West Sussex
Safeguarding Adults
Board
Making Safeguarding Personal

Annual Report

2022/23

Contents

Foreword

In my fifth year as Independent Chair and this being my sixth Annual Report, I am pleased to share that this is one of our most productive years to date.

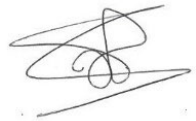
The report reflects real progress on our priorities for 2022/23: safeguarding older people, safeguarding those with complex needs, and communications and promotions for community engagement. We have also finalised work which was deferred from 2021/22 as a result of the impact of the pandemic pressures across the partnership.

With continued high levels of commitment, and the benefit of expertise from our Board members, along with the diligent and efficient work of the Board Support Team, we have been able to deliver on the majority of our Annual Business Plan objectives. I am sincerely thankful for this and am also delighted to have welcomed our second Lay Person.

In this report you will read of our key achievements. To highlight a few, the Safeguarding Adults Review (SAR) subgroup has progressed a number of Safeguarding Adult Reviews (SARs) with an increased involvement of families and carers and ensured resulting action plans are delivered on. Our Quality and Performance subgroup has gained assurance from audits and given us valuable insights into safeguarding in West Sussex and the steps needed to take forward learning from these. Our Learning and Policy subgroup has concentrated on making sure learning from audits and SARs are promoted by creating a range of learning tools including podcasts, recorded presentations and learning briefings**.** Within our Quality Assurance and Safeguarding Information subgroup, we have effectively continued the multi-agency work to anticipate and reduce safeguarding risk in provider services. Our Multi-Agency Risk Management subgroup has continued to support and find solutions for high-risk and complex cases. We have also continued to monitor any arising safeguarding risks, across the partnership, as a result of the cost-of-living-crisis.

Whist we have been committed to progress work to make adults safer, we acknowledge that there is more to do. We already have plans in place to progress new objectives this coming year and I have no doubt that next year will be equally industrious.

Annie Callanan, Independent Chair



About us

Our Board was established in 2011. It has a core membership of Statutory Partners from:

- West Sussex County Council (WSCC)
- Integrated Care Board (ICB)
- Sussex Police

Membership also includes a range of other members.

The purpose of a Safeguarding Adults 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 fulfil statutory requirements:

- Have a Strategic Plan
- Produce an Annual Report
- Carry out SARs

Case study

In 1998 Mr. M achieved his ambition to become a Commercial Airline Pilot, and just three days later, Mr. M and his wife celebrated the birth of their first child, a son. Sadly, the following year, in 1999, their baby son died. Following the death of their son, Mr. M could not face the pressured environment of commercial flying, and he began to drink alcohol as a way to hide from the world. Over time, Mr. M's drinking impacted both his marriage, and his relationship with his three daughters, and he moved out of the family home. Once living alone, he began to notice periods of collapse which appeared unrelated to his alcohol use.

Safeguarding referrals and the involvement of the West Sussex Fire and Rescue Service

Over a period of seven months, eight safeguarding referrals were received by West Sussex County Council (WSCC) Adult Social Care in relation to Mr. M. The themes of these referrals included falls, self-neglect, cuckooing, and fire risks. It was at this point that the West Sussex Fire and Rescue Service visited Mr. M at home to investigate the cause of a historic fire, and to provide fire prevention advice. The visit included the replacement of heat and smoke detectors at Mr. M's home.

Unfortunately, two calls to the Fire Service followed due to cooking-related fires, resulting in the Fire Service reporting grave concerns around fire risk.

Multi-agency response

In addition to concerns around the fire risk at his home, there were concerns regarding the general condition of his property, and injuries related to falls, which included five broken ribs and third-degree burns. In line with the Pan Sussex Self-Neglect processes, this necessitated a multi-agency response to provide support to Mr. M. Advice and support was provided by a wide variety of agencies, including Community Nurses, Housing, South East Coast Ambulance Service, Sussex Police, alcohol and substance misuse services, and mental health services.

During one admission to hospital, Mr. M was visited on a number of occasions by a Turning Tides support worker who provided, in Mr. M's words, "a true arm around the shoulder." Mr. M credits this support as giving him the strength to make a change in his life.

Outcomes and learning

Following his discharge from hospital, Mr. M began to focus on his sobriety, his new home, improving his family relationships, finding an understanding GP, engaging in meaningful activity in the community, and caring for his cat, BB. These outcomes continue to be his focus to this day, and in his efforts to involve himself meaningfully within his community, Mr. M is now a Lay Member of this Board, offering the invaluable perspective of a service user.

Key learning from Mr. M's experience and involvement with Health and Social Care services include:

- The importance of not making assumptions: Mr. M had been presumed drunk when experiencing falls, but a CT scan identified a brain injury.
- The importance of prevention services: The first intervention from the West Sussex Fire and Rescue Service was not until after the first fire incident. This highlights the need for better fire risk awareness, and the value of Safe and Well Visits, undertaken by the Service.
- The need for persistence by services: Mr. M was a very capable man, who was unable to recognise the severity of his situation due to his drinking behaviours. It was imperative that services left the door open to him, so that he felt able to access support when he was ready to accept it.

Our priorities for 2022/23

Based on data, audit outcomes, and learning from SARs, our Board decided on three priorities to focus on this year. We took forward a range of actions to deliver on these priorities via our subgroup workplans. Actions included workstreams to better understand and respond to safeguarding both complex cases and older people, and how we communicate and promote safeguarding messages to the public and West Sussex agencies. These actions included the following:

Safeguarding those with complex needs

Carried out a staff survey to consider issues, barriers, and positive factors relating to complex cases.

Undertook a case file audit of referrals to the Multi-Agency Risk Management (MARM) subgroup.

Focussed our Board case studies on complex cases, enabling service users to share their experiences.

1

Safeguarding older people

Began the process of carrying out a staff survey to consider issues, barriers, and positive factors relating to safeguarding older people.

Began a case file audit of safeguarding relating to older people.

Where a review of themes from SARs identified similar themes in relation to older people, we re-promoted relevant learning resources with agencies in West Sussex.

2

Communications and promotions for community engagement

An Engagement Task and Finish Group reviewed the promotional resources available and agreed the scope of new resources.

We led on work with East Sussex and Brighton & Hove SABs to develop a suite of new promotional resources and launched these during Safeguarding Adults Awareness Week in November 2022.

3

Our subgroups and key 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.

Safeguarding Adults Review (SAR) subgroup

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

SAR subgroup achievements this year

- Progression of six Reviews and consideration of nine new referrals, of which four met the criteria for a SAR leading to Reviews being 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.
- Reviewed specific themes and areas of development of SARs for complex cases and older people to identify practice development areas for agencies and inform targeted communications and promotion.
- Reviewed data and themes from SARs across the South East region to consider the context of our learning.
- Promoted learning from SARs in other neighbouring/wider areas which have similar or reoccurring themes for our Board.
- Re-promoted criteria information for referrers.
- Sought and considered feedback from professionals alongside the feedback from individuals/families involved in Reviews to help improve Review 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

- Dissemination of learning from our 2021/22 case file audit in relation to transition and safeguarding.
- Undertook case file audits in relation to self-neglect and safeguarding complex cases, including the development of action plans and dissemination of learning. We also began the process for undertaking a case file audit in relation to safeguarding older people; this workstream will be carried over to 2022/23.
- Carried out a staff survey to access feedback on issues, barriers, and positive factors of safeguarding complex cases and began a second survey in relation safeguarding older people.
- Analysed data in relation to older adults to identify what actions are required to improve safeguarding for older adults.
- Used data and audit outcomes to support targeted areas for promotion of learning.
- Completed actions resulting from the bi-annual pan-Sussex Safeguarding Self-Assessment process started in 2021/22.
- Created and trialled a new method of seeking assurance for the embedding of learning from SARs.

Learning and Policy subgroup

- Meets quarterly, chaired by a representative from the Integrated Care Board (ICB).
- 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 subgroup achievements this year

- Created and published learning briefings and podcasts regarding safeguarding early warning signs and multi-agency working and communication. Also agreed learning briefings in relation to the difference between quality and safeguarding and safeguarding policy and procedure, which will be published early in 2023/24.
- Created a short, recorded presentation about the Board, which has now been developed into an online training resource.
- Disseminated learning from transition and self-neglect audits via learning briefings and podcasts. Learning from the complex case file and older people case file audits will be disseminated in 2023/24.
- Re-promoted our learning resources where Quality and Performance audits identified reoccurring themes.
- Created and published learning briefings and podcasts for the three Reviews published this year.
- Contacted providers who report unusually high or low number of safeguarding concerns to analyse data and identify possible gaps in knowledge/training and address these.

Quality Assurance and Safeguarding Information Group (QASIG)

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

QASIG achievements this year

- Responded to safeguarding and quality concerns promptly by sharing information, including soft intelligence from partnership attendees.
- Maintained oversight of care homes with high and low reports of safeguarding and offered support to those providers where required.
- Escalated concerns to the Strategic Provider Concerns Framework.
- Cross-checked data between agencies.
- The Care Quality Commission (CQC) ratings for care homes for West Sussex have improved over the past year. Partnership working in QASIG could have contributed to this.

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 high risk, complex and challenging cases.

MARM subgroup achievements this year

- 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.
- A decision-making forum which shares progression of subgroup work plans and enables effective workflow between subgroups.
- Agrees the agenda for Board meetings.
- Attended by subgroup Chairs and Statutory Partners.

Additional Board achievements

This year we have worked with our colleagues in East Sussex and Brighton & Hove to create a suite of resources for use by professionals, community groups and organisations, and members of the public including:

- New posters designed to raise awareness of adult safeguarding and to signpost people to the relevant local authority to report concerns.
- New poster designed to explain what a SAB is, what we do, and where to find out more information our local SABs.
- New safeguarding leaflet which includes information about who might need safeguarding, as well as definitions of 'care and support needs', 'mental capacity', and the types of abuse and neglect someone might experience. The leaflet also explains how to refer concerns about adult abuse and neglect to the relevant local authority, and brief information about what might happen after a concern is raised.
- A 12-minute recorded presentation that shares four shared themes from recent SARs undertaken across Sussex, as well as some of the actions that have been undertaken in response.

We have also worked together with the Safeguarding Children Partnership and the Community Safety and Wellbeing Team to produce a recorded presentation on the shared learning from SARs, Child Safeguarding Practice Reviews, and Domestic Homicide Reviews.

In addition to this joint work, we have also published:

- Our 'Tricky Friends' short animation, which explains what a good friendship looks like, when friendships might be harmful, and how you can access support if your friendships are making you sad. The animation is just 3.5 minutes long and is designed to be used by anybody.
- A recorded animated presentation about our SAB which has been developed into an online training resource available on the WSCC Learning and Development Gateway
- In 2022 we have also started to publish our newsletters, sharing the headlines from our Board and promoting learning required from our SARs and audits, new policies, procedures, and guidance.
- Created our first easy-read Annual Report for 2021/22, to improve the accessibility of this document.

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 2022/23, we have achieved the following:

Quarterly Partnership risk report

Our risk report at SAB meetings is based on any risks escalated by subgroup Chairs, and any risks identified by the Board. Risks are defined as those relating to safeguarding which the SAB need to be sighted on or act on. The Board will then consider together these risks 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. From this work, the SAB will consider entry of a risk to the SAB's risk register which is reviewed at each SAB meeting.

A lead person is identified who updates the SAB on actions taken to mitigate risk, as well as when the risk can be closed. The report will also include safeguarding data by way of context for safeguarding activity. By doing this, we are able to understand, know, and respond to issues which may affect safeguarding. This year the impact of the cost-of-living crisis has featured permanently on our risk register.

Safeguarding case study presentations at Board

At SAB meetings, a member from the Partnership attends, with an adult with care and support needs, where possible, for us to understand safeguarding experiences to make meaningful improvements. Case studies this year were from: West Sussex County Council, West Sussex Fire and Rescue Service, Turning Tides and Age UK.

Presentations to Board

Speakers attend to provide assurance on safeguarding activity. This year, areas covered were:

- Fire risk and multi-agency working
- Changes from the Clinical Commissioning Group to the ICB
- Digital safety and online harm
- Police Harmful Practices Strategy, domestic abuse data/performance and Adult Death Protocol updates
- Trading Standards and safeguarding
- Mental health and safeguarding
- Learning from Lives and Deaths: People with a Learning Disability and autistic people (LeDeR) Annual Report
- Community Safety updates
- Public Health updates

SAR themes

We have continued to monitor 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. In addition to this, this year we have also considered themes from SARs across the South East region to consider the context of our learning.

Pan Sussex self-assessment and challenge events

This year we concluded our bi-annual safeguarding self-assessment process, which identified where Board agencies were in terms safeguarding practice in different areas such as safeguarding challenges; making safeguarding personal; leadership, governance and accountability, and learning and organisational development. Challenge meetings followed this process and provided an opportunity for agencies to explain their self-assessments and be challenged on their ratings. We will be undertaking this process again in 2023/24 and will be focussing on areas of learning identified from this self-assessment alongside learning from audits undertaken this year.

Multi-agency case file audits on: transition and safeguarding, self-neglect, safeguarding complex cases and safeguarding older people

This year our Quality and Performance subgroup has concluded the transition and safeguarding audit and the self-neglect audit which began in 2020/21, via the agreement of and signing off of action plans to take forward learning. We have also taken forward two new audits this year relating to safeguarding complex cases which has been concluded and safeguarding older people which is in progress. Through these audits we have been able to identify meaningful learning, agree actions required to make improvements, and share this learning across services through learning briefings and podcasts.

Safeguarding reporting by care providers

Data 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 requirement. It has involved questionnaire contact with care providers and, where required, telephone contact, to gain assurance of safeguarding activity/inactivity. This has been a great opportunity to provide additional advice and support.

Safeguarding Adult Reviews (SARs)

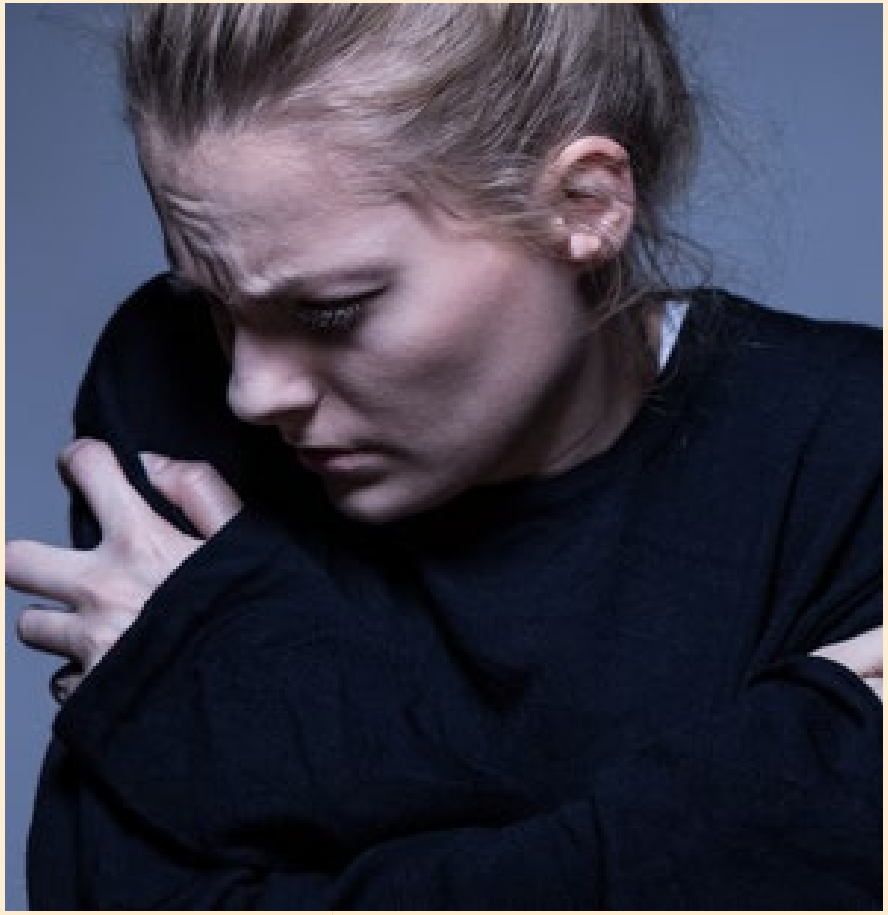
The purpose of a SAR is to determine whether the agencies involved with an adult could have acted differently to prevent harm or death.

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 the reduce risk of similar harm reoccurring.

SAR criteria from the Care Act 2014

A SAR should always be considered if:

- an adult has died, and the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died); or
- an adult has experienced serious abuse or neglect which has resulted in permanent harm, reduced capacity, or quality of life (whether or not it knew 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 2022/23 we published three Reviews with accompanying learning briefings and podcasts. Two of the Review referrals were received prior to April 2021 and resulted in a SAR in respect of Robert and a SAR in respect of MT.

In 2022/23 we received a further four referrals which met the criteria for a Review. One has been published this year. This was a Learning Together Review in relation to Beverley Smith. The further three SARs will be taken forward and published in 2023/24.

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

- Abuse and neglect not suspected to be a factor in the death of the two adults and good evidence of multi-agency working.
- Two referrals related to a national resource issue of available mental health beds and is being escalated via our Independent Chair.
- One referral was sent to the West Sussex Safeguarding Adults Board in error.

Demographics

Of the three reviews published in 2022/23, all were for older adults, one adult had a learning disability, and two had physical support needs. All adults were White British, two were female, and one was male. All three referrals were made by WSCC Adult Social Care and were all regarding concerns about neglect or acts of omission. There was also a theme of self-neglect for one adult.

Learning themes from our three published Reviews

SAR Robert

Robert was a 61- year-old man. He was registered blind, mostly non-verbal, had moderate/severe learning disability, and a diagnosis of schizophrenia. Robert lived in a care home for over ten years. In his last few years, he was subject to a number of safeguarding concerns. After a move to a new care home, he was soon admitted to hospital where he sadly died. The cause of Robert's death was inanition, which is an exhausted state due to prolonged under-nutrition or starvation, and a right fractured neck of femur.

Following Robert's death, a Learning Disabilities Mortality Review identified the need for improved coordination of care and providing holistic support.

Our Review found that we need to improve:

- Health oversight and coordination
- Person-centred planning
- Safeguarding responses
- Staff skills and knowledge

SAR MT

MT was an 83-year-old woman who is described by her daughter as a mother who stayed strong in the face of challenges. MT's neighbours also held her in high regard and described her as a very proud and independent person, and as a kind and lovely lady. MT's GP raised a safeguarding concern due to hoarding and infestation of mice in her home. Following intervention there was an improvement, however, the infestation remained.

A further safeguarding concern was raised by a friend, due to a marked deterioration in her health and her home circumstances. Sadly, MT was found deceased in her home having collapsed or fallen.

Our Review found that we need to improve:

- Safeguarding Adults practice
- Multi-agency needs assessment and risk management
- Mental Capacity Act and making sure the Adult's and their family's voices are heard

SAR in respect of Beverley

Beverley was a 67-year-old lady and a much-loved Mother, Grandmother, Great Grandmother, Sister, Aunty, and friend. She was described by her daughter as a very proud and independent person, and the "matriarch" of a very large family. Beverley's family and friends have contributed significantly to this Review, supporting a making safeguarding personal approach. The family encourage practitioners to "reflect and strive to remember that within their individual roles, the most important person of a multidisciplinary team, is the person themselves."

Beverley died in Worthing hospital in March 2022. Before admission to hospital, she had lived in a care home from 2020. Prior to this, she had lived independently in her bungalow. Beverley had several health-related issues which compromised her mobility for some time. After Beverley's death, a safeguarding enquiry concluded that improvements could have been made to the support and coordination of care for Beverley, and that she was not always part of the decision-making about her care.

Our Review found that we need to improve:

- Multi-agency working
- Workforce skills and knowledge
- Person-centred care planning

Sharing Learning and Assurance

In order to share learning widely and effectively from our Reviews, all Reviews are published with accompanying learning briefings and podcasts, which are created by our Learning and Policy subgroup.

To ensure that learning is taken forward from our Reviews, we hold a multi-agency action planning meeting for each Review to agree how we will individually and collectively improve safeguarding practice. This method ensures multi-agency ownership and accountability for the changes that are needed to reduce safeguarding risk.

Once this action plan has been agreed, actions are taken forward and monitored by the Board to ensure completion.

Six months post completion of the action plan, our Quality and Performance subgroup carry out an assurance survey with all involved agencies to ensure learning is embedding.

2022/23 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

In 2022/23, there were 1791 safeguarding concerns initiated. The number of concerns initiated each month ranged between 90 to 168. Of the concerns initiated, 1172 met the criteria and proceeded to a safeguarding enquiry (known as a Section 42 enquiry).

Types of abuse people experienced

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

This year, of the concluded enquiries, concerns regarding neglect and acts of omission accounted for 532 Adults, financial abuse for 185 Adults, and physical abuse for 184 Adults. Together, these three categories total 901 Adults. These have remained the top three categories of abuse for the last four years.

Neglect and acts of omission have been the most reported form of abuse over the past five 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 386 Adults. The next most common category is those whose who had no recorded support reason, this accounted for 298 Adults.

Gender, age, and ethnicity of those safeguarded

Please note that the Board acknowledges the limitation of the gender categories currently available.

Of the enquiries undertaken in 2022/23, 661 were for women and 409 were for men. There were 24 enquiries undertaken where an Adult's gender was not documented.

Consistent with previous years, the majority of Adults involved in an enquiry were over 65 years old, which accounts for a total of 719 Adults. The highest of this figure was for those aged 85-94 years old, which accounts for 291 Adults.

In 2022/23 the vast majority of enquiries were for Adults who identified as White, totalling 920 Adults. The data reflects the overall proportion of people's ethnicities in West Sussex and is consistent with previous years. Enquiries completed for all other ethnicity categories did not individually account for more than 10 Adults. There were 143 enquiries where an Adult's ethnicity was unknown, and this was either due to this information not yet being obtained, or because of the Adult declined to provide this information.

Location of abuse

This year, for completed enquiries, abuse in Residential and Nursing Homes accounted for 439 Adults and 398 Adults living in their own home. Therefore, the most common 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 for this has continued to reduce in West Sussex.

Making Safeguarding Personal

As part of a Section 42 enquiry, Adults are asked for their desired outcomes. In total 655 Adults expressed desired outcomes. Of the concluded enquiries this year, 313 Adults had these fully achieved and 342 Adults had these partially achieved.

How safeguarding changed risk

For the enquiries concluded this year there were 511 Adults where action was taken to reduce risk. There were 305 Adults where the risk was removed, and 69 Adults where actions were taken, and the risk remained.

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, the Government has taken the decision to delay the implementation of the LPS beyond the life of this Parliament. However, the focus remains on continuing to ensure vulnerable people's care and treatment is in their best interests.

Referrals received and the outcomes

In 2022/23 WSCC carried out activity on 9,349 DoLS cases. Of this activity, 4,943 were granted and 2,745 were not granted. At the point of submission there were 1,661 not yet complete.

Gender age and ethnicity

The majority of DoLS authorisations (i.e., where the DoLS has been granted) were for females. The majority of adults who received a granted DoLS were in the 85-94 age group category. The recorded ethnicity for most adults with a granted DoLS is white.

Primary support reason for DoLS authorisations

Adults were most likely to have had mental health need: Dementia, recorded as their primary support need. The second highest category was no disability.

Please note: *if you would like the data from this report provided in graph format, please contact the Board Support Team: safeguardingadultsboard@westsussex.gov.uk*

Our priorities for 2023/24

Based on data, audit outcomes, and learning from SARs, our Board decided on two priorities to focus on in 2023/24: Self-Neglect and Embedding Learning and Assurance. In addition, our Board recognises that there may be an impact on safeguarding from the current cost of living crisis. In response to this, our Board will look for evidence of any resulting increased risk for safeguarding. This will include considering data, details of referrals to our subgroups, and actions our Board can take to address any arising issues, including promotional information around financial fraud and scams which could also be a contributory factor to financial hardship. We will be taking forward a number of actions via our subgroup workplans to deliver on these priorities. Some of our planned actions are highlighted below.

Self-Neglect

Thematic Self-Neglect SAR to identify issues, barriers, and themes of recent published self-neglect SARs in Sussex in order to develop an action plan to improve systems, policy, procedure, and practice.

Carry out a self-neglect survey for staff across the partnership to identify issues, barriers and what is needed to better support practice.

Review of existing policy, protocol and guidance.

Consideration of creation of resources including a self-neglect tool kit to support practice.

1

Embedding Learning and Assurance

Re-promote our existing resources with a particular focus on learning from SARs/audits.

Share a focussed presentation at Board on learning from SARs, and audits to be promoted within member organisations.

Seek information and assurance from the partnership about how learning is shared within their organisations and how this is improving practice.

Develop a strategy to meet staff across the partnership to share information about our SAB, key learning areas from SARs and audits, and promotion of resources.

2

Compliments and complaints

In 2022/23 the Safeguarding Adults Board has not received any complaints. A copy of our Complaints Process can be found on our website.

In 2022/23 we received the following compliments:

- We received complimentary feedback and thanks from a family member for a published SAR.
- We received positive feedback from a representative of the ICB regarding our learning resources, particularly our learning briefings and podcasts.
- The Safeguarding Adults Board, along with the West Sussex Safeguarding Children Partnership, received positive feedback from North Tyneside Council, in relation to our Safeguarding Young People 17+ Protocol.
- We received positive feedback, alongside the West Sussex Safeguarding Children Partnership and West Sussex County Council's Community Safety & Wellbeing, from WSCC, regarding the voice-recorded presentation produced about learning from Reviews.

Report a concern

If you or someone you know with care and support needs, is experiencing or at risk of experiencing abuse or neglect, please report this 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 our Safeguarding Adults Board:

Visit: www.westsussexsab.org.uk

Email: safeguardingadultsboard@westsussex.gov.uk

Phone: 03302 227952

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