a SAR may vary, bringing together the individual agencies and professionals involved in supporting the person, to understand and analyse their actions, is key to make recommendations for improving future practice where this is necessary.

The BHSAB uses the following decision-making criteria when assessing any SAR referral that is received.

- The concerns relate to a person with care and support needs – whether the person was in receipt of services at the time of death or injury, or not.
- The cause of death has been established.
- Any safeguarding enquiry or investigative process has either concluded or is largely complete.
- There is evidence of a link between the death or serious harm that has occurred and abuse, neglect or acts of omission.
- The harm caused, or death is considered at this stage to have potentially been preventable.
- There are concerns about the way partners may have worked together to try and safeguard the adult.
- The concerns appear to relate to more than one single agency.
- There appears to be the potential for learning to be identified that would improve local safeguarding arrangements, multi-agency practice and partnership working.

The past year has been an exceptionally busy one for the BHSAB in terms of Safeguarding Adults Reviews, which may in part reflect the increasing engagement work undertaken over the past twelve months.

Over the course of 2020/21 the Brighton and Hove SAB received nine new formal referrals for SARs, with one referral from the end of the 2019/20 carried forward for further consideration. One other case was brought by a partner agency for an informal discussion in the first instance.

The issues raised in these referrals were in relation to;

- **Homelessness and the provision of Housing**
- **Hospital Discharge**
- **Self-neglect**
- **Domestic abuse (with a focus on coercion and control)**
- **Substance and alcohol misuse**
- **Working with complex and multi-factorial care needs**
- **Acquired Brain Injury**
- **Learning Disabilities**
- **Exploitation (including cuckooing)**

From the nine referrals received, and the one that was carried forward from 2018/19, one was incorporated into a Thematic Learning Review being undertaken and two further SARs were separately commissioned and are in progress. One of these SARs has been completed within a six-month period and is due to be published early in 2021/22. A SAR that had previously been commissioned was also completed and published.

Further information is in the process of being requested from two of the most recent referrals received in order to determine whether the eligibility criteria for a SAR has been met.

Whilst the other referrals were not felt to meet the criteria for a Safeguarding Adults Review in their own right the SAB sought assurance from partner organisations where considered necessary and identified a number of learning points to be taken forward.

Christopher

Christopher was a 39-year old white, British man with a history of chronic anxiety, a learning disability, substance misuse and homelessness who was supported by a range of professionals and agencies prior to sadly passing away.

A Safeguarding Adults Review was commissioned by the BHSAB to consider the care and support arrangements that were in place and whether more could have been done to protect Christopher. Areas of focus included multi-agency communication and collaboration, whether the policies and procedures in place were sufficient and appropriately followed as well as consideration of the challenges around supporting people with complex and multiple needs.

The review recognised the challenges of working with Christopher and identified that he received a considerable level of support from professionals and agencies, who worked hard and treated him with respect. However, the review has identified several improvement actions and made five recommendations. These include the SAB using audit processes to consider partners knowledge and understanding of formal safeguarding procedures under the Care Act, how trauma-informed practice has been implemented in supporting people with complex and multiple needs and how homeless and transient people are enabled to access services in Brighton and Hove.

The full report can be found here and an action plan is in the process of being developed in order to take forward the recommendations that have been made.

11. Our Data

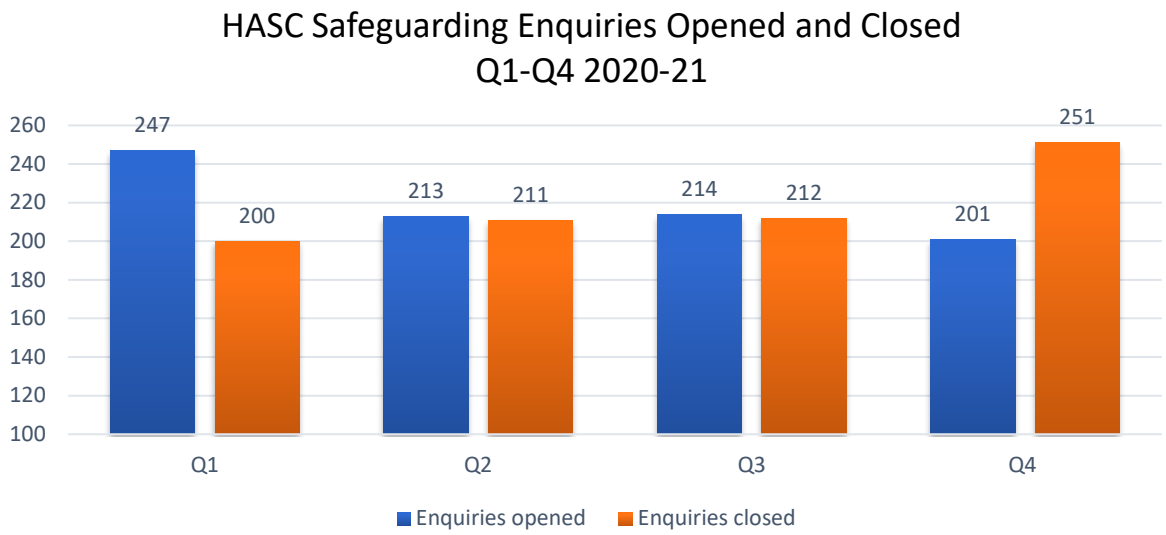
BHCC Health and Adult Social Care Safeguarding data for 2020-2021

Safeguarding Enquiries

In 2020-21, 875 safeguarding enquiries were opened, which is an 8% overall increase upon the number of enquiries opened during 2019-20. The objectives of a safeguarding enquiry are to:

- establish the facts
- ascertain the adult's views and wishes
- assess the adult's needs for protection, support, and redress
- make decisions as to what further action should be taken with regard to the source of the concern, abuse or neglect
- enable the adult to achieve resolution and recovery

A greater proportion of the annual total safeguarding enquiries were opened in Quarter 1 compared to the other three quarters; the lowest proportion of safeguarding enquiries opened, 23%, were opened during Quarter 4 of 2020-21.



874 safeguarding enquiries were completed by BHCC Health and Adult Social Care in 2020-21. This is a 29% increase on the corresponding data for 2019-2020 and is likely to be as a result of the creation of a safeguarding Hub, that centralised safeguarding activity, as well as the impact of the COVID-19 pandemic.

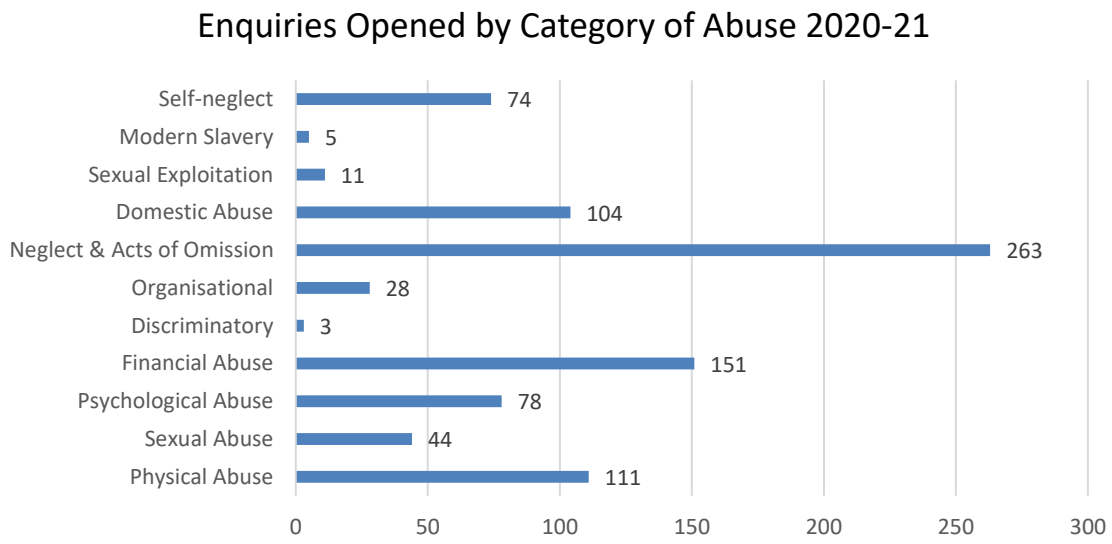
These figures include safeguarding enquiries undertaken by social care staff seconded from the local authority into Sussex Partnership Foundation NHS Trust, (SPFT), under a Section 75 (NHS Act 2000) agreement.

Enquiries by type of abuse

The chart shows the number of enquiries opened by abuse type in 2020-21. In line with the previous year, neglect and omission continues to represent the largest volume of enquiries undertaken followed by financial abuse and physical abuse.

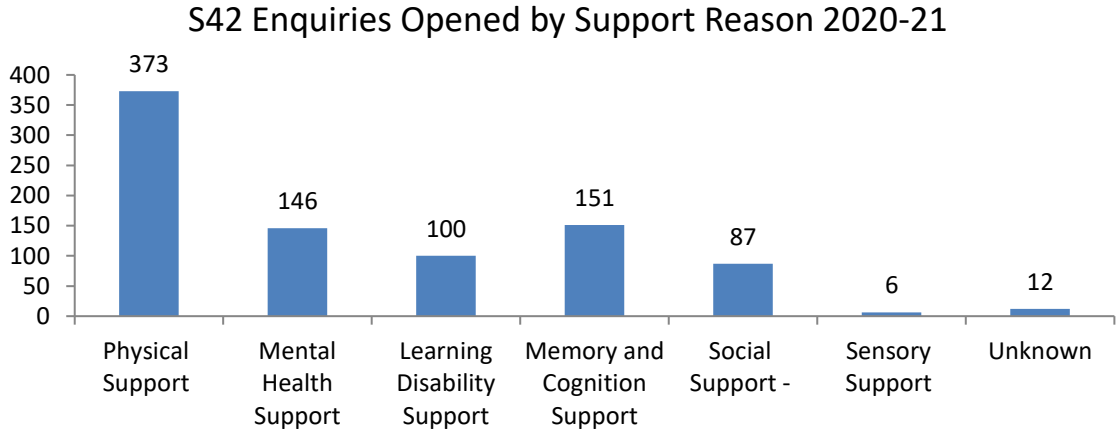
In 2020-21 there was an increase upon the same data for 2019-20 with regard to the number of safeguarding enquiries opened for domestic abuse, neglect and acts of omission, self-neglect, financial abuse, and organisational abuse.

The pattern of opened safeguarding enquiries by abuse type as a percentage of the total, has remained largely in line with 2019-20 with a couple of exceptions. When comparing to the data for 2019-20, 4% more of all enquiries opened in 2020-21 related to domestic abuse and 5% fewer related to concerns of physical abuse.



Primary support reason

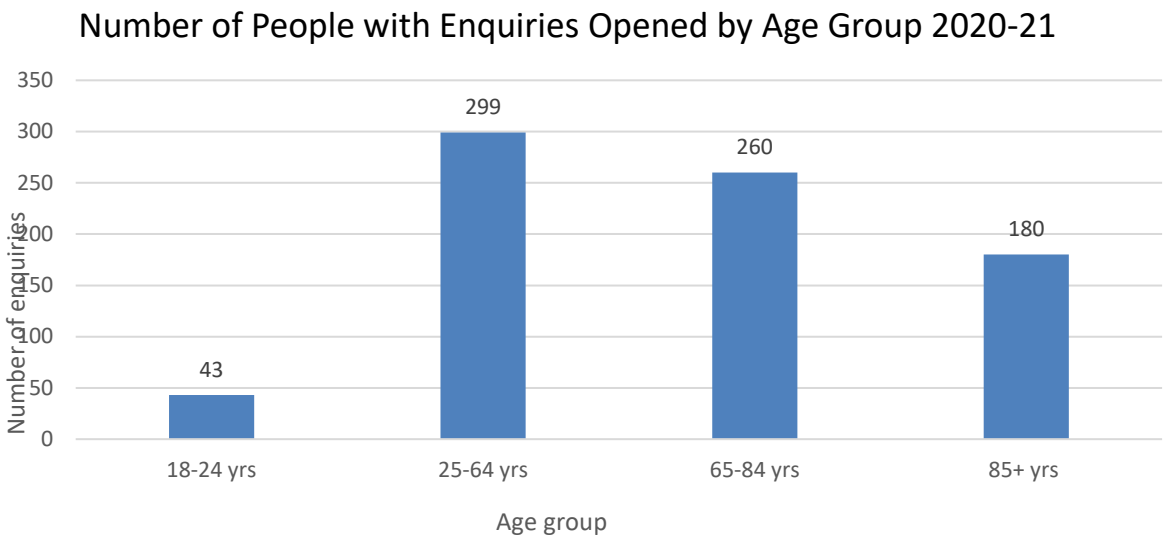
The breakdown of enquiries by primary support reason is broadly in line with the data for 2019-20, with physical support representing the largest category and is consistent with the latest available national data.[1]



Enquiries by age group

Overall, 56% of enquiries opened were with people over the age of 65years old, which is in line with the previous year. However, during quarter 1 of 2020-21 in which the highest number of enquiries were opened (247 in total), the age group with the most enquiries opened was for people aged 25-64 years old. There is not a direct comparison for this data to the previous year as HASC have developed a new data dashboard, with new age categories, which will provide improved analysis of safeguarding data for young adults and supports the SAB work on transitional safeguarding, the move from children's to adults' services.

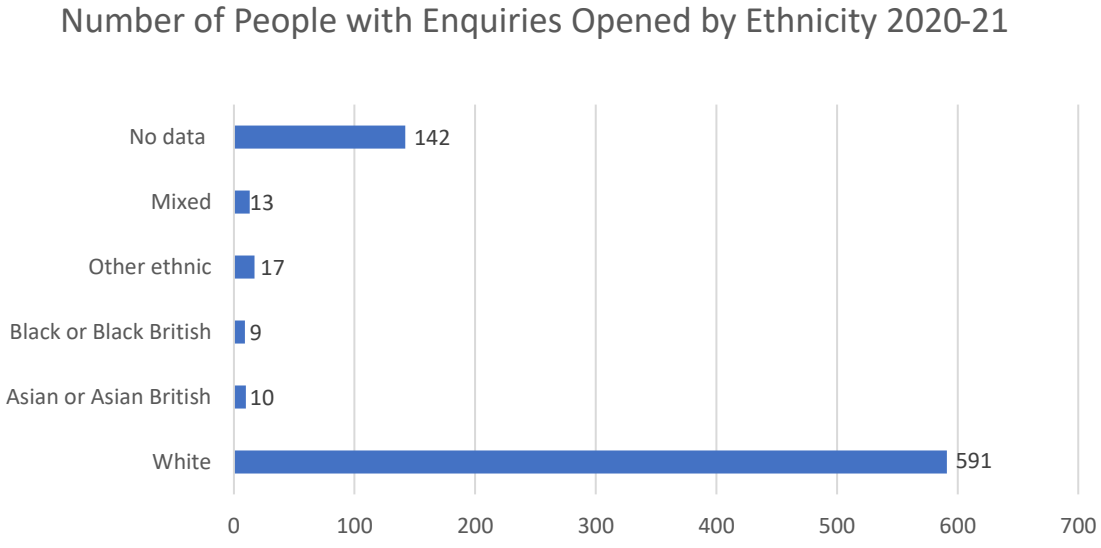
[1] Safeguarding Adults Collection 2019-20, NHS Digital, November 2020



Enquiries by ethnic group

The chart below shows the ethnicity of those involved in safeguarding enquiries undertaken by HASC. The distribution of enquiries across different recorded ethnicities is largely in line with the previous year. Enquiries involving adults where their ethnic origin is identified as white remains the highest proportion of enquiries in 2020-21 at 76%, which is lower than 80% recorded for the previous year. HASC advise in response to this reduction that whilst it is mandatory that ethnicity is recorded on their systems a high proportion of the enquiries in which ethnicity was not recorded was due to these being ongoing and it either being 'not stated', had not yet been obtained or that it was refused.

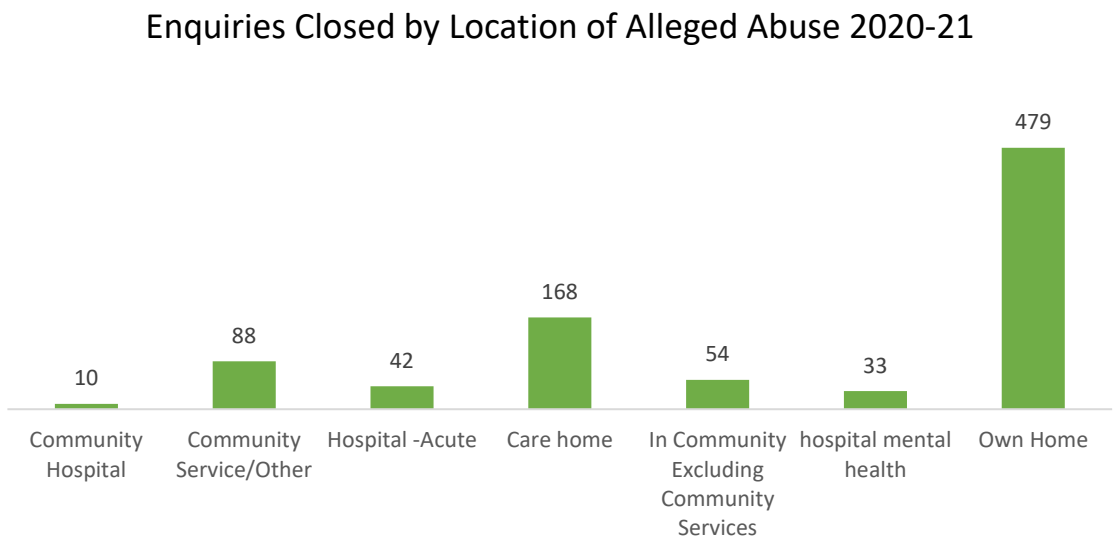
The proportion of people with safeguarding enquiries who are of Asian/Asian British ethnicity, at 1.3%, is in line with the previous year and remains low in comparison to the 4.1% of the local population who identify as Asian/ Asian British.[2] This is a trend repeated in other parts of the country and could be influenced by the different age profiles in ethnic groups.



[2] http:/ /www.bhconnected.org.uk/sites/bhconnected/files/4.2.2%20Ethnicity%20JSNA%202016.pdf

Settings where abuse or neglect occurred

The chart below shows where abuse or neglect was recorded as having occurred in safeguarding enquiries undertaken during 2020-21. The distribution of location of alleged abuse is broadly in line with the data for the previous year. The most common setting where abuse or neglect occurred is in people's own homes. 55% of safeguarding enquiries were relating to alleged abuse in the person's own home, this is a slight increase of 8% on the same data for the previous year. The percentage of safeguarding enquiries relating to residential and nursing care homes fell by 6% from 2019-20. This reflects the national picture and is likely to be attributable to the impact of the COVID-19 pandemic where face to face visits and social interactions were reduced for much of the year.



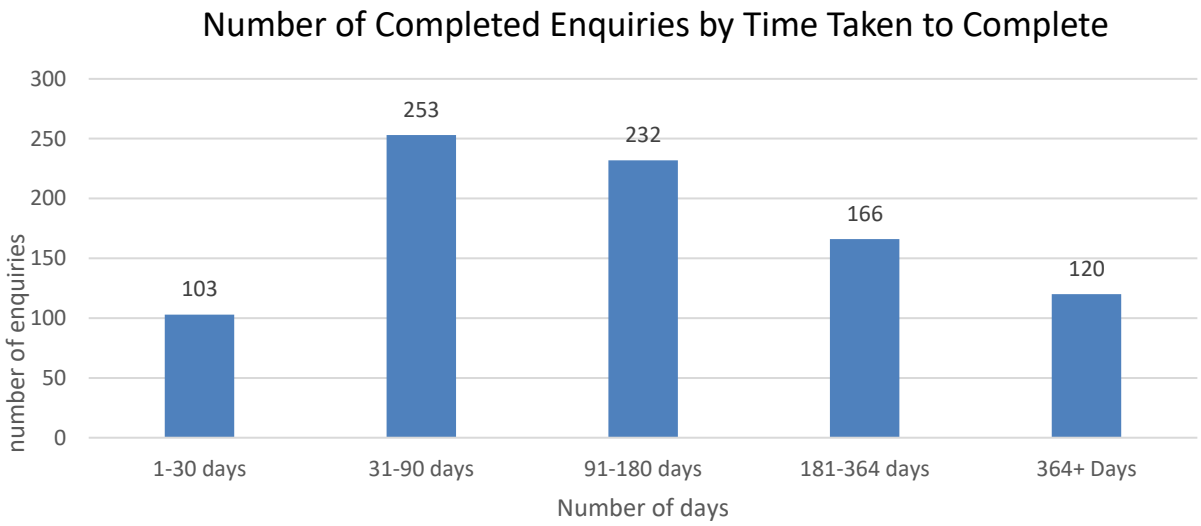
Making safeguarding personal

In accordance with the Care Act 2014, safeguarding enquiries must be person centred. An enquiry can range from a conversation with an adult to a series of more formal multi agency discussions, plans and actions that clearly set out to reduce identified risks and prevent abuse or neglect occurring in the future. There are no set timescales for completion of an enquiry but there is a clear 'principle of no delay'. Adults who are the subject in any safeguarding enquiry are asked what outcomes they want to achieve and asked at the conclusion of the enquiry whether they feel that these have been met.

Was the desired outcome achieved?

Of adults who had identified desired outcomes from safeguarding enquiries undertaken in 2020-21 on average 47% felt that these had been achieved, which is a slight increase of 4% from 2019-20, with 25% feeling their identified outcomes had been partly achieved. It should be separately noted that in nearly a quarter of safeguarding enquiries undertaken (24%) there were no desired outcomes identified or recorded from those people involved. This is the same percentage as for the previous year. The identification of outcomes is a mandatory category

but there is a category for 'no identified outcomes' so may be attributable to factors such as non-engagement in enquiry processes. HASC will consider how training can be used to reinforce the importance of outcomes being identified. The BHSAB will be reviewing the Making Safeguarding Personal (MSP) approach as part of the future quality assurance programme, which will include consideration of people's views and outcomes in safeguarding processes. It should also be noted that HASC have now introduced a non-engagement policy, which is hoped will enable increased engagement and the identification of outcomes going forward.



The chart above shows a breakdown of the number of completed enquiries and the time taken to complete. Overall, 41% of enquiries were completed within 90 days or less, a 4% increase upon the same data for the previous year. 15% of enquiries took 365 days or more; this is a slight increase upon 2019-20. In Q1 of 2020-21 more enquiries were completed within 30 days than in any of the other quarters, fewer were completed within 31-90 days than in any subsequent quarter. The picture is likely to have been influenced by the spike in enquiries opened in Q1 and the higher number of enquiries closed in Q4.

12. Data from our Partners

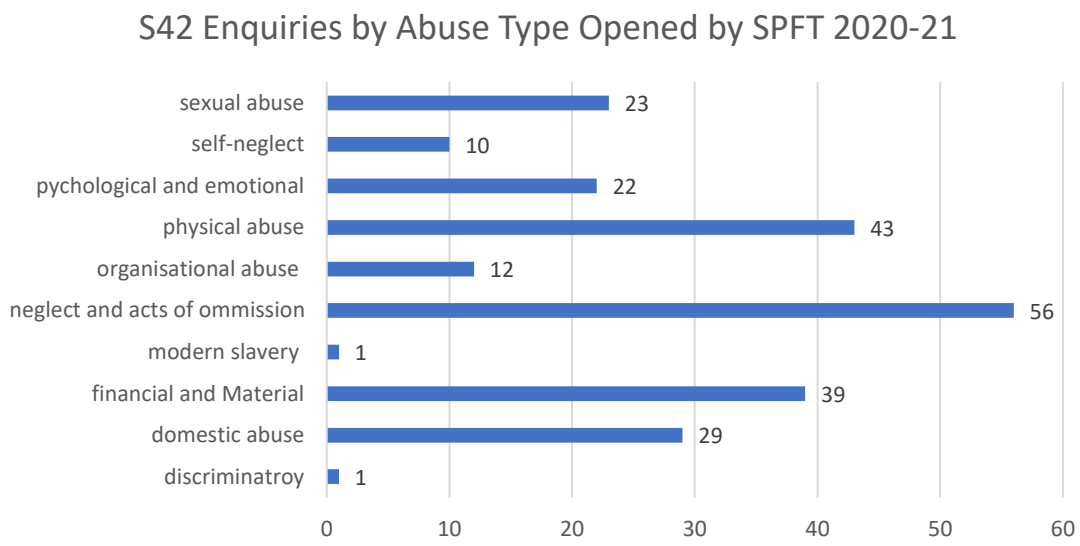
The SAB, through the Quality Assurance subgroup, works with partner agencies to take a holistic view of the quality of services across agencies, ensuring that any gaps, overlaps or misalignment can be identified.

The QA Subgroup receive a multi-agency data set report twice a year. A summary of the data collected by some of the SAB partner agencies for the financial year 2020-21 is included below.

Sussex Partnership Foundation Trust (SPFT)

Brighton and Hove adult mental health services are provided jointly by the Local Authority and SPFT under a Section 75 (NHS Act 2000) agreement, which allows for the integration of Health and Social Care services. Safeguarding enquiries are undertaken by the social care staff who are seconded within Sussex Partnership Foundation Trust, (SPFT), mental health services.

The following chart shows the number of safeguarding enquiries opened by SPFT for 2020-2021, by abuse type. The overall picture across abuse types is in line with 2019-20 and, as with HASC, it can be seen that neglect and omission continues to be the category where the highest number of enquiries were undertaken. Whilst, as with the data from HASC, Quarters 1 and 2 saw increased safeguarding activity this significantly reduced over the remainder of the year and in total the number of section 42 enquiries opened reduced by 15% compared to 2019-20. SPFT have advised this is because throughout 2020-21 they received a higher number of concerns around mental health welfare from other frontline services, which did not meet the eligibility criteria for a section 42 enquiry. SPFT have oversight of the conversion rates of safeguarding concerns into enquiries and are undertaking a focussed piece of work to ensure accuracy of recording and application of the S42 thresholds.



NHS Brighton and Hove Clinical Commissioning Group (CCG)

Over the last year the CCG has undertaken a range of actions in relation to adult safeguarding. This has included the development of an adult safeguarding data dashboard and a statutory review tracker that enables enhanced oversight of health action plans in relation to Safeguarding Adults Reviews (SARs) and Domestic Homicide Reviews (DHR's). This extends beyond the CCG itself and incorporates health providers in progressing identified actions from reviews undertaken.

Work has also been undertaken to develop a pathway to increase awareness within primary care of both children and adults referred to Multi-Agency Risk Assessment Conferences (MARAC), particularly in relation to situations where domestic abuse is occurring. This

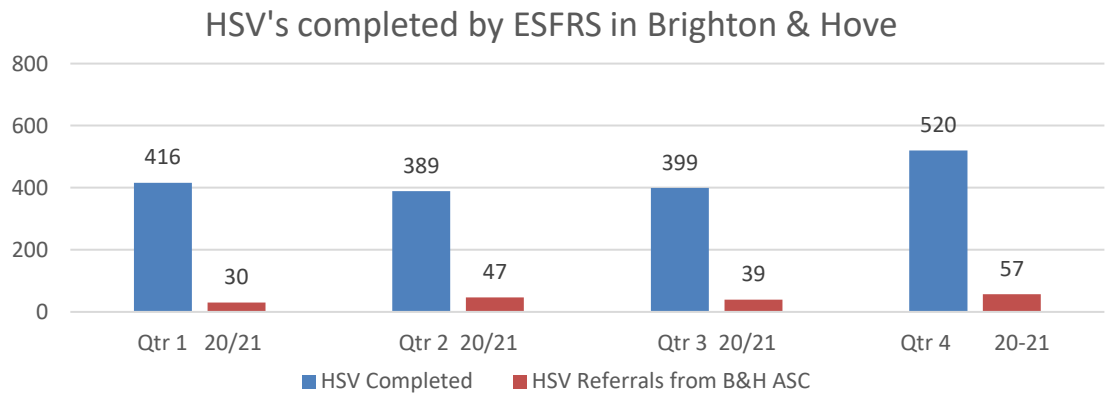
supports the 'Think Family' approach and will improved support risk management and safety planning.

From a staffing point of view a new Deputy Designated Nurse for transitional safeguarding was appointed, the first nationally, in progressing transitions work across the system. During 2020-21 the CCG also undertook recruitment to appoint to eight vacant named GP for safeguarding roles, which will strengthen partnership working going forward.

In responding to the Coronavirus pandemic the CCG developed resources for both primary care services and health providers to raise awareness of the risks that arose during lockdown.

East Sussex Fire and Rescue Service (ESFRS)

The chart below shows the number of home safety visits, (HSVs) conducted by ESFRS in 2020-2021, including the number of visits conducted as a result of referrals from Brighton and Hove City Council HASC. These visits are one element of the ESFRS targeted prevention work providing support to the most vulnerable members of the community who may be more at risk of having a fire in their home. Home Safety Visits are a key element of preventative work to help ensure that risks of neglect and self-neglect are addressed.



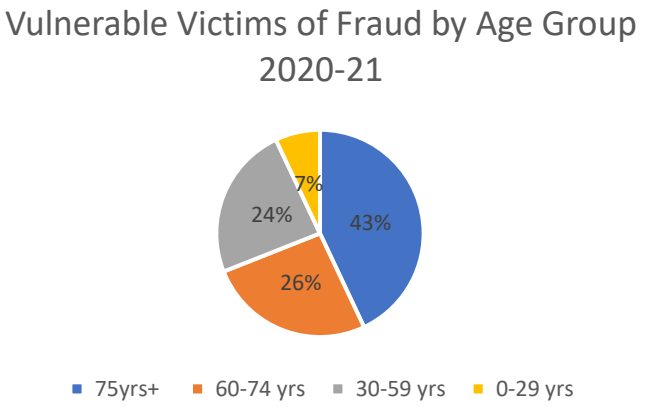
The impact of the COVID-19 pandemic can be seen in the overall 40% reduction in the number of HSVs completed in 2020-21 compared to 2019-20. This was especially marked during the first two quarters of the year when the government restrictions put in place due to the COVID-19 pandemic, were first implemented. The number of referrals to ESFRS from HASC requesting a home safety visit only reduced by 10% over the year, compared to 2019-20.

Whilst undertaking home safety visits if ESFRS identify any safeguarding concerns these are reported to the local authority via a Coming to Notice (CTN) referral. In 2020-21 the highest proportion of CTN referrals were in relation to hoarding. A pan-Sussex Hoarding framework is being developed to support practitioners to respond effectively to hoarding behaviour.

Sussex Police

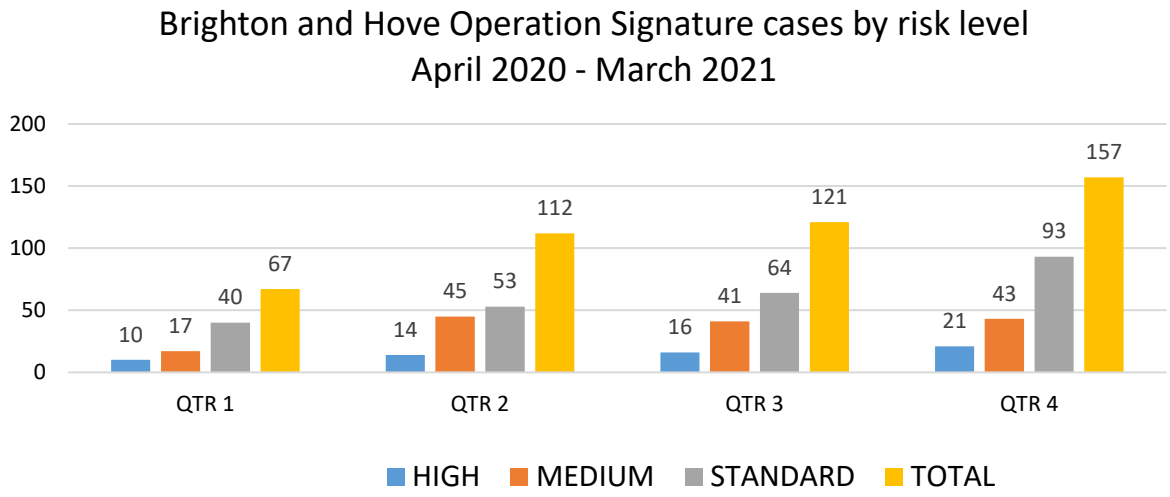
Operation Signature

Operation Signature identifies and supports vulnerable, and often elderly, victims of fraud of all types within Sussex. Across Brighton and Hove of Operation Signature case workers have supported 818 victims of fraud in 2020-2021, this is a 27% increase upon the previous year.



In 2020-21 a greater percentage of vulnerable victims were between 30-59 years of age than in the previous two years; 61% of vulnerable victims of fraud live alone. The average loss, where a loss was recorded, was £13.96K, this is an increase of 88% upon the previous year.

The chart below of recorded cases of fraud of vulnerable adults by quarter and by risk level, shows that the number of recorded cases in quarter four is approximately double of that in quarter one. During the first quarter of 2020-21 the government lockdown restrictions reduced opportunities for certain types of fraud with doorstep criminals less prevalent at this time. In addition, cases of romance fraud have significantly increased as more people experienced isolation and loneliness during the COVID-19 pandemic. Typically romance fraud includes a period of grooming until the fraudster demands money; the fraud activity might have started several months before it is reported.

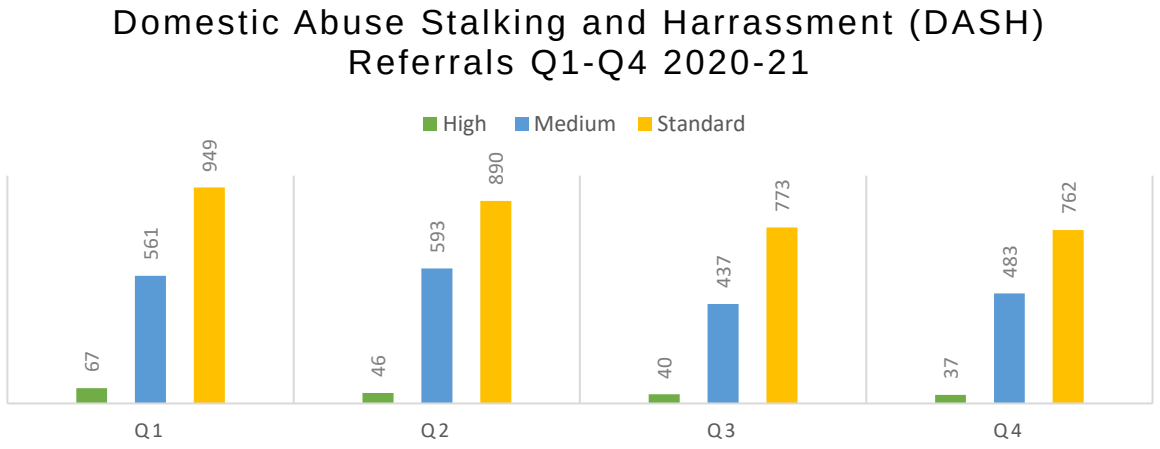


The most common types of fraud are telephone scams, courier fraud, rogue traders at the doorstep, romance, HMRC, financial abuse by a known person and investment fraud, sometimes posing as fraud recovery. This data will be extremely helpful in planning public awareness campaigns undertaken in the future by the SAB.

Domestic Abuse, Stalking and Harassment (DASH) Referrals

Incidents of Domestic Abuse are subject to a risk assessment using a Domestic Abuse, Stalking and Harassment, (DASH), checklist. An officer, with the victim, assesses the level of risk using this checklist and will take initial steps to manage this risk. Sussex Police Safeguarding Investigations Unit, (SIU) refer all cases of domestic abuse involving an adult with care and support needs, to Adult Social Care. This checklist provides information on whether the risk to an individual is high, medium or standard.

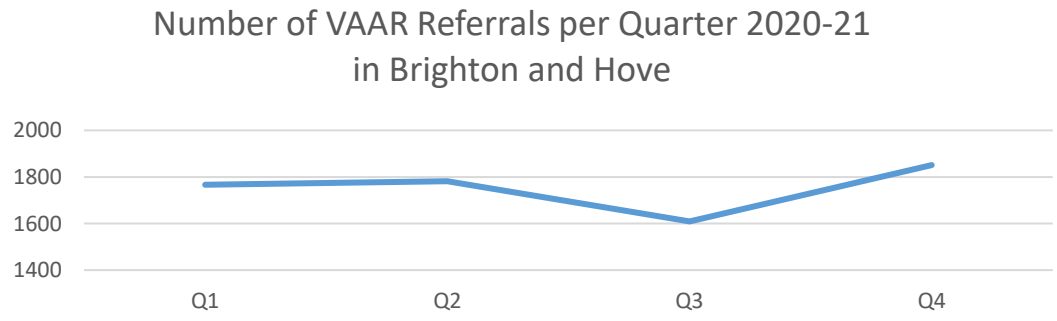
The chart below shows the number of DASH referrals made by Sussex Police in Brighton and Hove in 2020-2021, by risk level. The number of DASH referrals was highest in Q1 2020-21 which showed an increase of 17% upon the same data for the previous year. The number of DASH referrals reduced through the following quarters and for Q3 and Q4 the number of DASH referrals was lower than the same data for 2019-20; overall for the whole year, the number of DASH referrals was in line with 2019-20.



Vulnerable Adults at Risk (VAAR) referrals

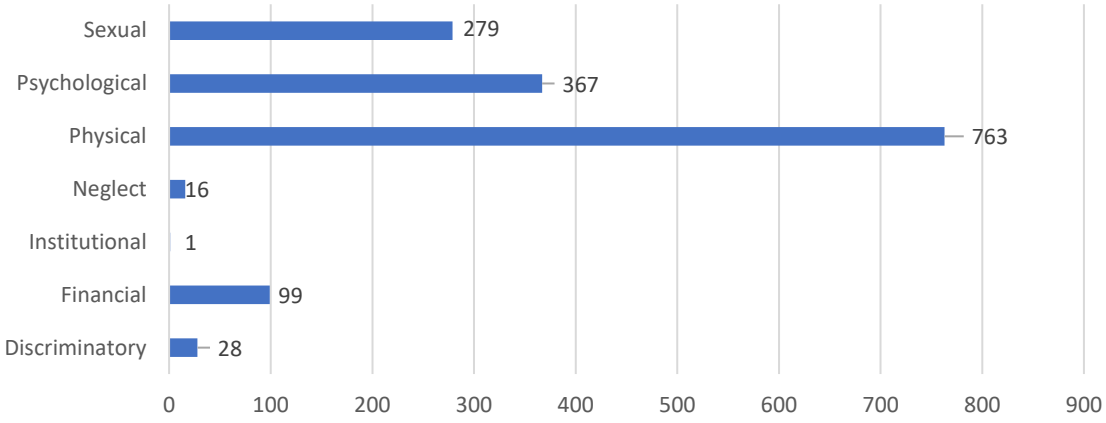
Vulnerable Adult At Risk, (VAAR) referrals are made by Sussex Police to the Local Authority when safeguarding issues or concerns are identified. The chart below shows the number of VAAR referrals made to Brighton and Hove in 2020-2021.

Referrals are assessed and allocated as considered appropriate within Brighton and Hove Health and Adult Social Care, (HASC). Not all VAAR referrals will involve a recorded crime. The number of VAAR referrals is therefore higher than the reported number of crimes involving abuse of an adult with care and support needs.



In 2020-2021 the total number of VAAR referrals recorded is 22% higher than the same data for the previous year with the biggest increase in the first quarter.

The chart below shows the number of crimes recorded by Sussex Police for Brighton and Hove in 2020-2021 per category of abuse risk. This data relates to recorded crimes, acts which may result in harm or loss, which is defined by parliamentary act as illegal. Sussex Police receive information about incidents not all of which will be recordable crimes. All incidents are reviewed for possible crime and intelligence, and those that meet the National Crime Recording Standard are recorded as crimes too.



The three main types of abuse risk recorded are physical abuse, psychological abuse, and sexual abuse. This is in line with the data for 2019-20.

Sussex Community Foundation Trust (SCFT)

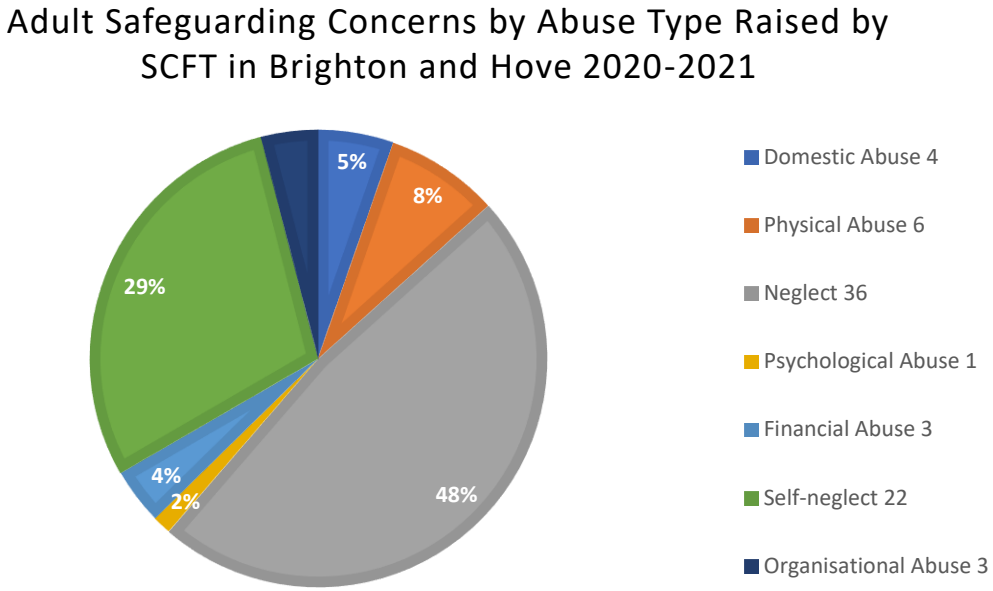
Sussex Community NHS Foundation Trust, (SCFT), are the main provider of community NHS health and care across Brighton and Hove. SCFT provide essential medical, nursing, and therapeutic care, helping people to plan, manage and adapt to changes in their health, to prevent avoidable admission to hospital and to minimise hospital stay.

During 2020-2021 national COVID-19 restrictions impacted on many services. The safeguarding team monitored data regarding concerns raised for COVID-19 themes and trends. Information sharing and partnership working with Sussex Clinical Commissioning Group Safeguarding Team ensured that any impact on care home settings and domiciliary environments were escalated via quality routes to ensure a timely and effective quality care delivery support.

The chart below shows that in line with the previous year, the most common type of abuse raised by SCFT as a safeguarding concern was neglect.

Self-neglect continues to factor as a regularly discussed concern and as a result of this the SCFT Safeguarding Team have embedded a specific self-neglect and hoarding intranet page,

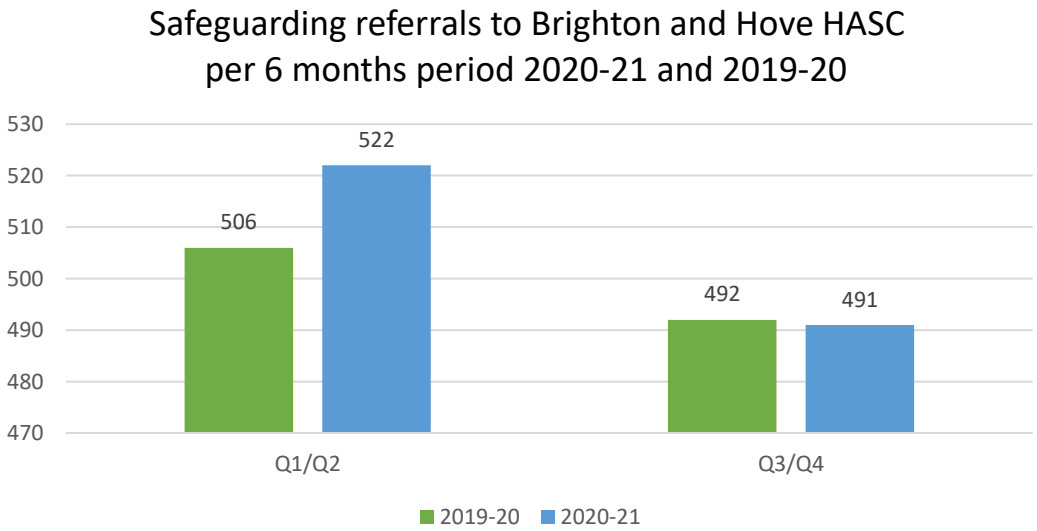
which is accessible to all staff and contains supportive information and local and national reference links



South East Coast Ambulance (SECAMB)

The first six months of the Covid-19 pandemic during 2020-21 has seen a 40% rise in concerns for patients' mental health including a 100% rise in low level parental mental health. The Safeguarding Team recorded a 60% increase in increasing care needs for patients and carers. Additionally, there was a 25% rise in referrals for individuals at risk of or suffering domestic abuse, compared to the same reporting period in 2019-20. SECAmb Safeguarding Team produced a suite of resources to support staff coming across cases of domestic abuse or heightened parental mental health.

In Brighton and Hove, in the first sixth months of 2020-21 SECAmb experienced a 3% increase in safeguarding referrals to HASC compared to the same period in 2019/20.



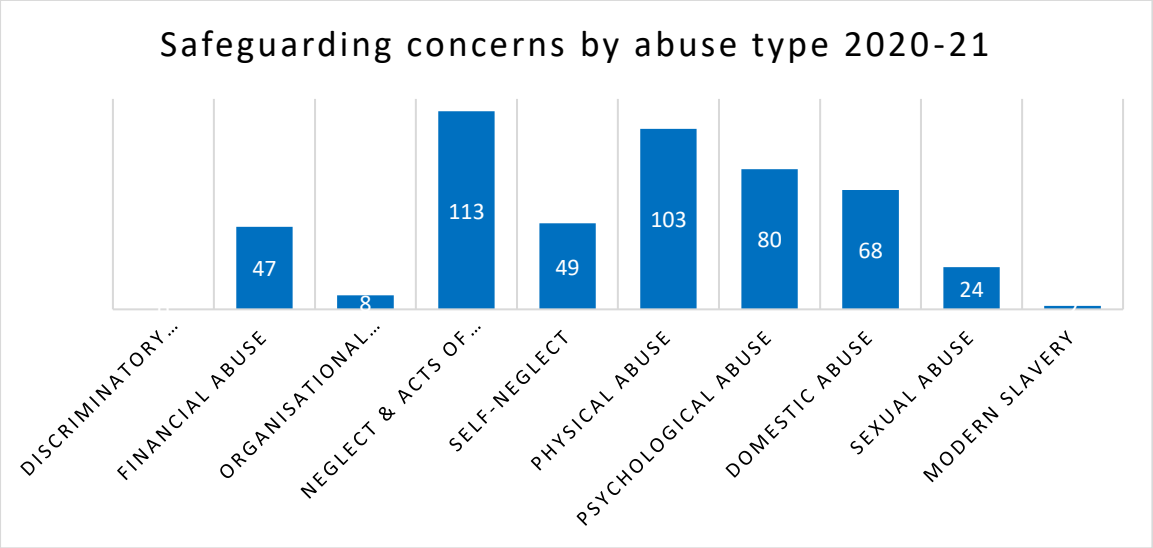
SECAmb amended their safeguarding referral to incorporate greater opportunities for staff and crews to recognise and escalate fire risks for vulnerable people. Where adults with care and support needs were living alone and not receiving usual help from close family members during lockdown, front line SECAmb crew were identifying potential fire risks; there has been a rise of 115% in referrals to Fire and Rescue Services compared to the previous year.

SECAmb's figures support the theory that patients have been contacting the NHS111 and ambulance services at the point of crisis when ordinarily contact would have been made with community providers before patients concerns escalate.

In line with the 'Homelessness Reduction Act 2018' 15 referrals were made to the local authority. There is good evidence that SECAmb are continuing to improve their safeguarding data capturing processes, enabling them to present a more accurate picture of current safeguarding arrangements.

Brighton and Sussex University Hospitals Trust, (BSUH)

There has been a significant increase during 2020-21 from 2019-20 in the number of concerns raised that involved physical abuse, neglect, domestic abuse, and psychological abuse. In contrast the number of concerns raised that involved self-neglect and organisational abuse reduced slightly when compared with the same data for 2019-20.



During the periods of lockdown in 2020-21 the Health Independent Domestic Violence Advisor, (HIDVA), based at BSUH worked remotely rather than on site at the hospital. During this time, BSUH saw an increase in domestic abuse being raised as a safeguarding concern whereas previously these concerns were more likely to have been referred directly to the HIDVA when they were able to work on site.

The safeguarding leads across health, including Sussex CCG and hospital trusts locally, met monthly to maintain a co-ordinated approach to safeguarding as part of a response to COVID-19 pandemic. This enabled a shared understanding of the impact of COVID-19 upon domestic abuse and changing pattern of risks and response.

The safeguarding adults and safeguarding children's team worked closely to promote 'Think Family', this became a bigger focus during COVID-19 because other services such as day centres and schools were closed. The approach allowed for greater consideration of the potential safeguarding risks to anybody left at home.

From the 1st April 2021 BSUH merged with Western Sussex Hospitals Foundation Trust to become University Hospitals Sussex NHS Foundation Trust.

13.Our Priorities in 2021-22

Over the course of 2020/21 the BHSAB has identified a number of targets and goals to work towards over 2021/22 as well as in the longer-term.

Peer Challenge Event

A pan-Sussex Self-Assessment and Peer Challenge Event will be held during the remainder of 2021, following on from the previous event that took place in 2019 and continuing the process of Peer Challenge Events occurring on a bi-annual basis.

A self-assessment tool is being developed collectively by all three Sussex SABs, which seeks to support the evolution of the process by developing a narrative approach that elicits more detailed information from partner agencies. There will be an increased focus on challenges and emerging safeguarding themes, to ensure the BHSAB is sited on these, as well as encouraging partners to consider how the learning from activities undertaken by SABs is incorporated in training and commissioning.

Safeguarding Annual Conference

A virtual Safeguarding Conference is being held in May 2021 by the BHSAB and East Sussex SAB. This was originally due to be held in February 2021 but due to the ongoing impact of the Coronavirus pandemic at that time, and the pressure this was having on all partners, it was postponed.

This Conference will be titled 'Learning from Reviews' and will comprise an introductory session and three workshops, which focus on common themes identified in reviews. There will be a keynote workshop on Trauma-informed Practice as well as further workshops on Mental Capacity and Inherent Jurisdiction as well as Professional Curiosity. The Conference will be hosted by our Independent Chair, Graham Bartlett, and the introductory session and workshops will be delivered by the BHSAB and ESSAB Managers as well as a range of colleagues from across the partnership and beyond.

Engagement

The BHSAB will continue to work in partnership with our neighbouring SABs in both East and West Sussex to continue to develop a pan-Sussex approach toward safeguarding arrangements and assurance wherever possible. During 2021/22 this will include publishing updates to the Pan-Sussex Safeguarding Adults Policy and Procedures, reviewing existing protocols and developing new Protocols as well as concluding and publishing the Coronavirus pandemic assurance audit currently in progress in order to ensure learning during this time is shared with partners.

Strategic Plan

2021/22 will be the last year of our current three-year Strategic Plan. Over the course of the year ahead the BHSAB will work with our partners to develop a new three-year Strategic Plan that continues to lead and oversee local adult safeguarding arrangements.

14. Raising a Safeguarding Concern

Reporting concerns about harm, abuse or neglect

Brighton and Hove City Council's Health and Social Care department (HASC) have an adult safeguarding hub. If you have a safeguarding concern about a vulnerable adult in Brighton then please contact them at hascsafeguardinghub@brighton-hove.gov.uk.

Safeguarding concerns can also be reported directly online at https://new.brighton-hove.gov.uk/adultsafeguarding.

If you have concerns that someone may have care and support needs then please contact Access Point at www.brighton-hove.gov.uk/adult-social-care or by calling 01273 295555, or emailing AccessPoint@brighton-hove.gov.uk.

If you have concerns about a child or family in Brighton, then please contact Front Door for Families at www.brighton-hove.gov.uk/front-door-families, or by calling 01273 290400.

If you have a safeguarding concern about a vulnerable adult who is in East Sussex, then please call 0345 60 80 191 or if it is in relation to a child or family then please call 01323 464222. If you have a safeguarding concern about a vulnerable adult in West Sussex then please contact Adult Social Care or if it is in relation to a child or family then please contact Children and Families.

If a criminal offence is in progress or has just been committed then please call 999 but if you have a non-emergency enquiry you can contact Sussex Police by calling 101 or at www.sussex.police.uk/contact/af/contact-us/.