11. Progress against our business plan

11.1. Priority 1: Embed and test practice change and improvement, aligned with statutory arrangements implemented from Care Act 2014 and the Mental Capacity Act 2005

Outcome for Adults: Better, differentiated care which reflects choice and expectations, whilst safeguarding them and their rights

- We have again this year sought assurance that all partners have in place audit arrangements that focus on the six safeguarding principles of Empowerment, Prevention, Proportionality, Protection, Partnership and Accountability.

- The Learning & Development Subgroup has met 4 times this year and has supported our understanding of how competent and well-informed the safeguarding workforce is across the city.

- Throughout the year the Sussex Safeguarding Adults Policy and Procedures have been rewritten (official launch outside the time period of this report). The rewrite aims to reduce repetition, incorporate policy and legal updates and learning from Safeguarding Adult Reviews, audits and developments in practice

- We have formally tested, via the Strategic Safeguarding Self-Assessment, that partners have structures and accountabilities which meet the requirements of the Care Act 2014 – see page 26

Conclusion

We have made great progress on this priority area. Next year we will be auditing to test that those agencies which may be required to implement the MCA/ DOLs arrangements, have achieved or are working towards the Mental Capacity Act (MCA)/Deprivation of Liberty Safeguards (DoLS) Gold Standards. We will also be looking to develop a local Mental Capacity Act Competency Framework, and to test compliance against this in future strategic safeguarding self-assessments.

There remains one piece of outstanding work against this priority area. This is the development of a Complex Abuse Protocol to make sure that all our partners work seamlessly together in such instances where there is abuse involving one or more abusers and a number of adults with care and support needs (related or non-related). This was delayed at the request of the West Sussex Safeguarding Adults Board so that the learning from a recently published Safeguarding Adults Review could be considered.

11.2. Priority Area 2: Develop and strengthen quality assurance

Outcome for Adults: Adults will be confident that through an on-going cycle of quality assurance, we are able to take an independent and critical assessment of how their needs are being met thereby enabling us to drive up standards

- Our Quality Assurance Subcommittee and framework is very well established.

- The audit programme is informed by the Business Plan as well as themes that are highlighted as being of high risk through client or professionals' feedback, Safeguarding Adult Reviews, Learning Reviews, national concerns and/or performance gaps.

- This year has seen a multi-agency audit examining safeguarding responses to adults who had experienced sexual assault or abuse. Read more about this work on page 25.

- Throughout the year we have received assurance that partners are quality assuring their own safeguarding arrangements. You can read more about what our partner agencies have been doing on pages 15, and 32.

- We have developed a robust process to easily share audit findings and/ or recommendations widely with staff across the safeguarding partnership which is both quick to digest and informative.

- We have devised a tracking system to monitor progress of actions arising from multi-agency audit.

- Throughout the year we have received updates from Brighton & Hove Clinical Commissioning Group on efforts to ensure that GP practices with safeguarding challenges, identified during Care Quality Commission inspections, are followed up to make sure they are now either working towards or meeting fundamental safeguarding standards.

- We have continued our efforts to develop a truly multi-agency data set to inform safeguarding practice

Conclusion

This is one of our major statutory responsibilities. Our unique position to take a holistic view of the quality of services across agencies enables us to find any gaps, overlaps or misalignment of services. We have made very encouraging progress. In 2018-19 we will be putting in place mechanisms to assure ourselves that feedback from clients, carers and professionals informs policy, procedure and practice at a single agency level. We will also be undertaking a multi-agency audit to test how well personalisation and effective joint working is embedded in all safeguarding enquiries across all agencies.

Last year we reported that we would be undertaking a survey to ask those actively experiencing homelessness their views and opinions of services. This work was superseded in November 2017 when GalvaniseBH[1] undertook a Vulnerability Index Assessment Tool with homeless people. At the time of writing feedback from this activity has not yet been collated. We hope to report on this within next year's annual report.

[1] GalvaniseBH is a campaign run by volunteers from many organisations across the city, with funds raised currently held by YMCA Downlink Group (YMCA DLG).

One area we have made limited progress on is assuring ourselves that Deprivation of Liberty Safeguards are embedded and effective, both within and across the relevant agencies. Next year we intend to incorporate this into the strategic safeguarding self-assessment.

11.3. Priority Area 3: Focus on Prevention and Early Intervention

Outcome for Adults: Their risk of being abused or neglected is minimised or, where prevention has not been possible, everything they wish to be done is done to stop it getting any worse

- Through the strategic safeguarding self-assessment process, we have tested how agencies embed in their services the enablement of adults to identify and manage risk of abuse and neglect for themselves.

- Throughout the year we have encouraged partners to promote their own pathways of support and referrals for clients and carers so that they are enabled to access support suitable to their wishes and needs at the earliest opportunity.
- Both the strategic safeguarding self-assessment and our quality assurance frameworks have been our key mechanisms to hold partners to account for their safeguarding work, including prevention and risk management.
- Our annual safeguarding conference and single agency safeguarding training offered across the partnership has also assisted prevention and early intervention.

Conclusion

This is an area we would have liked to do more around. Many of the objectives and success criteria for this priority area overlap with priority area 4. Similarly to last year, our focus has again been on coordinating and evaluating the effectiveness of safeguarding responses to the homeless population and people with a personality disorder, thus reducing our capacity to test the local mechanisms which enable people to live independently. Going forward we will need to consider whether the objectives for prevention and early intervention sit more comfortably under priority area 4, empowering both communities and professionals to recognise safeguarding concerns as they emerge and to precipitate activity which prevents or stalls abuse or neglect from the outset.

11.4. Priority Area 4: Community Awareness and Capacity Building

Outcome for Adults: More people can act as their eyes and ears and provide support, interventions and seek help and interventions should they witness or suspect abuse or neglect is happening

- The joint LSCB and SAB Participation & Engagement Subcommittee have been developing a communication strategy on behalf of both safeguarding Boards.

- Via the strategic safeguarding self-assessment, we have been assured that all partners have briefing and awareness mechanisms that provide staff with emerging local and national developments about the protection and support of vulnerable adults.

- Board briefings which summarise the discussions held at each main SAB meeting continue to be distributed by partner agencies. These can also be read here.

- Quality Assurance briefings have also been developed this year. Following the sexual abuse audit a short briefing summarising learning was produced and disseminated across the safeguarding partnership. This can be read here.

- The SAB Website and our Twitter have gone some way to supporting the public to understand the role and remit of the board. We have continued to share news and links about good safeguarding practice on Twitter.

- We have promoted awareness campaigns to raise the profile of the nature of abuse and neglect this has included World Mental Health Day, Anti-Slavery Day, National Hate Crime Awareness Week and Get Safe Online Week.

- We have promoted the use of the Stop, Look & Care booklet, which was developed by Brighton & Hove Clinical Commissioning Group. Whilst this is aimed at care workers to ensure effective standards of care provision, we think it is also a useful tool for people receiving care and support and their relatives.

- We have supported the development of the following resources:

1. What to do if you or someone you know may be being neglected or abused – Leaflet

2. What is Abuse? Where Can I Get Help? – Easy Read Leaflet

Conclusion

Previous good progress on this priority has continued. Thanks to the strategic safeguarding self-assessment we are better sighted on the methods by which our partners gather feedback from clients on the outcomes of the service they have provided. What we now need to test is how well this is informing their policy, procedure and practice. Via our multi-agency auditing programme, we have been able to independently assure ourselves that the wishes and views of clients are being routinely sought in safeguarding work.

It is our intention next year to work with the Advice Services Partnership to promote information about what to do when capacity is lost, i.e. power of attorney. We will also be undertaking a scoping exercise with Brighton Crime Reduction Partnership to examine how we can engage local businesses with safeguarding. We also hope to work more closely with the Learning Disability Partnership Board to involve them in our future business planning

11.5. Priority Area 5: Locate the work of the SAB in wider structures.

Outcome for Adults: The response of agencies and decision makers is consistent and connected to ensure that all meet their responsibilities to protect vulnerable adults from abuse and neglect.

- The SAB continues to have a clear and influential role on the Health and Wellbeing Board, evidenced by constructive challenge, an independent voice, the reflection of safeguarding throughout the Board's business and escalation of SAB matters where required.

- We have continued to expand our networks with regional SABs and LSCBs to scope collaboration of functions and harmonisation of business, including joint meetings, training events and sharing of resources.

- The Lead Member for Adult Services and the Director of Adult Services have provided political and operational direction to the SAB throughout the year.

- The Police and Crime Commissioner has been represented at several board meetings and briefed the SAB on relevant commissioned services.

- We have developed a Board Constitution and Information Sharing Agreement. The constitution; articulates the role of the Board, our membership & expectations, details how we are organised and financed, and also sets out how the chair is appointed. The Information Sharing Protocol sets out the principals of partners sharing information amongst themselves and with the Board to promote the safeguarding of adults with care and support needs.

- We have also developed a Memorandum of Understanding for multi-agency safeguarding audits. This provides a framework and defines roles and responsibilities of agencies when participating in the multi-agency audit programme.

Conclusion

Communication and accountability mechanisms between the SAB, and the chief officers and governing bodies of the SAB's constituent agencies, are robust. Our arrangements with neighbouring SABs, in activities such as the pan Sussex strategic self-assessment and subsequent challenge event, have enhanced cross-border collaboration engendering a culture that reduces the risk of the negative impacts of any variable approaches to safeguarding.

This year we began work on a Partnership Protocol. This is a proposed framework outlining the relationship between the SAB, LSCB, the Health and Wellbeing Board (HWB) and the Safe in the City Partnership Board, and the Children, Young People & Skills Committee. These are the key partnerships in the city who share a commitment to ensuring the safety and wellbeing of the community. This document aimed to confirm; membership, accountability and governance arrangements and arrangements for conflict resolution, challenge and scrutiny. However, this work was stalled by the announcement that LSCBs were to be abolished. We will revisit this

piece of work when the city's child safeguarding partnership arrangements are confirmed.

Next year we will be joining with the LSCB Leadership Group to support collaboration in work streams that are of interest to both safeguarding boards. We will also be exploring the possibility of a joint safeguarding learning and development strategy across the county.

11.6. Safeguarding Adult Reviews

The Care Act 2014 (Section 44) requires SABs to carry out a Safeguarding Adult Review (SAR) when there is reasonable cause for concern about how partner organisations worked together to safeguard the adult and a) the adult died, and the SAB knows or suspects, that the death resulted from abuse or neglect, or if b) the adult is still alive and the SAB knows or suspects that the adult has experienced serious abuse or neglect.

The overall purpose of a Safeguarding Adult Review is to promote learning and improve practice, not to re-investigate or to apportion blame. These reviews provide us with a view as to how effective the multi-agency response is to the identification and response to clients' needs.

No safeguarding reviews have been initiated or published this year. Three referrals for reviews were received. After careful consideration one of these led to a single agency review as there were concerns about how one agency worked to safeguard the adult.

Last year we told you about a safeguarding adult review we had published, SAR X. This year we have been making progress against the action plan and can report:

- Social work capacity in Health and Adult Social Care has increased, with an additional ten social work posts recruited to across services
- A 'Trailblazer' social worker has been in post in Health and Adult Social Care since July 2017 (funded for two years). This social worker supports people whose tenancies are under threat, assessing needs under the Care Act and finding solutions to help them maintain their accommodation.
- With the exception of Health and Adult Social Care, all statutory partners have reviewed/ quality assured their approaches, protocols and strategies for working with clients who are hard to engage/ persistently dis-engage with services / treatment (specifically clients who self-neglect, as well as clients who are diagnosed with or suspected of having a Personality Disorder (PD). Health and Adult Social Care will have completed their review by Autumn 2018.
- We hosted a workshop to support frontline staff across the partnership with a basic awareness and understanding of working effectively with service users with a diagnosis of PD.
- The Quality Assurance Subgroup is overseeing progress on learning from a multi-agency case file audit of a sample of

cases regarding homeless individuals who were, at that time, actively in receipt of city services.

Work in progress:

- Commissioners continue to review the effectiveness of the current commissioned PD evidenced pathway to better meet the complex needs of the homeless population
- The SAB Participation & Engagement Subgroup, in consultation with the PD review group are developing a short awareness-raising resource for frontline staff to improve knowledge and understanding of personality disorders.
- The SAB has identified a need to better equip staff when working with transgender and non-binary clients. Initial plans for the Community Safety Partnership to host a workshop during Safeguarding Week in 2017 to supplement practitioners' knowledge were not realised. A staff briefing paper is in development instead.

11.7. SAR Protocol Event

On14 March 2018 the Sussex SABs ran an event to support staff to understand the Safeguarding Adult Review criteria and share learning from local reviews. Staff were provided with a number of case studies and asked to consider whether a SAR should be conducted, to explain their decision making and to advise on what action/s they would take if the decision was not to conduct a SAR.

We were fortunate to be joined by experienced reviewer, Michael Preston-Shoot who discussed the benefit and challenges of the different models for undertaking a SAR, the importance of family and practitioner involvement, how to run SARs alongside parallel processes/investigations and how best to embed organisational change. The event was really well attended and evaluated.

"Very comprehensive. A good balance between 'lecture' style, group discussion, Q&A, and the promotion of reflection."

"It was very useful looking at case studies, understanding what other reviews may be used alongside or instead of SARs, as well as being helped to understand the statutory criteria for SARs to be triggered."

11.8. Assuring the quality of safeguarding practice

The Care Act 2014 provides that the SAB must lead adult safeguarding arrangements across its locality and oversee and coordinate the effectiveness of the safeguarding work of its member and partner agencies. The Quality Assurance subgroup is the vehicle for this work.

11.9. Multi-agency auditing

This year we have undertaken a Sexual Abuse Audit, which examined safeguarding responses to adults who had experienced sexual assault or abuse. The audit was led by the Strategic Commissioner, Joint Domestic, Sexual Violence & Abuse and Violence against Women & Girls (VAWG) Unit and a Detective Inspector from Sussex Police.

The audit looked at four cases involving adults who had experienced sexual abuse. All four adults included in the audit had multiple or complex support needs.

Examples of what is working well

- Several cases highlighted good support to clients with multiple and complex support needs, including clients with substance misuse and mental health support needs.
- There were examples of effective joint working between agencies.
- Where there were specific language support needs these were generally addressed well.
- Safeguarding awareness and professional curiosity among staff was generally good.

Examples of what needs to be improved

- There was a lack of clarity and consistency in the recording and sharing of information in relation to the risk of sexual abuse.
- Greater awareness of the role of the MARAC (Multi-agency Risk Assessment Conference) and the role of specialist sexual abuse services e.g. Survivors' Network and the Sexual Assault Referral Centre (SARC) is needed.
- In some cases, staff were not fully aware of the correct process for assessing clients' mental capacity under the Mental Capacity Act.
- In some cases the response to a client who had experienced sexual abuse was 'incident based' where a more 'trauma-informed approach' might have been more appropriate.
- There remain challenges in supporting clients with multiple and complex support needs who are difficult to engage.

Recommendations

- All agencies to review their needs and risk assessment procedures to improve how clients are supported to disclose sexual abuse and exploitation so that appropriate support can be provided, and appropriate specialist referrals made.
- All agencies to be reminded of the referral process for specialist sexual abuse support services including SARC and Survivors' Network
- Agencies to consider how a 'trauma-informed approach' might be used to improve support to clients who have experienced sexual abuse, including identifying appropriate staff training.

- The SAB to request the MARAC to review its information sharing arrangements to ensure agencies who cannot attend MARAC meetings are kept informed about clients they are involved with.

11.10. Single Agency Auditing

This year agencies have shared their safeguarding audit schedules. This helps to assure us that partners are quality assuring their own safeguarding practice. To support agencies with this we developed a 'good practice for agencies when conducting single agency audits' guide.

11.11. Strategic safeguarding self-assessment

All of our partners undertook a strategic safeguarding self-assessment in July 2017. This exercise required agencies to reflect on how well they meet expected safeguarding standards.

Standards for the self-assessment

- Senior management commitment to the importance of safeguarding, making safeguarding personal and promoting the wellbeing of adults with care and support needs
- Organisation's responsibilities towards adults & accountability
- Staff training
- Safe recruitment practice
- Effective inter-agency working to safeguard and promote the wellbeing of adults
- Information sharing
- Allegations against staff

Headlines

- All agencies have a senior staff member who has responsibility to "champion" safeguarding adults throughout.
- All agencies had, or were in the process of updating, procedures and written information which reflect the Care Act, Making Safeguarding Personal, and Sussex Safeguarding Adults Procedures.
- The majority of agencies were able to describe how new staff members are made aware of their responsibilities to safeguard adults through clear induction or had actions in place to meet expected standards.
- All agencies confirmed arrangements to raise organisational concerns to the SAB that may be relevant to safeguarding.
- The majority of agencies felt confident that their workforce are trained as appropriate to their roles and responsibilities, including undertaking safeguarding enquiries where required
- Agencies provided assurance that they undertake DBS checks, prior to appointment.
- All agencies described with confidence their internal systems to ensure information is cascaded successfully to frontline workers
- Commitment to inter-agency working was well evidenced in partner's strategy documents, policies and procedures.

- On the whole agencies were able to talk knowledgeably to their policy/ procedure concerning information sharing, consent and confidentiality.
- Whistle-blowing policies are in place and agencies were able to describe these with confidence.

Themes

- A number of agencies struggled to demonstrate compliance with the requirements of the safer recruitment standard. A practice reminder was circulated by the SAB across the partnership.
- A number of agencies were not sufficiently able to evidence how they take steps in line with the Mental Capacity Act. Whilst some agencies explained this well, for some it proved more of a challenge. Addressing this will be a priority for us in 2018-19.

Areas for development

All agencies have action plans in place to address deficit areas. All agencies have reported on progress against these on page 33. Whilst there was evidence that staff working with adults receive regular supervision and appraisal this is something that we will want to test out further in the future.

Similarly, although assurances were given that staff are aware of both the Safeguarding Adult Review protocol and referral mechanisms, this is not being borne out in the number of referrals received. Again, this is an area of focus for us over the coming months.

11.12. Managing Allegations of People in Positions of Trust

The Care and support statutory guidance advises that the board develop a framework for how allegations against those working with adults with care and support needs should be notified and responded to. Board partners and care providers should have equivalent policies for dealing with such allegations.

Locally, the council's Health and Adult Social Care (HASC) directorate has oversight of positions of trust. This function is provided both by the Professional Standards, Safeguarding, and Quality Monitoring Team, and by Children's Services. Operational advice for practitioners is provided on a case-by-case basis, however specific input and management of individual cases is 'the responsibility of the employer. Information is monitored, collated, and fed back annually to the SAB.

Achievements

- Increased awareness of importance of considering such cases
- Effective communication between local agencies, and across Sussex as necessary
- Multi-agency work supports balance between safeguarding vulnerable adults, data protection, and information governance requirements.

Work in 2017/2018

- Practice guidance has been provided for Local Authority Social Work staff
- The section 42 Safeguarding statutory enquiry tool was amended, enabling frontline staff to check historical information where needed.
- An information safekeeping and sharing protocol for Professional Standards and Safeguarding is in development.

Challenges

Further consideration is needed around cases where people in positions of trust have not been notified that their information will be shared between partners in order to consider safeguarding and risk. Partners should work together to consider this issue further.

11.13. Safeguarding training

The Safeguarding Adults Board Learning & Development Subgroup met 4 times in 17-18. This group is responsible for providing us with assurance that single agency safeguarding training is fit for purpose, as well as facilitating and commissioning any multi-agency training which reflects priorities of the SAB business plan and which complements the training provided by each agency to their own staff.

This year we have asked our partners to provide assurances regarding the following training standards:

- Staff members are trained as appropriate to their roles and responsibilities, including undertaking safeguarding enquiries where required

- Safeguarding adults is integrated into all training and the training needs analysis/plan. This includes Domestic Violence and Abuse, Self-neglect, Modern Slavery and the PREVENT Agenda.

- Safeguarding training is measured to ensure knowledge and competency in recognising abuse and how to raise a concern. This forms part of existing supervision and appraisal systems.

- Safeguarding training is compliant with Sussex Safeguarding Adults Procedures.

- The outcomes of Safeguarding Adult Reviews (SARs) are shared with all to promote learning and sharing of outcomes

Partners were able to evidence compliance against these standards to differing degrees. All partners who identified sup-optimal or deficit areas of compliance have an improvement plan in place. The Quality Assurance & Learning Development Officer has sought routine updates on progress through the year. The Learning & Development Subgroup has been monitoring advancement.

11.14. Safeguarding Conference 2017

At this year's conference we were joined by two keynote speakers:

- Alison Powney from Daybreak presented on *Family Group Conferencing*
- Lynne Phair, Independent Consultant Nurse, spoke passionately about *Showing Care and Compassion in Difficult Situations.*

Participants were also able to attend two workshops to further explore and complement the learning from the presentations.

Workshops included such themes as self-neglect, modern slavery, working with clients with personality disorder and safeguarding and consent.