West Sussex
Safeguarding Adults
Board
Making Safeguarding Personal

Annual Report 2021/22

Contents

Foreword from Annie Callanan, Independent Chair

This is my fifth Annual Report and marks my fourth year as Independent Chair of the West Sussex Safeguarding Adults Board.

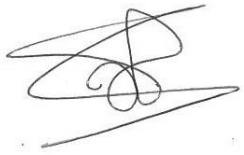
Following the unprecedented challenges as a result of COVID-19 in 2020/21, this last year has been a continued challenge for both the Board and our partner agencies. In the past year we have continued to adapt to new challenges, whist considering the impact of our work on our partner agencies. With the commitment of our Statutory Partners, Board Members, and with the efficient and diligent work of the Board Support Team, these challenges have not prevented the Board in progressing our planned work. All of our Board Meetings and Subgroup meetings have continued as scheduled this year; this has ensured continuation, as far as possible, to the vital work to protect adults at risk of abuse and neglect.

I am pleased to say that by doing this, we have been able to deliver on the vast majority of our objectives as outlined our annual Business Plan, including those which were postponed last year due to the impact of the pandemic pressures across the partnership.

I sincerely thank all our members for making this possible.

Later in this report you will read the key achievements for all of our Subgroups; to highlight but a few: the Safeguarding Adults Review (SAR) Subgroup has focussed on progressing actions resulting from the National SAR Analysis Project, to improve the quality and experience of SARs; in our Learning and Policy Subgroup, we have focussed on the learning from SARs by creating several learning briefings and podcasts on key safeguarding themes; our Quality and Performance Subgroup has focussed on gaining assurance from the pan-Sussex Safeguarding Self-Assessment and case file audits; within our Quality Assurance and Safeguarding Information Subgroup, we have strengthened our use of data to understand and gain assurance of safeguarding activity; and our Multi-Agency Risk Management Subgroup has continued to support high-risk cases.

Through the work progressed by the Board in the past year we are assured that adults with care and support needs in West Sussex are safer as a result. We acknowledge that there is more to do and have plans in place to progress new objectives this coming year.



About the West Sussex Safeguarding Adults Board (WSSAB)

Our Board was established in 2011.

It has a core membership of Statutory Partners from:

- West Sussex County Council (WSCC)
- NHS West Sussex Clinical Commissioning Group (CCG)
- Sussex Police

Membership also incluses a number of other partners.

The purpose of a Safeguarding Aduts Board (SAB) is to safeguard adults with care and support needs by ensuring that:

- Local safeguarding arrangements are in place as defined by the Care Act 2014 and statutory guidance.
- Safeguarding practice is person-centred and outcome-focused.
- Safeguarding practice is continuously improving and enhancing the quality of life of adults in its area.
- Agencies give timely and proportionate responses when abuse or neglect have occurred.
- Agencies are working collaboratively to prevent abuse and neglect where possible.

SABs have three core duties to fulfill statutory requirements:

- Have a Strategic Plan
- Produce an Annual Report
- Carry out Safeguarding Adult Reviews (SARs)

You can find out more about our core duties on our website.

Case study: Our Safeguarding Adults Review for TD

About TD

TD was a 63-year-old man described by his brother as very caring, but that he was also prone to mood swings when not corrected by medication. They grew up together with their parents and grandparents, and his brother recalls that TD had a difficult childhood due to a speech difficulty, which meant that he received unkind comments. His schizophrenia began in his teenage years and subsequently worsened. TD's brother feels that the stress on their parents was a contributory factor in their separation, after which TD continued to live at home with his mother.

Throughout his life, TD had a number of mental health inpatient admissions. During one stay he met his life-long partner. Initially they lived together, however, subsequently they moved into separate accommodation. TD experienced a couple of moves, before becoming a resident in a Nursing Home. TD died in Hospital in November 2019 and, in the eight months prior to his death, there were concerns about abuse and neglect. In preparing for an Inquest into TD's death there were found to be concerns relating to risk management and safeguarding decisions and actions.

Our Review

Our Review identified the learning required to ensure that future risk is minimised to other vulnerable adults. In the spirit of making safeguarding personal, TD's brother provided information about TD and a perspective on the care received from agencies. The Review considered key areas, and within several of these, TD's brother provided views; these are shared below:

How effective was needs and risk assessment, and communication?

TD's brother considers that the Nursing Home was 'not geared up' to meet his complex needs and that TD developed pressure ulcers because there was a delay in providing a pressure relieving mattress. He also feels that hospital discharge was rushed, that 'systems let him down', and that agencies could have communicated more effectively.

How effectively was mental capacity and the person's voice addressed?

TD wished to move to Berkshire and, whilst his brother acknowledges that the funding authority were finding it difficult to find a suitable placement, he feels that this was an unmet need, and that transfer would have made visiting easier. He believes that this should

have been more proactively followed up. He was aware and in agreement for medication being administered covertly at times as he felt it was necessary for TD's needs and risks to be addressed.

How effective were Safeguarding Adults responses in reducing the risk of abuse and neglect?

TD's brother states that TD's partner had been raising concerns about physical abuse of TD by staff at the Nursing Home. TD's brother would discuss these concerns directly with the Nursing Home but, in view of TD and his partner's mental health conditions, he did not and still does not believe that his brother was physically abused or neglected.

Outcome of Review

Recommendations for our Board were made considering the views of TD's brother, alongside information provided by agencies.

TD's brother considered that the following recommendations were appropriate measures to reduce the risk of similar circumstances arising in future:

- A multi-agency risk management meeting, leading to a co-ordinated response, 'could have helped'; particularly as transfer was not sufficiently prioritised.
- Increased prioritisation of TD's wishes in respect to transfer would have been beneficial, as he does not consider that the Nursing Home was appropriate to meet his needs.
- TD's brother is not concerned about the decision-making regarding covert medication and, having Lasting Power of Attorney for health and welfare and finances, he was aware of and supportive of this practice when necessary. He was not aware of a Mental Capacity Assessment having been undertaken at any time.
- He was not aware of any Safeguarding Adults considerations and agrees that this may have been a potential vehicle to a more effective care management response.
- TD's brother considers that improved communication between agencies would be beneficial in meeting the needs of people in future.

As a result of discussions with TD's brother and involved agencies, recommendations were made under five key areas, noted below. These are being taken forward in a multi-agency action plan to ensure learning and future risk is minimised.

1. Planned and completed actions
2. Multi-agency risk management
3. Safeguarding Adults thresholds and enquiries
4. Mental Capacity Act training and recording
5. Service user voice

The Safeguarding Adults Desktop Review in respect of TD was published in March 2022 alongside a learning briefing and podcast to help promote and support learning.

Our three Board Priorities for 2021/22

We took forward a range of actions, via our Subgroup workplans, to deliver on our three priorities. These were:

Collaborative working focussing on:

- Information sharing
- Monitoring of safeguarding concerns
- Safeguarding pathways

Learning and embedding practice focussing on:

- Risk assessment
- Professional curiosity
- Understanding of differences between quality and safeguarding
- Understanding of safeguarding policy and procedure

Assurance and engagement focussing on:

- Compliance with safeguarding policy and procedure
- Person-centred approaches
- Consideration of protected characteristics
- Engaging with the private and voluntary care sector and families/representatives
- Multi-agency auditing

Our Subgroups and achievements

Our Subgroups deliver on the work of the Board in order to meet the Board's Annual Business Plan and Board priorities.

We have six Subgroups, which are comprised of five working subgroups and one decision-making Chairs Subgroup. The Terms of Reference (ToR) for each of our subgroups can be found on our website.

Safeguarding Adults Review (SAR) Subgroup

- Meets monthly and is chaired by our Board representative from Sussex Community NHS Foundation Trust (SCFT).
- Considers SAR referrals and the process thereafter.
- Attended by a core group of Statutory Partners, Sussex Partnership NHS Foundation Trust (SPFT) and SCFT.

SAR Subgroup achievements this year

- Progression of six Reviews and consideration of 10 new referrals, of which three met the criteria for a SAR and Reviews were commissioned (further details can be found in the SAR section of this report).
- Monitoring of themes of Reviews/Referrals to consider prominent themes and feeding these back to our Quality and Performance Subgroup, to seek assurance that learning is taken forward.
- Progressed actions resulting from the National SAR Analysis Project.
- Further focus on composition of Review panels to ensure appropriate participation, including from the private and voluntary sector.
- Produced guidance for SAR panel members and Reviewers, to ensure clear understanding of role and expectations.
- Revised and agreed Subgroup ToR.
- Produced a SAR Subgroup Members Pack which includes ToR, SAR criteria, assurance process, SAR methodologies, and expectations of Reviewers to ensure that this information is clear and easily accessible.
- Revised Review and publications processes.
- Sought and considered feedback from professionals alongside the feedback from individuals/families involved in Reviews to help improve Reviews processes.

Quality and Performance Subgroup

- Meets quarterly, chaired by a Sussex Police representative.
- Has oversight of, and response to, Board assurance such as multi-agency audits and analysis, and response to safeguarding data.
- Attended by Statutory Partners and senior leads across the partnership.

Quality and Performance Subgroup achievements this year

- Arranged, held, and followed up actions resulting from the bi-annual pan-Sussex Safeguarding Self-Assessment process.
- Developed a tool and process, and undertook, case file audits in relation to; transition and safeguarding and began the process of a self-neglect and safeguarding case file audit.
- Further use of data to identify possible health and social care inequalities.

Learning and Policy Subgroup

- Meets quarterly, chaired by a representative from the CCG.
- Responds to learning from SARs and audits and develops policies and procedures.
- Attended by Statutory Partners and senior leads across the partnership.

Learning and Policy achievements this year

- Confirmation of all partners agreement to the Information Sharing Protocol.
- Contacted providers who report usually high or low number of safeguarding concerns to analyse data and identify possible gaps in knowledge/training and address these.
- Created and published learning briefings and podcasts regarding: What is Safeguarding, Making Safeguarding Personal, Professional Curiosity, Safeguarding Young People Age 17.5+, Self-Neglect, Risk Assessment, and Person-Centred Approaches.
- Created and published learning briefings and podcasts for the six Reviews published this year.
- Undertook a professional survey to seek awareness and understanding of the WSSAB, learning briefings, and podcasts; feedback from this will be taken forward in 2022/23.
- Contributed to development of WSSAB Transitions and Safeguarding Protocol.
- Developed a Safeguarding Young People section in the WSSAB new safeguarding leaflet.
- Continued to promote new resources via our newsletters including features on Professional Curiosity and Self-Neglect.
- Contributed to the review of sections of the Pan-Sussex Policies and Procedures.
- Contributed to the development of a Pan-Sussex Escalation and Resolution Protocol.

Quality Assurance and Safeguarding Information Group (QASIG)

- Meets monthly, co-chaired by a representative from WSCC and the CCG.
- Responds to known risk and takes preventative actions regarding potential and emerging risk in the provider market.
- Attended by Statutory Partners and senior leads across the partnership.

QASIG achievements this year

- Responding to safeguarding and quality concerns promptly by sharing information, including soft intelligence, between participating agencies.
- Maintaining oversight of care homes with high and low reports of safeguarding and offering support to those providers.
- Escalating concerns to Strategic Provider Concerns Framework.
- Cross-checking data between agencies and information sharing.

Multi-Agency Risk Management Subgroup (MARM)

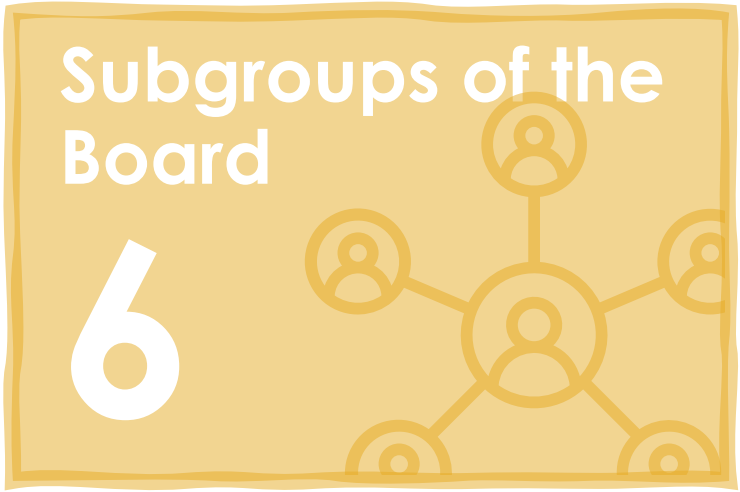
- Meets monthly and is chaired by a representative from WSCC.
- Ensures comprehensive multi-agency communication and information sharing to support agencies in managing the most complex and challenging cases.

MARM achievements this year

- Contributed to the creation of WSCC's Complex Case Review Panel.
- Encouraged collaborative and effective partnership working.
- Raised awareness of other services/routes of support for professionals to access.

Chairs Subgroup

- Meets prior to each Board meeting and is chaired by our Independent Chair.
- Is a decision-making forum which shares progression of Subgroup work plans and enables effective workflow between Subgroups.
- Is attended by Subgroup Chairs and Statutory Partners.

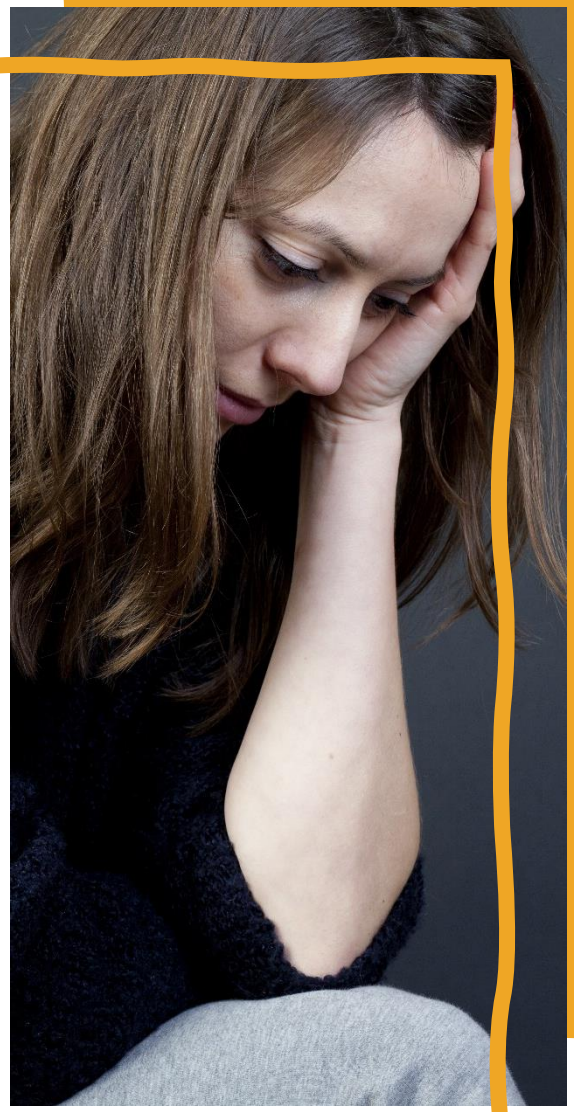


Additional Board achievements

This year we have been able to produce and widely promote new resources to help the residents of West Sussex to understand what safeguarding is and how to report safeguarding concerns. These resources are:

- New safeguarding leaflet and easy read leaflet created with the support of local people with learning disabilities.
- New posters with quotes from adults who have received Safeguarding support.
- New safeguarding resource pack which includes a Safeguarding PowerPoint Presentation for community groups and agencies to use.
- Promotional flyers to highlight key safeguarding messages to partnership staff.

All of these resources can be found on our website.



What we did to improve Safeguarding

Our Board looks to continuously improve safeguarding for the residents of West Sussex. We do this in a variety of ways. In 2021/22, we have achieved the following:

Quarterly Partnership pressures and risks reporting

Every Board meeting, we report on what pressures and risks may exist across the Partnership to make sure that all agencies are aware of any impact to services and consider how we may be able to support to mitigate against these risks. By doing this we are able to understand, know, and respond to issues which may affect safeguarding. This has been particularly important during the pandemic given increased demands on services.

Presentations to Board

To have assurance of safeguarding activity across the partnership, we invite speakers to our Board meetings to share information on specific service areas and projects. Last year, areas covered were: The National SAR Analysis Project; Domestic Homicide Reviews; Learning from Lives and Deaths – People with a Learning Disability and Autistic People (LeDeR); Report on Safeguarding by South East Coast Ambulance Service (SECAmb); our Collaborative Working Agreement; Report on Violence and Exploitation Reduction; Suicide Prevention; Bridging Hotels and Violence Against Women and Girls.

Safeguarding Adult Review (SAR) themes

We have been monitoring the themes from our SAR referrals and Reviews, on a quarterly basis. We do this to identify any reoccurring themes so that we can promote learning by raising awareness of the resources we have to help improve practice (e.g., learning briefings, podcasts, and flyers).

SAR action planning

Last year we improved our process to make sure that learning was taken forward from our Reviews. This now involves agencies meeting to agree how they will individually and collectively improve safeguarding practice within set timescales. These meetings have been productive in ensuring multi-agency ownership and accountability for the changes that are needed to reduce safeguarding risk.

Pan Sussex Self-Assessment and Challenge Events

Our bi-annual safeguarding self-assessment process identified where our agencies are in terms of their maturity in safeguarding practice, and the challenge events that followed helped agencies reflect and reconsider their self-assessment and what actions are needed to improve safeguarding in different areas such as safeguarding challenges; making safeguarding personal; leadership, governance, and accountability, and learning and organisational development. This has been an important assurance process for our Board to understand safeguarding activity in West Sussex and the actions that will be taken forward to improve it.

Multi-agency case file audit for Transition and Safeguarding

This audit followed our multi-agency challenge meeting on transition and Safeguarding in 2020. The audit for safeguarding cases for people age 17½ to 25 helped us understand key themes and areas for development including making safeguarding personal; case recording; decision-making; professional curiosity; multi-agency working and managing ongoing risk. The majority of actions from the audit recommendations to improve practice in these areas have now been achieved.

Multi-agency case file audit for Self-Neglect and Safeguarding

This audit process was started this year and continues into 2022/23. It aims to evaluate and reflect on practice; learn from experience; inform multi-agency practice development; and strengthen multi-agency working. We will be taking forwards the actions identified to improve self-neglect practice next year.

Safeguarding reporting by care providers

Information on care providers who report a high or low level of safeguarding concerns has been collated and assessed every quarter to identify where there may be a knowledge gap or training need. It has involved questionnaire contact with care providers to gain assurance of safeguarding activity/inactivity and has also been an opportunity to provide additional advice and support.

Safeguarding Adult Reviews (SARs)

SARs are a legal duty under the Care Act 2014.

Purpose of a SAR

The purpose of a SAR is to determine what agencies involved with an individual might have done differently that could have prevented harm or death.

It is not an investigation, and it is not to apportion blame. Instead, it is to learn from situations, and to ensure that any multi-agency learning is applied to future cases to prevent similar harm occurring again.

SAR criteria

- An adult has died (including death by suicide), and abuse or neglect is known or suspected to be a factor in their death; or
- An adult has experienced serious abuse or neglect which has resulted in permanent harm, reduced capacity, or quality of life (whether because of physical or psychological effects), or the individual would have been likely to have died but for an intervention; and
- There is concern that partner agencies could have worked more effectively to protect the adult.

SAR Referrals and Reviews in 2021/22

In 2021/22 we published six Reviews with accompanying learning briefings and podcasts, which can be accessed on our website. Three of the Review referrals were received prior to April 2020 and resulted in a Thematic SAR for three adults, a SAR in relation to Jean Willis, and an Organisational Learning Review for a Residential Service.

In 2021/22 a further six referrals met the criteria for a Review. Three of these were taken forward as a SAR and will be published in 2022/23, and three have been published this year. Two of the published Reviews were Desktop Reviews for TD and BK, and one was a Review in Rapid Time.

There were also seven referrals received which did not proceed to a SAR, for the following reasons:

- No abuse or neglect was identified in two cases.
- No multi-agency learning was identified in two cases.
- Referred prematurely in two cases.
- Referred to WSSAB in error.

Demographics

Of the six Reviews published in 2020/21, five were for older adults and one for an older adult with a mental health diagnosis. There were two Reviews carried out for provider services for older adults (male and female residents) and the Thematic Review was with respect to one female and two males. For the Reviews carried out for just one individual, all were White British, one was female, and two were males. All six referrals were made by West Sussex County Council Adult Social Care and were all regarding concerns about neglect or acts of omission.

Learning and themes from Reviews

The six Reviews published in 2020/21 identified key themes and areas of learning for the WSSAB to take forward. In summary these are:

- Person-centred practice and Making Safeguarding Personal.
- Proactive measures to improve health outcomes, care co-ordination, and assessments under statutory frameworks.
- Adherence to Policies and Procedures including Safeguarding Policy; Self-Neglect Procedure; and the Mental Capacity Act.
- Identifying and managing decision-making regarding risks.
- Professional Curiosity.
- Ambiguous, inconsistent, and inaccurate information was not clarified.
- Impact of resources, operational pressures, and the national context.
- Multi-agency working, approaches and information-sharing.
- Management of quality concerns.
- Processes for obtaining information and for making decisions.

The following are specifically related to a care home:

- Poor care and lack of responsiveness to care needs.
- Lack of robust internal oversight.
- Inadequate staffing levels and concerns with staff morale.
- Lack of reporting of safeguarding and quality concerns.
- Residents' family members appear to have been unaware of concerns.
- Staff management and supervision.

Recommendations from all published Reviews have led to multi-agency action plans to take forward learning.

Data

WSCC is the lead for safeguarding and records all safeguarding data. Concerns about abuse and neglect are reported using an online form and triaged by WSCC's Safeguarding Hub. The following data provides an overview of safeguarding activity and the demographics of those safeguarded in West Sussex.

The figures provided within this report relate to the first submission for NHS Digital and may be subject to change post-further analysis.

Safeguarding concerns received and Enquiries undertaken

This year, 2021/2022, there were 2,083 safeguarding concerns initiated. The number of concerns initiated each month ranged between 141 to 214. Of the concerns initiated, 1,337 met the criteria and proceeded to a Section 42 Enquiry. There were 5 concerns which did not meet the criteria, however, did proceed to enquiry. An example of a reason for this could be due to an identified risk to others.

Types of abuse people experienced

It is important to note with this data that one individual may have experienced more than one type of abuse, therefore, multiple abuse types may be entered for one individual.

This year, of the concluded enquiries, concerns regarding neglect and acts of omission accounted for 542 individuals; financial abuse for 178 individuals; and physical abuse for 154 individuals. Together, these three categories total 857 individuals or 79.42% of all concluded safeguarding enquiries. These have remained the top three categories for the last four years, which is consistent with the national picture.

Neglect and acts of omission have been the most reported form of abuse over the past four years.

Primary support needs of those safeguarded

Of the concerns received where the Section 42 criteria were met, those with physical support needs were the most likely to require an enquiry. This accounted for 475 individuals or 40.70%. The next category is those whose who had no recorded support reason, this accounted for 306 individuals or 26.22%.

Gender, age, and ethnicity of those safeguarded

Of the enquiries undertaken in 2021/22, 691 (59.21%) were for women and 463 (39.67%) were for men. There were 13 (1.11%) enquiries undertaken where an individual's gender was not documented.

As with last year, the majority of adults involved in a enquiry were over 65 years old, which accounts for a total of 738 individuals (63.23%) The highest proportion of this figure was for those aged 85-94 years old, which accounts for 310 individuals (26.56%).

In 2021/22 the vast majority enquiries were for adults who identified as White, totalling 935 individuals (80.11%) The data reflects the overall proportion of people's ethnicities in West Sussex and is consistent with last year. Enquiries completed for all other ethnicity categories did not individually account for more than 14 individuals (1.19%). There was 183 (15.68%) of enquiries where an individual's ethnicity was unknown, and this was either due to this information not yet being obtained, or because of the individual declined to provide this information.

Location of abuse

This year, for completed enquiries, abuse in Residential and Nursing Homes accounted for 428 individuals (40.30%) and 381 (35.87%) individuals living in their own home. Therefore, the most likely location to experience abuse remains Residential and Nursing Homes. Although West Sussex remains an outlier for this, as nationally most abuse happens for those living in their own home, the gap has reduced.

Making Safeguarding Personal

As part of a Section 42 Enquiry, people are asked for their desired outcomes. In total 655 (58.42%) individuals expressed desired outcomes. Of the concluded enquiries this year, 350 (53.43%) individuals had these fully achieved and, 315 (48.09%) individuals had these partially achieved.

How safeguarding changed risk

For the enquires concluded last year there were 554 (63.75%) individuals where action was taken to reduce risk. There were 244 (25.77%) individuals where the risk was removed, and 71 (8.17%) individuals where actions were taken, and the risk remained, this would include adults who have capacity and choose to live with risk.

Deprivation of Liberty Safeguards (DoLS)

The Deprivation of Liberty Safeguards (DoLS) is part of the Mental Capacity Act and is a legal measure to protect people who lack capacity to make decisions about their care and treatment. DoLS has been scheduled to be replaced by the Liberty Protection Safeguards (LPS). However, further government guidance on the timescale for implementation is awaited. LPS will create a difference in administration and practice, but the focus remains on continuing to ensure vulnerable people's care and treatment is in their best interests.

Referrals received and the outcomes

In 2021/22 there were a total number of 6,928 DoLS referrals being progressed. From the 6,928 referrals, there were a total of 5,373 DoLS assessments completed in 2021/22. Of these assessments, 2,611 were granted and 2,762 were not granted. There are a total of 1,555 assessments in progress.

Where referrals came from

The majority of DoLS referrals were made by for individuals who live in West Sussex accounting for 4,837 referrals. There was a total of 2,091 referrals for individuals who live outside of West Sussex.

Gender and ethnicity

The majority of granted referrals were for females, accounting for 1,773 out of a total of 2,611. This is consistent with the national picture as women tend to live longer. The majority of granted referrals were for White people, accounting for 2,385 which, reflects WSCC's demographic.

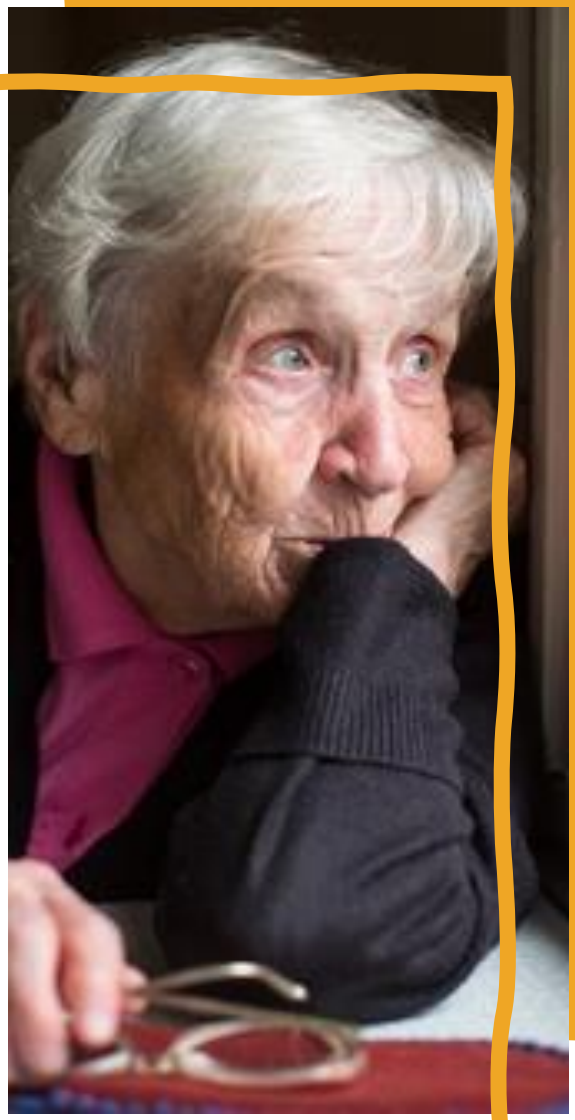
Primary support reason for granted referrals

For granted referrals individuals were most likely to have had Dementia recorded as their primary support need. This accounted for 785 out of a total of 2,611 grated referrals. The second highest category was other mental heath needs accounting for 169 individuals.

Compliments and complaints

In 2021/22 the Safeguarding Adults Board have received no complaints. A copy of our Complaints Process can be found on our website.

In 2021/22, we received two compliments, one regarding how the WSSAB share published Reviews and accompanying learning resources, and one regarding our podcasts to say that they were of good content and the right length to support learning.



Our priorities for 2022/23

Based on data, audit outcomes, and learning from SARs, our Board has decided on three priorities to focus on this year. These are:

- Safeguarding complex cases
- Safeguarding older people
- Communications and promotions for community engagement

Our annual Business Plan details how we will deliver on these three areas and includes a range of actions to understand and respond better to safeguarding both complex cases and older people, and how we will communicate and promote safeguarding messages to the public and West Sussex agencies.

Report a concern

If you or someone you know with care and support needs are being harmed, neglected, or exploited, or are at risk of this, you can report concerns to WSCC.

If you think the danger is immediate, phone the emergency services on 999.

Otherwise, please:

- complete an online adult safeguarding concern
- Contact WSCC Adults' CarePoint on 01243 642121
- Use NGT Text Relay for people with hearing loss (available as a downloadable App for tablets and smartphones): 018001 01243 642121
- Write to Adults' CarePoint at Adults' CarePoint, Second Floor, The Grange, County Hall, Chichester, PO19 1RG
- Phone Sussex Police on 101

Contact us

If you would like to find out more about this report, or the work of the Safeguarding Adults Board:

Visit: www.westsussexsab.org.uk

Email: safeguardingadultsboard@westsussex.gov.uk

Phone: 03302 227952

If you would like to access West Sussex County Council's safeguarding training programme or would like more information on safeguarding training in general, please visit the West Sussex Learning and Development Gateway

Visit www.westsussexsab.org.uk