Making adult safeguarding everybody's business

West Sussex Adult Safeguarding Board
Annual Report 2014 to 2015

WEST SUSSEX SAFEGUARDING ADULTS BOARD

Everyone's business
Working together to prevent harm and abuse

Foreword

I am pleased, as the first Independent Chair of Safeguarding Adults Board, to introduce the West Sussex Adult Safeguarding Annual Report for 2014/15, and would like to take this opportunity to thank my predecessor Judith Wright (former Director for West Sussex County Council) for her leadership and commitment to inter-agency working in West Sussex.

Before commenting on the work of the Board over the past year, it is worth reflecting on the very challenging national and local context in which safeguarding operates. Indeed I draft this foreword in November 2015 on the Eve of the Chancellors Autumn Statement, and at a time when Health and Social care services face significant financial challenges.

The English Health and Social care system is under severe pressure, as evidenced by the recently published OECD assessment of healthcare across developed countries (Health at a Glance, 2015) which found the UK lagging behind on several quality indicators, while the Joseph Rowntree Trust and Health Foundations annual 'Quality Watch' (Closer to Critical) also found the quality is also deteriorating in some areas, despite excellent care in others, and The Care Quality Commission's annual 'State of Care' report raised concerns about patient safety across all the services they inspected.

These challenges are mirrored locally in West Sussex where data indicates wide variations in the quality of care services, and where significant financial pressures on all local services has resulted in wide organisational change in the County Council, Sussex Police, Probation and NHS amongst others, as they attempt to 'do more with less'.

The main focus, rightly, of the Boards attention over the past year has been Orchid View. The conclusion of the Coroner's Inquest in October 2013 into the deaths of 18 people was followed immediately by a Serious Case Review (SCR). The review was not designed to place blame on any individual or organisation, however the report highlighted a number of failings by organisations, not least the owners of Orchid View, Southern Cross Healthcare, which had been deemed to have failed.

Following the publication of the Serious Case Review in June 2014 the Safeguarding Adults Board established an Improvement Board, to develop an action plan to implement the 34 recommendations arising from the SCR, while progress on implementing the lessons learned from Orchid View was the subject of a workshop ('Orchid View-One year On') involving relatives of the residents of Orchid View, and representatives of local partner organisations, held in June 2015; as I have indicated elsewhere while there has been progress, there has also been slippage, and there is still more to do.

What has impressed me since I took over the chairing of the Safeguarding Board has been the continued engagement and commitment of the relatives of the residents of Orchid View, and their determination to ensure that the partner agencies now take responsibility for implementing the recommendations from the Serious Case Review.

Another major area of work for the partner agencies of the Safeguarding Board, especially West Sussex County Council, has been preparing for the implementation of the Care Act 2014, which from April 2015 placed the Board onto a Statutory footing for the first time, involving extensive staff training, a review of safeguarding procedures, and local awareness raising etc.

As the section of the Annual Report on 'updates from partner agencies' demonstrates, there has been much progress, with auditing of safeguarding investigations cases to improve practice, providing more training for Health staff in the areas of Mental Capacity and Deprivation of Liberty, raising the awareness of domestic abuse, increased examples of user and carer engagement in the safeguarding process etc.

The Safeguarding Board is also strengthening its structures with partner agencies agreeing to joint funding for an Independent Chair, Board Manager and associated support.

Looking ahead our priorities for 2015/16 are highlighted in the report, I would personally note;

- developing improved Quality and Performance information to support safeguarding
- engaging service users and carers in safeguarding systems and the work of the Safeguarding Board (Personalisation)
- working across geographical as well as organisational boundaries where appropriate, to make best use of limited resources
- strengthening arrangements across partner agencies to learn the lessons from Safeguarding Adult Reviews

Finally, I would like to take this opportunity to acknowledge the hard work and commitment of the members of the Safeguarding Board, and the support of their partner agencies.

Yours

David Cooper
Independent Chair
West Sussex Safeguarding Adults Board
November 2015

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Annual Report 2014 / 2015
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Executive Summary

This has been a very important and busy year for safeguarding adults nationally and locally with fundamental changes introduced to the legislative framework.

The Care Act received royal assent in May 2014 and becomes law from 1st April 2015. It introduces far reaching changes to legislation for adults covering a wide range of important areas including: assessment for adults and carers; eligibility criteria for Local Authority funded services; as well as in relation to safeguarding adults. The Care Act replaces No Secrets Statutory Guidance (2000) that previously outlined the approach agencies and organisations should take in relation to safeguarding adults. It introduces legislation regarding safeguarding adults for the first time that includes legal duties for:

- Local Authorities to make enquires or cause others to make enquiries when it suspects an adult is experiencing, or is at risk of, abuse or neglect
- Local Authorities to establish local Safeguarding Adults Boards (SAB) in their area
- Partner agencies to work together and to share information with the Safeguarding Adults Board to enable it to carry out its functions

Each Safeguarding Adults Board must:

- Produce an annual Strategic Plan regarding what it, and its members, will do
- Publish an Annual Report regarding what it has done to achieve its Strategic Plan
- Ensure Safeguarding Adults Reviews (SAR), formerly known as Serious Case Reviews, are undertaken where an adult has died or been seriously harmed, if there is learning for agencies that could prevent this from happening again. The Board's annual report should include the findings and recommendations of any Safeguarding Adults Reviews it undertakes

In May 2014 the Department of Health produced draft statutory guidance for the Care Act and the West Sussex Safeguarding Adults Board provided a response to this as part of the formal consultation process. The final statutory guidance published in late October 2014 was very different from the earlier draft, leaving only a short period of time available to undertake the significant amount of work required to prepare for its implementation.

West Sussex Safeguarding Adults Board

The Board is responsible for the overall governance of adults safeguarding work in West Sussex. It is a partnership of agencies and organisations, represented by senior managers of those organisations, committed to working together to ensure adults safeguarding arrangements in the County are as effective as possible.

Safeguarding Adults Peer Reviews were introduced nationally across local authorities, supported by the Local Government Association (LGA), with the aim of helping local partners drive improvement in outcomes for adults; enhance partnership working; and provide joined up, quality services. In West Sussex a Peer Review of adult safeguarding that included a focus on strategic partnership

arrangements and the Adults Safeguarding Board was undertaken and presented its findings to the Board in June 2013.

All partners were involved in the Review, and progress of the multi-agency action plan developed following this has been monitored regularly by the Board. Work undertaken included a fundamental review of the Board's form, function, effectiveness, resources, priorities, and business plan for 2013/15.

Arising from this, statutory agencies agreed a Financial Constitution with a collective annual funding commitment totalling £207,000 for an initial period of three years. This has enabled the Board to create a team to take forward its business plan and uphold its new statutory functions more effectively. The Board recruited an Independent Chair (David Cooper) in December 2014. This post is an important element of the Board's approach to the development of its arrangements in relation to governance, accountability, and independent challenge.

The Board would also like take this opportunity to thank out-going Chair of the Board, Judith Wright, Director of Public Health and Commissioning, WSCC, for the work she has undertaken in previous years.

The ***Board's Business Plan 2013-15*** has five key priority areas:

- Customer feedback
- Performance
- Learning and development
- Governance
- Communication and engagement

A copy of the Board's Business Plan is available in the Appendices.

Main areas of work completed in 2014 /2015 included:

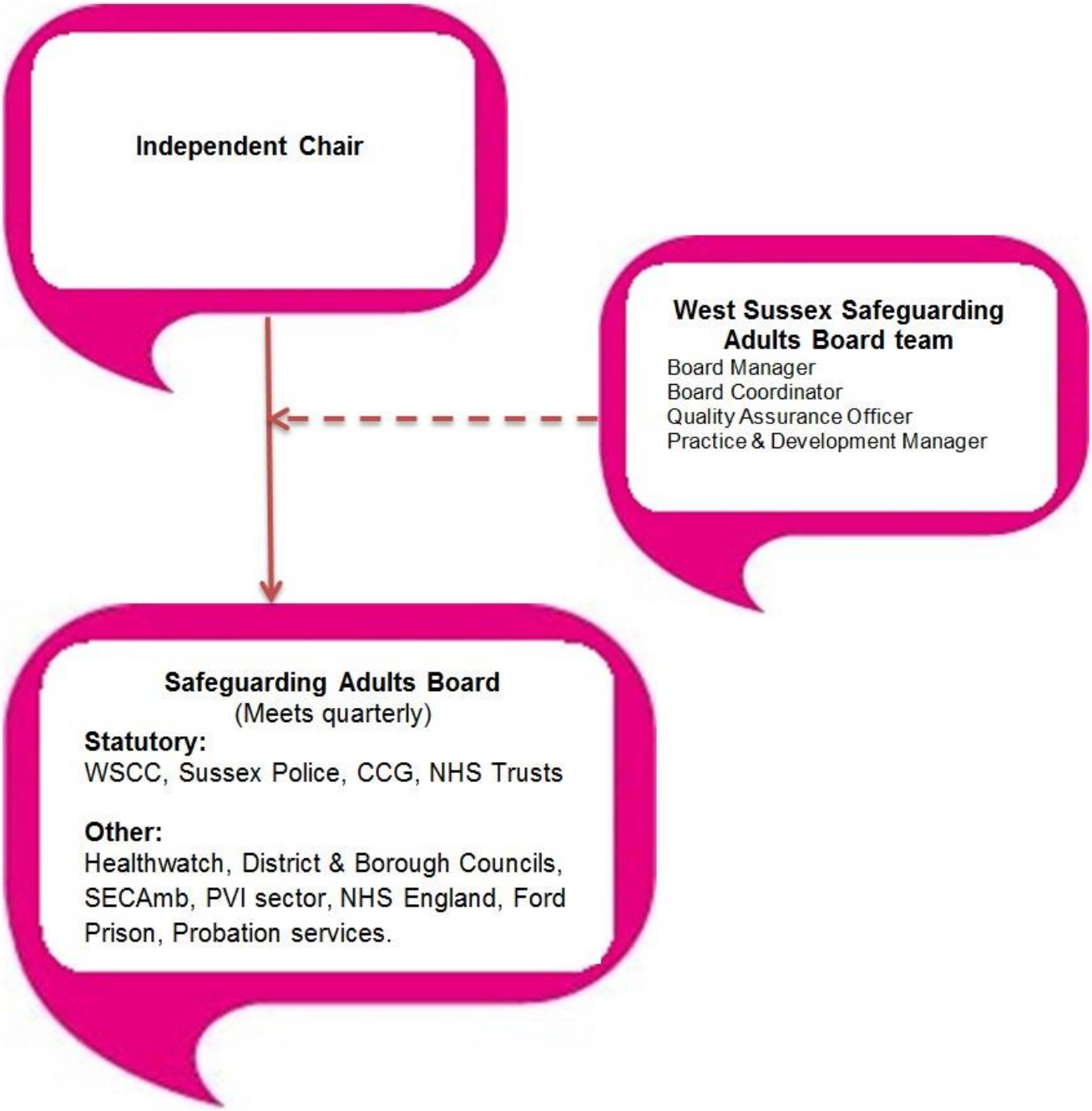
- Implementation of the recommendations from the report of the Serious Case Review regarding Orchid View published in June 2014
- Preparation for implementation of the Care Act from 1st April 2015
- Recruitment & establishment of the new multi-agency funded Safeguarding Adults Board team
- Work undertaken through the subgroups to deliver the Board's key priorities and objectives

Preparation for compliance with the Care Act included:

- Development of new Sussex wide Safeguarding Adults Policy and Procedures and local practice guidance through multi agency work locally and with partners in East Sussex and Brighton and Hove
- Revised strategic protocols for Safeguarding Adults Reviews (formerly Serious Case Reviews) and Information Sharing to provide a consistent approach across Sussex (The Board is grateful to the East Sussex Safeguarding Adults Board for their willingness to share these Protocols)
- Development of a training and briefing program, materials and packs delivered to key managers and practitioners across the statutory, private, voluntary and independent sectors
- Twelve road shows were held across the County from March 2015, led by the Board Team's newly appointed Practice and Learning Development Manager,

with input from the Local Authority and other partners. These events were attended by over 1200 participants
- Existing information was updated and developed for the public, service users and people working with adults

The Safeguarding Adults Board structure:



Other key developments:

The Cheshire West Supreme Court decision
The Cheshire West Supreme Court decision in March 2013 clarified the criteria for assessing whether a person who lacks capacity regarding decisions for their care and support is deemed to be being 'deprived of their liberty' in a care home, hospital or other care setting.

The implications of the judgment have been significant nationally, and locally the number of people for whom assessments under the Deprivation of Liberty Safeguards legislation (Mental Capacity Act) have been requested has increased dramatically. This has had a marked impact on how this process is managed in the Local Authority, on partner agencies, and on those who provide care for people who lack capacity. Locally work has been undertaken to increase the numbers of staff trained and available to undertake these assessments and more work is in progress regarding this.

Making Safeguarding Personal (MSP)

Making Safeguarding Personal was published in March 2013 by the Local Government Association (LGA), the Association of Directors of Social Services (ADASS), and Social Care Institute for Excellence (SCIE). This national report arose from the findings of Peer Reviews across the country. It highlighted that safeguarding adults work was often experienced as, and focused on, following a procedure and a process, rather than on the person and what they want to achieve.

West Sussex participated in the national 'Making Safeguarding Personal' project that concluded in January 2014. The Department of Health has subsequently extended funding of the project until April 2017 and the Safeguarding Adults Board was pleased to sign up to this project again in April 2014, given it is such an important area of work. The Care Act Guidance in October 2014 has since also included this as a mandatory approach to all safeguarding work.

The project aims to support local areas in developing their safeguarding practice to ensure a person centred and outcomes focused approach and provides a regional forum for sharing good practice and materials. The Board continues to monitor this work through the Quality and Audit Subgroup.

Orchid View Serious Case Review

The conclusion of the Coroner's Inquest in October 2013 into the deaths of 19 people was followed immediately by a Serious Case Review commissioned by the West Sussex Safeguarding Adults Board in relation to Orchid View. Orchid View was a nursing home in Copthorne, Crawley which was owned and managed by Southern Cross Healthcare. It was registered with the Care Quality Commission (CQC) as a care home with nursing to accommodate up to 87 people in the categories of old age and dementia. Orchid View opened in November 2009 and was closed by its owners in October 2011. While it was open there were a number of safeguarding alerts and investigations, including the deployment within the home from August 2011 of a team of health and social care staff to

mitigate the poor quality of care, leadership and management that existed in the home.

The Serious Case Review report was published in full June 2014 and can be found on the West Sussex County website.

The Board accepted the report's recommendations in full and in response to this the Safeguarding Adult's Board established an Improvement Board which included representatives from key agencies. The Improvement Board worked to implement an Action Plan which was developed to take forward the 34 recommendations.

Orchid View – One Year On:

In June 2015 an Orchid View One Year on workshop was organised with the relatives. The purpose of the workshop was to bring the relatives of Orchid View together with the agencies involved in the recommendations; giving everyone involved the opportunity to:

- Review the 'Orchid View – One Year On' report and feed views and opinions into the publication
- Enable each agency to report and update the relatives on what had been done over the past 12 months to achieve the recommendations
- Offer relatives the opportunity to ask questions and have conversations with agencies about the work achieved

The workshop was planned and developed with the relatives to ensure they had the opportunity to have the conversations that mattered most to them, with the agencies involved in the recommendations.

Progress on the Board's key priority areas for 2014/15:

The Board identified five priority areas for its work plan in 2013/14.

1. **Customer feedback**:
   The overall objectives were to ensure the Board has robust processes in place to engage with adults and utilise their experiences, views and feedback to inform and improve safeguarding arrangements; support for adults at risk of or experiencing abuse and neglect.

   Involvement of adults work undertaken has included:
   Discussion and involvement of the Customer and Carer Forum regarding changes introduced by the Care Act and how their experiences could inform development of learning materials and training courses, their future involvement, and their own potential needs in relation to this. Links have also been made with the Black and Ethnic Minorities Representatives Group. Both groups have been included in the development process for the new Sussex Safeguarding Adults Policy & Procedures, updated and accessible information leaflets.
   - The Board Manager appointed in March 2015 is working to improve adult and carer involvement in the Board including a customer reference group to ensure people's experiences and views are at the centre of all decision making

- Healthwatch 'Can't Complain' project involved residents of large provider services in the county, to share their experiences of how complaints were responded to. The report was discussed by the Board and presented at the care home provider workshop in November 2014, which focused on the learning from Orchid View

2. **& 3. Performance and Governance:**
   The overall objectives were to ensure the Board has robust systems in place to assure safeguarding arrangements, and the work of partner agencies and organisations, are effective. This would also evidence a level of positive challenge and scrutiny for Board members.

   Understanding the Board's effectiveness, scrutiny arrangements and governance - work undertaken includes:
   - Creation of a multi-agency funded Safeguarding Adults Board team and Independent Chair to progress the Board's Business Plan; and to strengthen its scrutiny and governance arrangements.
   - A Quality Assurance Officer is now in post and reviewing the role of the Quality & Audit Subgroup; developing key performance indicators with Board member, and reviewing the Board's approach to multi-agency audit work. A review of the Board's governance arrangements & effectiveness is in progress.
   - The Care Act guidance is clear that concerns relating to care services should be addressed through quality assurance processes rather than under safeguarding procedures that focus on individuals. Further work is needed to develop a clearer understanding of how these two processes work together
   - Collation of baseline information systems and storage for safeguarding & quality related information has been identified across partner agencies to inform this work.
   - Compliance with the Care Act from 1st April 2015 has been achieved with plans in place for the Board to assure itself regarding the on-going implementation and embedding of this
   - Three Safeguarding Adults Champions (elected Council Members) attend the Board

4. **Learning and development:** overall objectives were to develop a culture of learning and improvement that is informed by the experiences of adults and by learning from safeguarding adults' reviews and practice.

   Learning and improvement work undertaken includes:
   - Implementation and progress of recommendations from Orchid View Serious Case review are overseen by a multi-agency improvement Board accountable to the Board that will report its progress in June 2015
   - Focus on disseminating learning from Orchid View has included:
     - An event arranged and led by the Leader of WSCC and the Chair of Crawley Clinical Commissioning Group. This was attended by relatives of residents who lived at Orchid View, Chief Officers of agencies and organisations in the County, and Chief Inspector of Care Quality Commission
     - A workshop attended by care home managers in the County to also enable sharing of good practice across the sector in relation to the Serious Case Review

- New Safeguarding Adults Review (SAR) and Information Sharing protocols agreed to be compliant with Care Act (pan Sussex)
- A Learning & Practice Development Manager has been recruited and undertaken a review of the Board's multi-agency training strategy; working closely with multi agency training leads across Sussex
- Review of all training materials; practice guidance for compliance with Care Act in conjunction with the WSCC Adults Safeguarding Unit, utilising available information alongside the experiences of patients, customers and carers
- Safeguarding Adults Care Act Implementation Roadshows between March 2014 and May 2015 were attended by over 1000 representatives from private, voluntary, independent and statutory sectors, and copies of the new Procedures, briefing packs and learning materials were distributed to attendees
- A range of training and briefing sessions held across the County to support Care Act implementation, safeguarding adults awareness and learning from practice and Serious Case Reviews

Communication and engagement:
Overall objectives were to ensure effective mechanisms and information are in place to achieve and sustain good levels of awareness of safeguarding adults with the general public.

Communication and awareness:
Work undertaken includes:

- Safeguarding adults identified as a core priority for WSCC Communications Team with resources identified to support public awareness campaigns including a focus on 'what good looks like' campaign; information regarding this and how and where to report any concerns included in the West Sussex Care Guide
- The Sussex Safeguarding Adults Policy and Procedures and awareness leaflets have been made available on line and through libraries, services and organisations across the county
- Development of independent website for West Sussex Safeguarding Adults Board is being scoped and anticipated to be completed in early 2016
- Safeguarding adults information and posters displayed in 35 libraries across the county throughout June 2014 to coincide with Action on Elder Abuse national awareness campaign

The Board would like to take this opportunity to thank its partners for their hard work and continued commitment to safeguarding adults work and for the progress we continue to make on behalf of adults in West Sussex who may be at risk of, or are experiencing, abuse or neglect.

Key objectives for 2015 and beyond:
The Safeguarding Adults Board's Business Plan (its Strategic Plan post April 2015) covers the period from 2013 to the end of 2015. One of the Board's key priorities and that of its new Independent Chair is to review the Strategic Plan as part of a wider review of the Board's functions and effectiveness in the context of the new statutory duties under the Care Act. This is anticipated to take place in autumn 2015 when it will also be possible to reflect on the impact and embedding of the changes introduced by the new legislation.

Key objectives for 2015:

1. Continue to engage with customers and using their experiences and views to inform and improve the work we do. Key work includes establishment of the customer reference group; utilising adults experiences captured in the Healthwatch 'Can't Complain' project; and additional work to develop a mechanism to ensure adults' and their relatives' experiences of care provider services and responses to safeguarding concerns are captured and inform the Board's work

2. Improve understanding of the effectiveness of the Board's safeguarding arrangements through robust scrutiny arrangements. Key work includes establishing a set, or 'dashboard', of quality assurance indicators for regular reporting for Board members, and ensuring scrutiny reports are shared routinely between other Boards and the Safeguarding Adults Board, including the new NHS Commissioning Board.

3. Develop a culture of learning and improvement, by utilising available information alongside the experiences of patients, customers and carers. Key areas of work include: completing the review of the multi-agency safeguarding adults training strategy and business plan to reflect this; focus on embedding learning from practice including from Serious Case Reviews (Safeguarding Adults Reviews); and from work undertaken by partners e.g. Healthwatch

4. Establish more robust arrangements to ensure scrutiny, overview and challenge between partners of the Board that includes issues relating to health and social care service provision in the County. Key work includes: a focus on the interface between quality assurance related and safeguarding related processes and procedures; development of the Firefly system in WSCC Contracts Service that enables a summary profile of service provision across the county to be provided. It is anticipated that this will also be made accessible to other key agencies such as the Fire Service and Care Quality Commission by late 2015.

5. Continue to raise awareness of safeguarding with the general public. Key work includes: developing the Safeguarding Adults Board's website to enable consistent information to be more readily and easily available and for the public and professional ; and delivery of focused publicity campaigns including 'What good looks like' in relation to care provided in care home settings.

Bev Morgan –
Principal Manager Safeguarding Adults, WSCC

This Annual Report is available on line at www.westsussex.gov.uk

Subgroup Reports 2014/15

This section gives you more information about the role and work of each of the Safeguarding Adults Boards Subgroups

The Board has four multi-agency subgroups that carry out the work of the Board and report back progress made, overseeing the delivery of the Safeguarding Adults Board Business Plan. The subgroups include:

- Training
- Quality and Audit
- Communication Promotion and Engagement
- Serious Case Review Overview Panel

Training Subgroup:

General overview of the year:
Preparation for the incoming Care Act has been the main focus of the work undertaken this year. The sub-group was augmented by a Care Act implementation 'task and finish' working group to enable it to undertake appropriate planning and oversight of safeguarding adults training arrangements needing to be in place to ensure compliance with the Act from 1st April 2014 across partner agencies and organisations. The Task and Finish group has been well represented and supported by partner organisations and its work has informed the training strategy and plans presented to the Board in March 2015. The Board has identified as a core standard that 'all partners should have an adult safeguarding Training Plan in place' and this has been achieved.

The newly developed Safeguarding Adults Board Team includes a Practice and Learning Development Manager who took up post in December 2014 and now chairs the group. The creation of this post will also enable further development work to take place across Sussex with other Safeguarding Adults Boards.

Developments, achievements and work undertaken:

Number of individuals who attended courses available to all partners through the WSCC Learning and Development Gateway in 2014/15:

Total attendees: 1301 of which:

- 727 - Private, independent and voluntary sector
- 460 - Local Authority staff
- 105 - Other Government agencies, including District and Boroughs and NHS staff
- 9 - Other community groups

Total number of hours learning: 6147

Improvements made to data reporting available from the WSCC Learning and Development Gateway, through which all partners are able access safeguarding adults training, now enables better evaluation of the impact of training events. This has contributed to partners' and the Board's improved understanding of training

activity and its impact. This is one of the key objectives of the Board's Business Plan and reflects one of the standards identified by the Board regarding partners having arrangements in place to evaluate the impact and effectiveness of training its staff have received in relation to their practice.

Other work undertaken has included:

- Re-development and re-design of training materials and courses to reflect incoming legislation, statutory guidance and the new Sussex Safeguarding Adults Policy and Procedures
- Learning from national and local practice and Serious Case Reviews, including Orchid View, being embedded within the training
- Continued development of minimum standards for safeguarding training across the partnership for benchmarking Basic Awareness, Enquiry Officer and Enquiry Manager training
- Co-ordination and support for partners to develop training for compliance with Care Act from April 2015 through the Task and Finish Group
- Signposting provided via the Learning and Development Gateway to a growing range of e-learning materials available nationally
- On-going training program continuing to be delivered focusing on raising awareness, understanding and improving the practice of staff working with people who self-neglect – updated guidance relating to this area of work is now incorporated into the new Sussex Safeguarding Adults Procedures
- Provision of safeguarding training to GPs and Clinical Commissioning Groups
- A series of twelve Road Shows for statutory, independent and voluntary sector managers and staff commenced in March 2015 (running until May 2015) focus on understanding and implementation of the Care Act and Making Safeguarding Personal in practice have been well attended and well received. A range of materials and a briefing pack provided to all attendees and available electronically for all partners - hard copies of Sussex Procedures also distributed via these events & other briefings and training courses
- WSCC safeguarding adults Train the Trainer courses to support the private, voluntary and independent care sectors have been in demand and the new Care Certificate module 10 will support new staff on induction regarding awareness, prevention and action to take if they are concerned
- Development of a training strategy and plan for changes introduced regarding adults safeguarding in the Care Act 2014

Priorities for 2015/16:

- Ensure training and information reflects learning from people's experiences and practice including serious case reviews, focus on raising awareness of the public and professionals by work closely with Communication, Promotions and Engagement subgroup
- Continued delivery of training to embed changes introduced in the Care Act– utilise/develop a range of approaches to support this
- Evaluate effectiveness of safeguarding adults training delivered and available across partnership - identify core performance information and data required from all partners
- Review the multi-agency Strategic Training Plan and core training programs, informed by evaluation process, and develop a quality assurance framework

and agreed standards to underpin these - work closely with the Quality and Audit Subgroup regarding this
- Explore further opportunities for improved joint working and links with partners across Sussex
- Review of the terms of reference and role the training subgroup in the context of the other work the Board is undertaking to ensure it functions as effectively as possible

Dr Andy Mantell – Practice and Development Manager
West Sussex Safeguarding Adults Board (Chair)

Communication, Promotion and Engagement Subgroup:

General overview:
The group has continued to work on availability and access to relevant and useful information. Specific focus has also been on availability of information relating to effective implementation of the Care Act, and a publicity campaign linked to on-going work to raise public awareness regarding 'what good looks like' regarding quality of care in line with learning from the Serious Case Review regarding Orchid View.

Developments, achievements & work undertaken:

- 'What good looks like' publicity campaign included information published in the West Sussex Care Guide, information leaflets and articles in local press and on WSCC website
- Healthwatch 'Can't Complain' project regarding experiences of residents of care homes of a large provider service in West Sussex. Report published in November 2014 presented to the Safeguarding Adults Board and discussed at workshop for care home provider managers regarding learning from Orchid View review
- Adults safeguarding awareness poster display campaign in 37 libraries across the county for the month of June 2014 coinciding with Action on Elder Abuse national awareness week
- Review and update of information for public and professionals to reflect incoming Care Act, available on the WSCC and partner agency websites, and printed version distributed widely across the County
- Production and distribution of hard copies of new Sussex Safeguarding Adults Policy and Procedures, available through main libraries across the county and on line.
- On-going links with the Joint Commissioning Engagement & Communications Group, customer and carer's forum and Black and Ethnic Minority Representatives Group.

Future plans and priority areas for 2014/15:
In addition to the Board priorities:

- On-going work regarding general awareness including web-based materials; e-learning/e-information; and publicity through a range of publications and articles and review of easy read and accessibility of information

- Development of independent website for Safeguarding Adults Board
- Share information with the public where there are significant safeguarding concerns regarding a care home, in line with recommendation from Orchid View review
- Further work to develop improved processes for engaging, seeking and receiving feedback from people who have been directly involved in or affected by adults safeguarding, including development of a service user reference group for the Safeguarding Adults Board, and continued links with the customer and carer forum and Black and Minority Ethnic Representatives Group
- Support marketing and delivery of information aimed at independent sector organisations and groups; produce and disseminate related learning and information materials
- Continue to develop work undertaken through the Joint Commissioning Communication and Engagement Group and customer and carer focus groups
- Annual publication and dissemination of the Board's Strategic Plan, Annual Report and updated Sussex Safeguarding Adults Policy and Procedures and information supporting implementation and embedding of learning, national policy and incoming Care Act
- Review of the terms of reference and role the training subgroup in the context of the other work the Board is undertaking to ensure it functions as effectively as possible

Bev Morgan – Principal Manager, Adults Safeguarding, WSCC (Chair)

Quality & Audit Subgroup:

General overview of the year:
This multi-agency group is responsible for overseeing work related to quality regarding adults safeguarding and identifying areas for improvement, using a range of multi-agency information and reports, and links closely with other subgroups reporting to the Board.

The group focuses on the analysis of local quality assurance information; activity reports and learning from local practice using case file audit reports; local and national good practice examples; and learning from local practice and national serious case reviews and reports.

What has worked well / challenges:
The Quality and Audit subgroup continues to identify good practice, and support to the Board and its partners as we prepare to implement the Care Act.

Following the publication of the Orchid View Serious Case Review, one of the primary functions of the subgroup has been ensuring that the key themes and learning points from the review have been shared appropriately with partners and providers of care across West Sussex. More information regarding this is included elsewhere in this report. Work is continuing to ensure the recommendations from this review are implemented and embedded robustly in practice across all partners in the County, overseen by the Improvement Board Task that also links closely with the Quality and Audit subgroup's work. The Board will provide a further report in

June 2015 regarding the progress made in relation to the implementation of the review's recommendations.

Developments, achievements & work undertaken
The subgroup continues to complete six monthly, multi-agency case audits, auditing six cases in May and in November 2014. All of the cases identified have at least three agencies involved and representatives from those agencies contribute to the audit. Round table presentation of key information and identification of learning, good practice, and any action or areas for improvement are highlighted and then referred back to the appropriate agency. These audits have been taking place for several years now and have proved a valuable forum for partnership working, discussion and as an aid to practice development and improved communication.

Jon Borthwick took up post in September 2014 as the Quality Assurance Officer for the Safeguarding Adults Board Team and now chairs the subgroup on behalf of the Board. His initial work has included a baseline review of systems and practice currently in place across agencies in relation to information sharing. This will assist development of information sharing pathways and thresholds regarding the interface between responses required under safeguarding adults procedures for individuals and quality assurance processes where information relates to a health or care service.

The subgroup has also had a role in providing overall monitoring of implementation plans regarding the Sussex Safeguarding Adults Policy and Procedures, and training and development in preparation for compliance with the Care Act. Both areas of work have been overseen individually by task and finish groups attended by Board members.

As the Board moves onto a statutory footing from April 1st 2015, the group will be reviewing its terms of reference to reflect this and to support effective multi-agency performance monitoring arrangements to enable it to report to the Board regarding this. This will include completion of work to identify a set of multi-agency performance indicators (a 'dash board') for all partners to assist in measuring the effectiveness of the Board and its partners in achieving the aims and outcomes set out in its work plan and strategic plan. This will to enable partner agencies and organisations to be held accountable individually and to each other regarding the effectiveness of safeguarding adults' arrangements in place and the outcomes this achieves for people in the county. A multi-agency workshop to progress this work further took place in May 2014, and included learning from the approach used by the Local Safeguarding Children's Board. Input from the newly created Quality Assurance Officer post will enable this work to be completed.

Future priority areas for 2014/15:
To deliver the Adults Safeguarding Board's priorities with specific focus on:

1. Developing improved mechanisms to ensure the experiences and feedback from adults and those affected by adults safeguarding informs and guides the Board's work. Case file audit work to continue to include engagement and outcomes achieved for individuals
2. Conclude work to develop an agreed set of outcomes measures for the Board and regular reports to the Board regarding these from all partners

3. Oversee monitoring arrangements for compliance and embedding of Care Act 2014, the Mental Capacity Act, and Deprivation of Liberty Safeguards
4. Provide analysis for, and recommendations to, the Board regarding improved performance and outcomes for adults in the county
5. Incorporate learning and improvement areas identified from Orchid View Serious Case Review and other Safeguarding Adults Reviews and learning into the group's work plan and activity
6. Review of the terms of reference and role the training subgroup in the context of the other work the Board is undertaking to ensure it functions as effectively as possible

Jon Borthwick Quality Assurance Manager, Safeguarding Adults Board Team (Chair)

Serious Case Review Oversight Panel:

General overview
The Panel's multi-agency membership includes the Police, the Local Authority and NHS, with other members attending where their expertise, knowledge and input may be required. The Panel is responsible for: considering referrals from partner agencies and organisations regarding cases for individuals where a Serious Case Review may be required; making recommendations to the Chair of the Board regarding the need for review; overseeing arrangements where it is determined a review is required; monitoring progress of improvement plans and actions where these are identified; and for reporting back regularly to the Safeguarding Adults Board regarding this.

In **West Sussex Serious Case Review Policy and Procedures** have been in place and regularly reviewed since 2000. From April 2015 the Care Act introduces a new legal duty for Safeguarding Adults Boards to ensure Safeguarding Adults Reviews (SAR), formerly known as Serious Case Reviews, are undertaken where an adult has died or been seriously harmed, if there is learning for agencies that could prevent this from happening again. Boards' annual reports should also include the findings and recommendations of any Safeguarding Adults Reviews it undertakes.

The West Sussex Board has always worked closely with the East Sussex and Brighton and Hove Safeguarding Adults Boards, with a shared aim of achieving consistent approaches to safeguarding adults work across Sussex and sharing good practice wherever possible.

As part of the review of its existing Serious Case Review Procedures and pan Sussex partnership working, the three Boards have agreed that the East Sussex Safeguarding Adults Review Protocol will be adopted across Sussex from April 2015. We would like to take this opportunity to acknowledge and thank the East Sussex Safeguarding Adults Board for their willingness to make their revised Protocol available, which having undergone a recent multi-agency review, ensured its compliance with the Care Act Guidance published by the Department of Health.
In 2014/15 the Board undertook one Serious Case Review.

Orchid View Serious Case Review
The conclusion of the Coroner's Inquest in October 2013 into the deaths of 19 people was followed immediately by a Serious Case Review commissioned by the West Sussex Safeguarding Adults Board in relation to Orchid View, the nursing home in Copthorne where they lived that was owned and managed by Southern Cross Healthcare.

The Coroner's Inquest followed a multi-agency investigation under the Sussex Safeguarding Adults Procedures that also involved a police investigation. The Coroner found that five people had *"died from natural causes attributed to by neglect"* and that several other people *"died as a result of natural causes"* with *"insufficient evidence before me to show that this suboptimal care was directly causative"* of their deaths.

The Serious Case Review report was published in full in June 2014 and can be found on the West Sussex County website here:
https://www.westsussex.gov.uk/media/5171/orchid-view-serious-case-review.pdf

The report made 34 recommendations to reduce the likelihood of further incidents of substandard care, management and neglect that contributed to the deaths of the five residents at the home.

The recommendations were accepted wholeheartedly by the Safeguarding Adults Board and a key priority for this year has been implementation of these. A Serious Case Review Improvement Board was set up to oversee and coordinate this work and reported progress back to the Board regularly. The then Chair of the Board and Head of Adults and Children's Safeguarding, WSCC also met with the relatives of those who were residents at Orchid View on a regular basis throughout this time.

As part of this work in November 2014 an event was arranged with care home providers to consider the learning from Orchid View and how best to achieve the eleven recommendations that were particularly important and relevant for care homes. Over seventy care home managers and proprietors attended the event which provided a forum for discussion, exchange of ideas and enabled sharing of existing, good and innovative practice between providers across the county. This information was also circulated to all providers in the county following the session.

Also in November 2014, the Leader of the Council and the Chair of the Clinical Commissioning Group in Crawley, where Orchid View was situated, held a conference for senior officers of partner agencies and organisations in the county, also attended by relatives of those who were Orchid View's residents, to consider the learning and how this can be used to inform future working together. A series of road shows held across the county between March and May 2015 were attended by over 1,000 representatives from statutory, independent, private and voluntary sectors and included key learning from the review. The 'what good looks like' publicity campaign focused on providing the public with information about what standards of care should be expected from care services.
In addition the annual multi-agency safeguarding adults' workshop convened between local agencies safeguarding leads and the Care Quality Commission in December 2014 included a focus on the learning from Orchid View. The aim of these workshops is to provide a forum to build on existing multi-agency partnership

working, to build on existing working relationships, and improve the effectiveness of safeguarding adults work.

The Improvement Board will continue until June 2015 when the one year on progress report and workshop will be completed.

Cases considered for review by the Panel in 2014/15:
The Panel received two referrals for consideration regarding the need for Serious Case Review. Following consideration of information provided to the panel, in some cases additional information was sought from partner agencies to aid decision making, recommendations were made to the Chair of the Board for a decision. Of the cases considered one resulted in the commissioning of a Serious Case Review.

An Independent Chair for the review has been commissioned and the review commenced in March 2015. One case was referred for a multi-agency review where it was felt that although the criteria for a Serious Case Review was not met, there was potential multi-agency learning to be identified and a convening a multi-agency review would be beneficial. This review commenced in January 2015 and will report its findings back to the Panel and the Board later in 2015.

The findings of all reviews undertaken will be reported back to the Board. Any recommendations or actions identified will be taken forward and the progress of this will be overseen by the Serious Case Review Overview Panel.

The Serious Case Review Overview Panel will review its terms of reference in light of the changes introduced by the Care Act and in the context of wider development work and review the Board is undertaking.

Sam Bushby, Head of Adults and Children's Safeguarding, WSCC (Chair)

Safeguarding Adults facts and figures

This section gives you more detailed information on the numbers of safeguarding investigations raised from *April 2014 to March 2015*

Key Points:

The figures in this report are based on information relating to all safeguarding work undertaken in West Sussex for 2014/15 provided from the WSCC Adults Services system. This includes safeguarding cases where there may be gaps in the availability of some areas of data, for example the gender or date of birth of the person.

All Local Authorities are required to provide information to the Department of Health (DoH) annually regarding work they have undertaken in relation to safeguarding adults. Reports to the DoH can only include cases where all key information required is known and where information such as gender or date of birth is not known, these cases cannot be included in the return. Where data included below relates to local activity that has been excluded from the Department of Health return it is highlighted in this report.

Challenges affecting data reporting and year on year comparisons:
The Department of Health introduces amendments to the way data is collected each year and for the 2014/15 report this necessitated some changes to recording and reporting systems in West Sussex. Locally service redesign work for WSCC Adults Services and preparation for the incoming Care Act have also required changes to reporting systems. The combined impact of these changes has made some year on year comparisons of activity in this report more difficult.

Year on year comparison of concerns received and investigations:

Year	2012/13	2013/14	2014/15
Incidents (All)	1516	1418	1595
Alerts (All)	1743	1578	927
Total Incidents + Alerts	*3259*	*2996*	*2522*
Investigations (All)	1064	1177	886
Repeat Investigation (All)	194	354	133
Complete Investigations (All)	1046	1921	1085

Key:
Incident: information received regarding a potential safeguarding concern that did not meet the criteria for being recorded as an alert
Alert: information received that indicates harm may have/has occurred to the person or there appears to be risk of significant harm to the person/others
Investigation: a response to an alert made under the adults safeguarding procedures
Repeat investigation: more than one investigation undertaken for the same person within the same 12 month period
Complete investigation: investigation concluded in the reporting period i.e.: before 1st April 2015
All: total numbers of alerts and investigations including, for example, those where other data relating to gender may not have been captured

Safeguarding incidents and alerts:
The number of safeguarding incidents received by WSCC Adults Services in 2014/15 (information received that did not meet the criteria for being recorded as an alert) and the two previous years have remained relatively constant, although there has been an increase of 177 (12%) in 2014/15 from 2013/14.

The number of alerts recorded (information indicating harm may have or has occurred to the person or there could be a risk of significant harm to them or others) has dropped significantly by 41% from 1578 in 2013/14, to 927 in 2014/15. This significant reduction is due to two main factors: a lot of work has been undertaken to remove any duplicated data from the reporting system; and changes to safeguarding practice regarding responses to information received.

In 2013 additional changes were made to the Adults Safeguarding Procedures to build on work already undertaken to support an increased outcomes focused approach to responses to safeguarding concerns, in keeping with the aims of Making Safeguarding Personal work. Since then we have continued to develop this practice which includes an increased emphasis on proportional responses to safeguarding concerns received. This also includes proactive consideration of alternative responses to the safeguarding procedures where appropriate, and where this would best achieve the outcome the person wants, whilst ensuring that agencies' duty of care towards the person, and in relation to ensuring others are safeguarded, continues to be met.
Work to embed changes in practice in relation to the key principles of prevention, proportionality, and having an underpinning person centred and outcomes focused approach is on-going.

Of all information received that related to a potential adults safeguarding concern in 2014/15, 63% were treated as safeguarding incidents and 37% were recorded as alerts, compared to 50% treated as incidents and 50% recorded as alerts in 2012/13. This trend also evidences the changes in practice discussed above.

Case file audits are undertaken regularly on a random selection basis and include a focus on decision making and responses to safeguarding concerns received, outcomes achieved for the person, and appropriateness and consistency of risk assessments.

Investigations undertaken and outcomes for the person:
The number of investigations (responses to an alert under the adults safeguarding procedures) undertaken in 2014/15 is 886, a decrease of 25% (291 fewer) compared to 2013/14 (1,177). In 2014/15, 95% of alerts recorded resulted in investigations undertaken using the safeguarding adults procedures, compared to 75% in 2013/14, and 61% in 2012/13, reflecting the changes in practice to a achieve a more proportionate, person-centred response to information received that may indicate safeguarding concerns for an individual and towards a preventative approach wherever possible. When this is also taken in the context of a 40% reduction in alerts recorded for 2014/15 the reduction in numbers of investigation for 2014/15 is as anticipated.

Case file audit work has confirmed appropriate use of other processes or actions to respond to concerns, including where these responses have been coordinated under Safeguarding Adults Procedures. In turn, this has enabled operational teams to

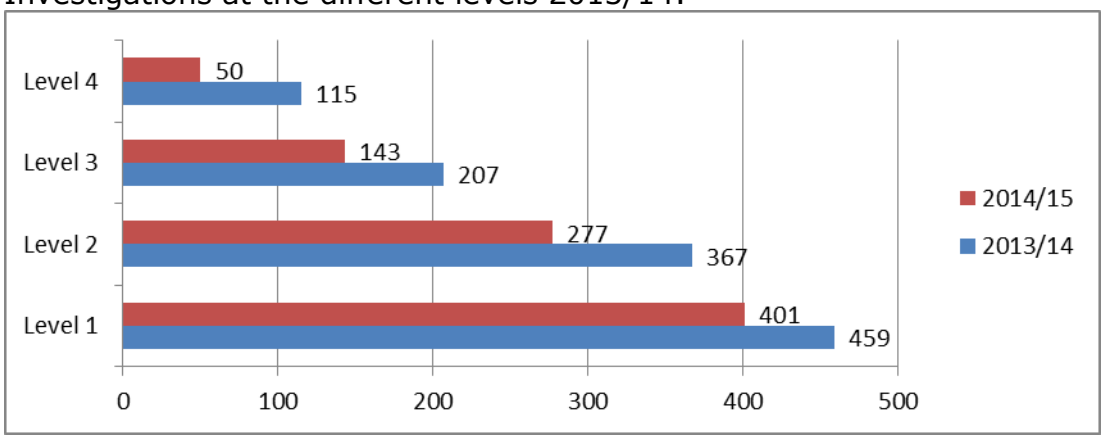
focus resources more effectively on to those who may be most at risk. This work also focuses on the outcomes achieved for individuals where an investigation has been undertaken and is now included in data collected by the Department of Health regarding safeguarding enquiries and information in relation to risk.

Completed investigations:

In 2014/15, 886 investigations were started and 1085 were completed. That more investigations were completed than opened reflects a number of factors: overall reduction in number of investigations undertaken in line with on-going changes to practice outlined above; significant and sustained improvements regarding the ability to respond quickly where investigations are deemed to be required compared to previous years; and improved recording.

Levels of investigations undertaken:

Investigations at the different levels 2013/14:



Key:
Level 1: Harm appears to have occurred / risk of significant harm (provider services asked to investigate)
Level 2: Harm appears to have occurred / risk of significant harm
Level 3: Significant harm appears to have occurred to an adult at risk
Level 4: Harm / significant harm appears to have occurred /or risk of significant harm to more than one adult at risk (may include possible indicators of institutional abuse)

In 2014/15 of all investigations where the level was recorded (871): 6% (50) were recorded as Level 4 (where more than one adult at risk was affected) which is a decrease from 2013/14 when this was 10% (115 investigations out of 1148 undertaken).
The numbers of Level 3 investigations reduced slightly to 16% (143) compared to 18% (207) in 2013/14; Level 2 investigations reduced by 25% (277 in 2014/15 compared to 367 in 2013/14); and 46% were responded to through a Level 1 investigation (i.e. the provider service was asked to look into the concern and advise Adults Services or the mental health Trust of the outcome of this) compared to 48% (459) in 2013/14.

Conclusions of completed investigations:
The main focus of safeguarding activity is to develop a safeguarding plan in line with the adult at risk's wishes and to ensure any other actions are taken to safeguard others and prevent harm or abuse from occurring or recurring. The term 'investigation' refers to any activity undertaken in response to a safeguarding concern (alert) and where an investigation is needed its aim is to understand what has happened in order to prevent this happening again as far as possible.

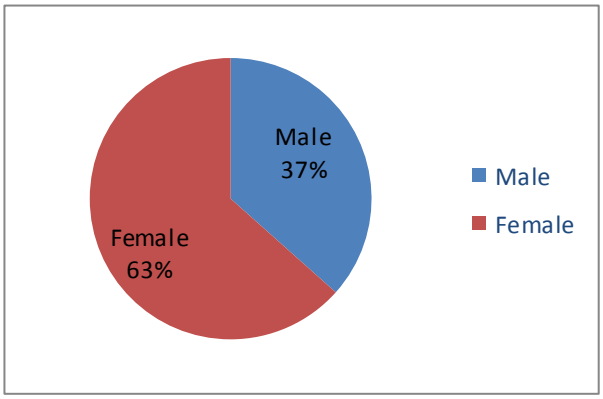
All Local Authorities are required to report to the department of health what the outcome of the adults safeguarding investigations was deemed to be based on the 'balance of probabilities'.

An investigation has one of four possible outcomes determined:

- Substantiated (The abuse is likely to have taken place): 44% in 2014/15, compared to 46% in 2013/4 which is likely to indicate a more appropriate level of referral to investigation stage compared to previous years where the number of investigations with an outcome as 'substantiated' was consistently lower. (NB: this includes cases where an outcome was 'Partly Substantiated' i.e.: more than one concern of harm or abuse was investigated and at least one concern was deemed likely to have taken place).
- Inconclusive (it is not possible to determine from the information gathered whether the abuse is likely to have taken place or not e.g. there is one person's word against another's and no other witnesses or relevant information available): 26% in 2014/15 compared to 22% in 2013/14.
- Not substantiated: the abuse is not likely to have taken place - 28% in 2013/14 compared to 31% in 2013/14.
- Investigation ceased at the individual's request: this category was recorded for the first time this year. 2% (18) of investigations were recorded as not being progressed further for this reason. Investigations would only be closed in these situations where there was no identified risk of abuse for other adults.

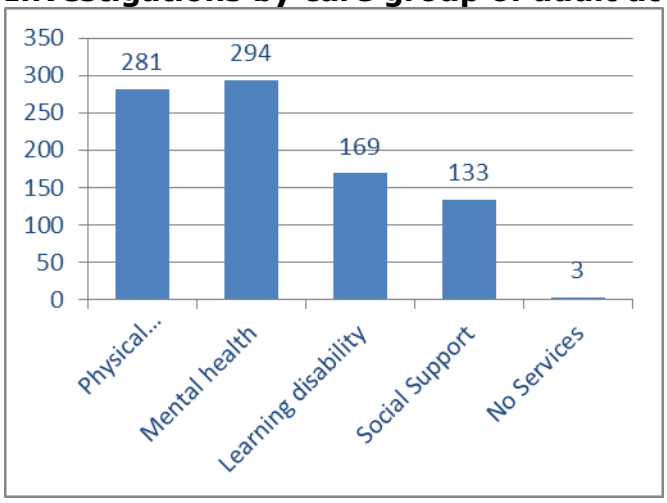
Repeat investigations: (more than one investigation undertaken for the same adult at risk within the same 12 month period):
There were 133 repeat investigations in 2014/15, which represents nearly 15% of the total completed investigations. This appears to fall back in line after an unexpected increase in 2013/14 to 31% of the total completed and brings the trend back in line with the 19% repeat investigations in 2012/13. This is likely to be due to improved processes of recording and reporting following a redesign of Adult Services recording systems.

Completed Investigations by Gender 2014/15: (based on the data reported to the Department of Health).



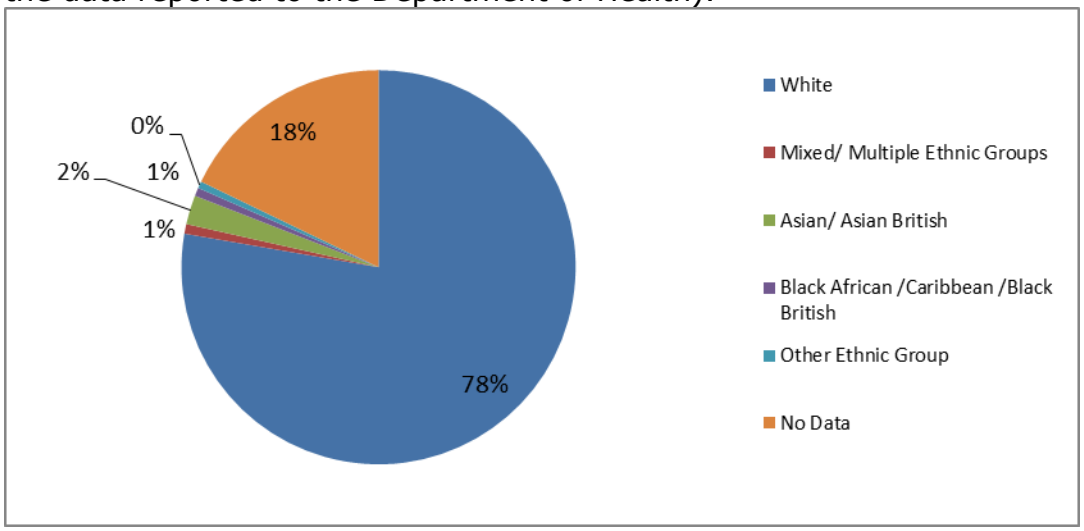
This reflects a steady trend - in 2013/14 - 37% male and 63% female – with 7 cases where gender was recorded 'not known'.

Investigations by care group of adult at risk 2014/15:



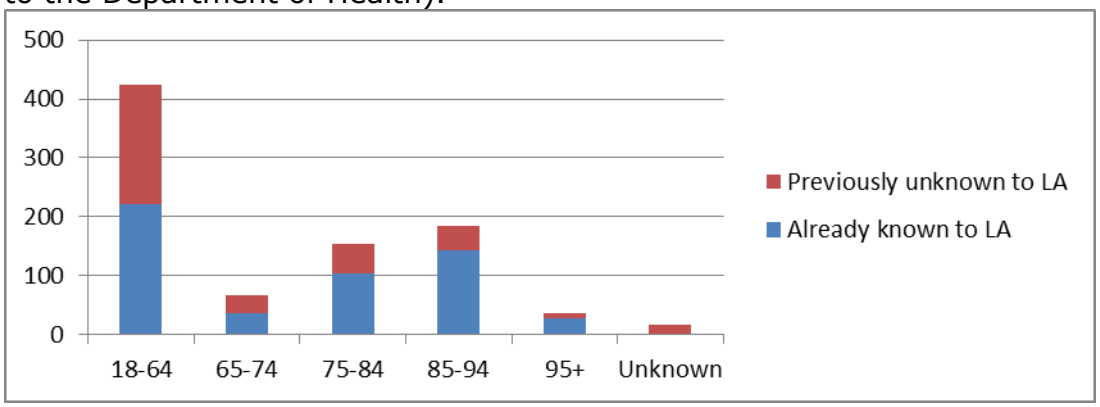
Investigations related most to adults at risk with mental health support needs (33%) that included 110 cases for people who needed support with memory and cognitive impairment); and those with physical health needs (32%). 19% related to people with a learning disability, and 15% had other social support needs. (This includes adults of all ages and is similar to 2013/14)

Ethnicity of person to whom an investigation related 2014/15: (based on the data reported to the Department of Health).



Further work is being undertaken to improve recording in relation to ethnicity. The above information broadly reflects figures in the census for the County.

Investigations by age of adults at risk 2014/15: (based on the data reported to the Department of Health).

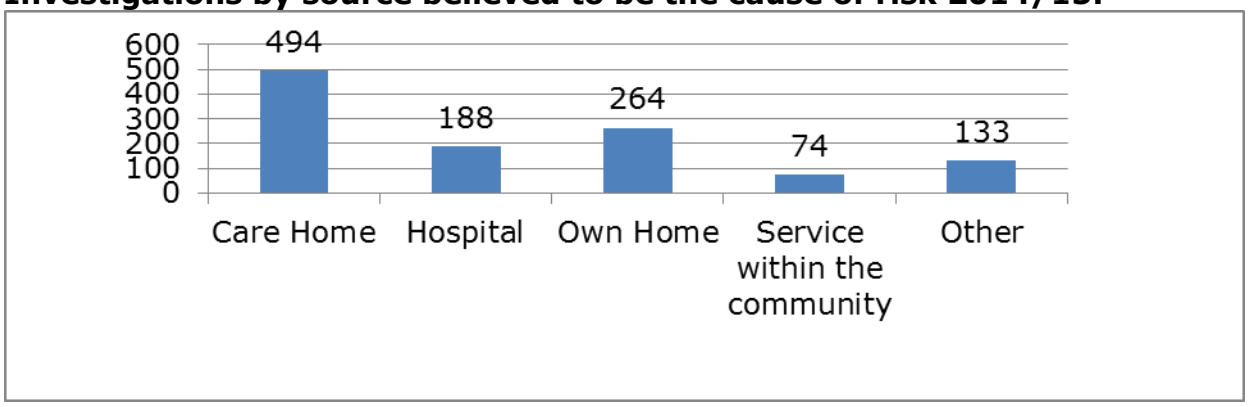


440 (50%) of investigations related to people over 65 years of age, of which 220 investigations related to people 85+ years, which is similar to last year's data (60% of over 65s, including 28% who were 85+ in 2013/14).

Of all investigations in 2014/15: 50% related to 18-65yrs, 25% for 65-84yrs and 25% for 85+ years, compared to 2013/14 when: 40% were for 18-64 years; 39% for 65-84 years; and 36% for 85+ years.

Of those for whom investigations were undertaken where this information was available, 61% were previously known to adults' services and 39% previously unknown to the service.

Investigations by source believed to be the cause of risk 2014/15:



NB: there may be more than once source of risk related to an investigation.

Of concerns investigated: 23% were in the person's own home compared to 24% in 2013/4; and 16% took place in a hospital setting compared to 11% in 2013/14. There was a slight decrease in investigations relating to care homes settings with 43% in 2014/15, compared to 46% in 2013/14, which remain the setting where most risks / concerns were reported.

This is at variance with national data reports where 42% of allegations occurred in the person's own home and 36% within a care home setting. Further work is being undertaken to understand the factors that might underpin this difference, including further work to raise awareness in relation to domestic abuse. There were a number of large scale investigations that related to care homes, including Orchid View, where a number of residents were affected which will have affected this.

Significant work has been undertaken and continues to address this issue and is referred to in more detail elsewhere in this report. It is also important to ensure this information is seen in context of the majority of good quality care provision that exists in the County.

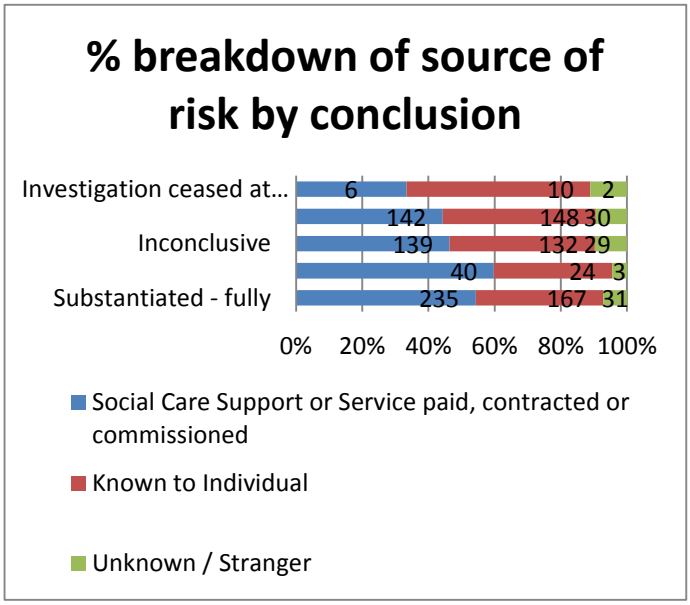
Investigations by individual / organisation believed to be source of risk and by type of abuse 2014/15 compared to 2013/14:

	Social care/ support paid for services 2014/15	Other known to the person 2014/15	Other unknown/ stranger 2014/15	Total 2014/15	% of all types of abuse investigated 2014/15	% of all types of abuse investigated 2013/14
Physical	161	114	29	304	**25%**	**32%**
Sexual	12	42	10	64	**5%**	**6%**
Psychological / emotional	60	79	22	161	**11%**	**14%**
Financial/ material	33	72	28	133	**13%**	**16%**
Neglect / acts of omission	286	145	14	445	**43%**	**54%**
Discriminatory	0	0	1	1	**1%**	**0.3%**
Institutional	21	0	1	22	**2%**	**3%**
Total nos. 2014/15	**573**	**452**	**105**	**1130**	**100%**	**100%**
% of all thought to be cause of risk 2014/15	**51%**	**35%**	**8%**	**------**	**------**	**------**
% of all thought to be cause of risk 2013/14	**18%**	**78%**	**4%**	**------**	**------**	**------**

Where the information was available, neglect and acts of omission by an individual or organisation known or unknown to the person were the highest source of risk (43%) compared to 54% in 2013/14.

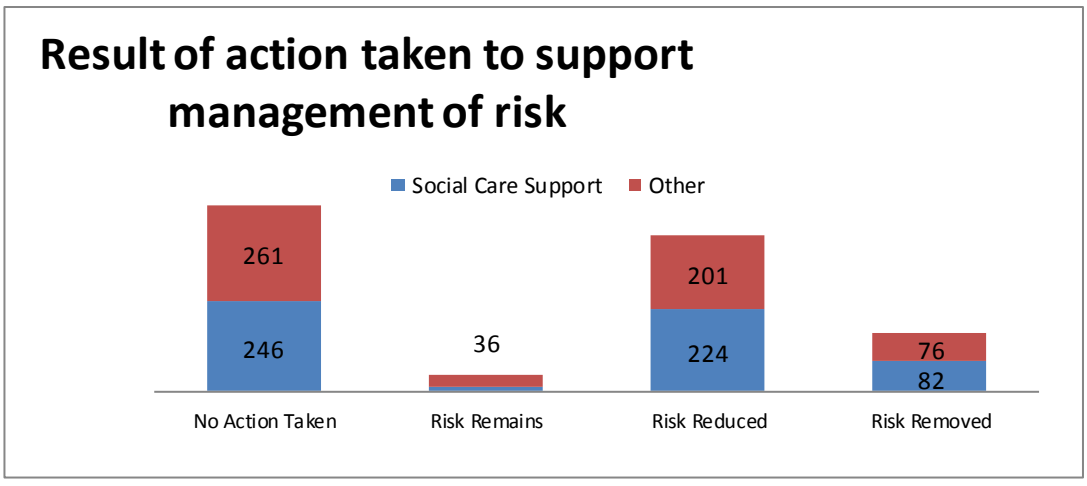
Physical abuse related to 25% of abuse investigated compared to 32% in 2013/14; 13% related to financial / material abuse compared to 16% in 2013/14; and 11% to psychological / emotional abuse, compared to 14% in 2013/14. These reductions also reflect the overall reduction in the numbers of investigations undertaken (25% fewer in 2014/15 than 2013/15).

Investigations by individual or organisation believed to be the source of risk by conclusion 2014/15:



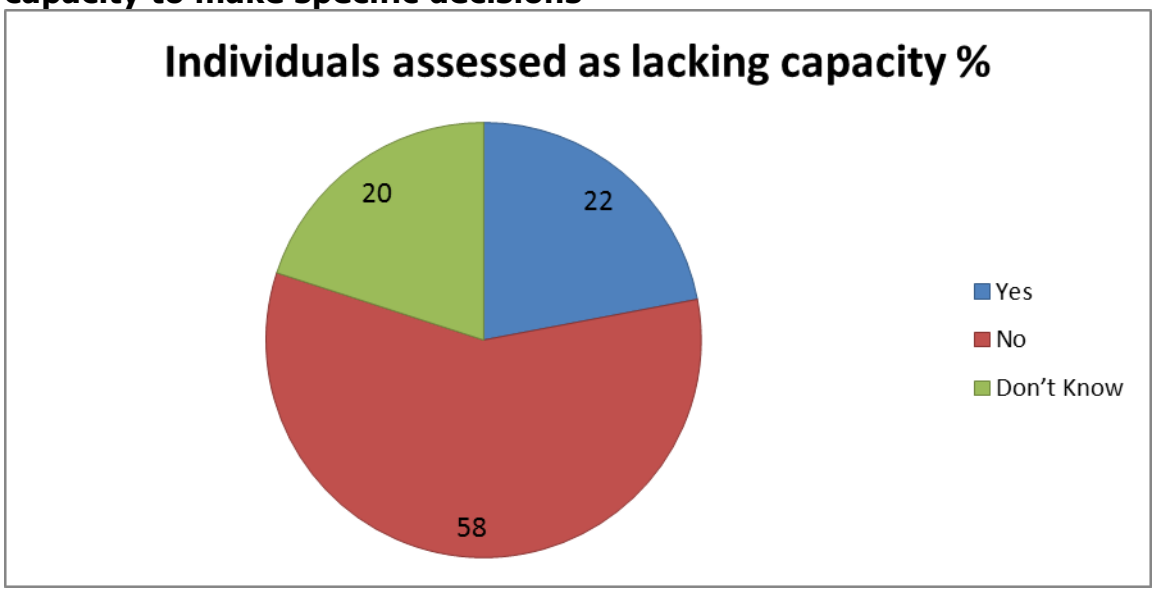
In 10 cases of 18, where the person thought to be the cause of risk was known to the person and the person's wishes were that the investigation did not take place.

Impact for individual adults as a result of action taken arising from investigations 2014/15:



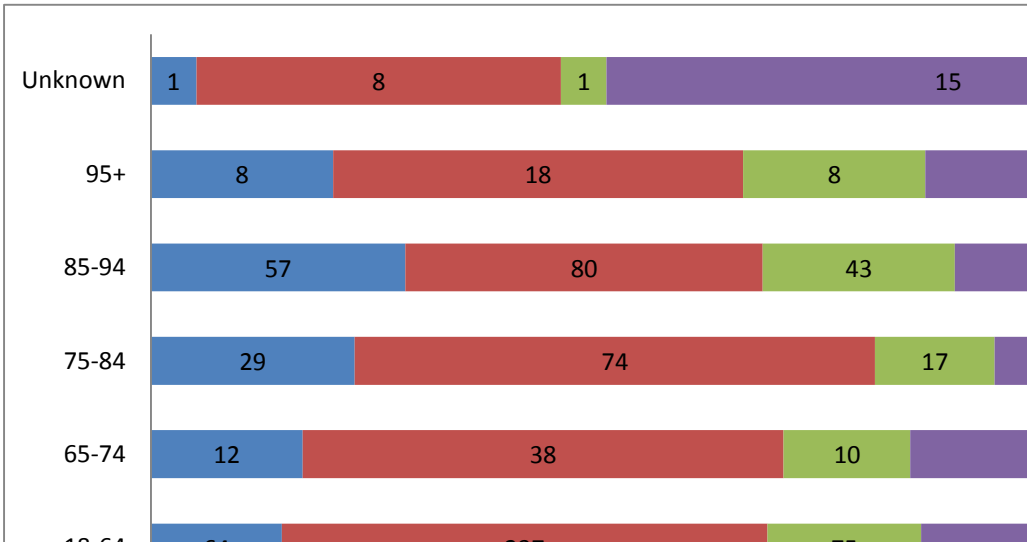
Of 1126 cases where this information was recorded, for 3% of adults the risk remained, for 38% the risk was reduced, for 14% the risk was removed, and in 45% of cases there was no action recorded as being required or taken arising from the investigation process. In situations where risks remained, safeguarding plans were agreed with the adult as far as possible in line with their wishes to support them, and offer future support mechanisms should their views or their situation change or deteriorate. In the majority of cases (52%) where action was taken this resulted in risks for adults either being removed or reduced.

Investigations undertaken where the person was assessed as lacking capacity to make specific decisions



Of 780 people where the information was recorded, across all age ranges 455 (58%) lacked capacity; 171 (22%) were assessed as having capacity; for 154 (20%) it was recorded that their capacity was not known; and of all people where this was recorded 385 (46%) people were supported by an advocate, friend or family member.

Number of individuals assessed as lacking capacity - By age shown as a percentage



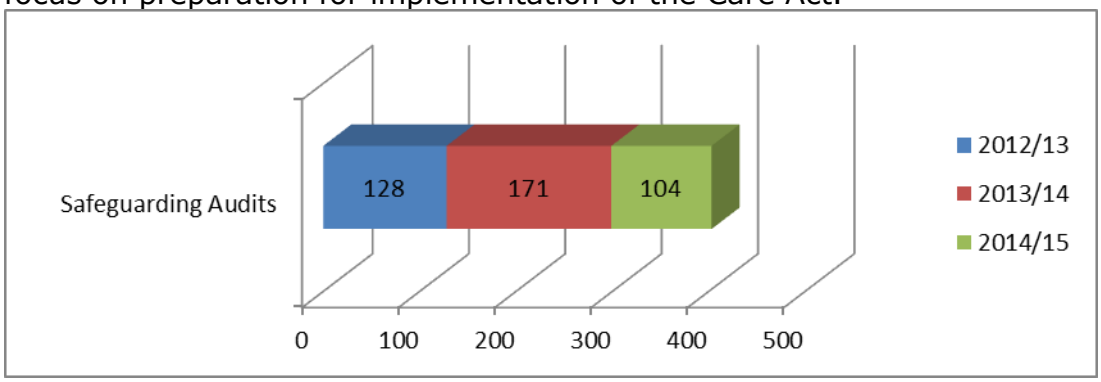
Of 171 people who were recorded as having been assessed as lacking capacity: 37% were aged 18-64 years; 7% were aged 65 to 74 years; 17% aged 75-84 years; 33% aged 85-94 years and 5% aged 95 years and over.

Quality Assurance:

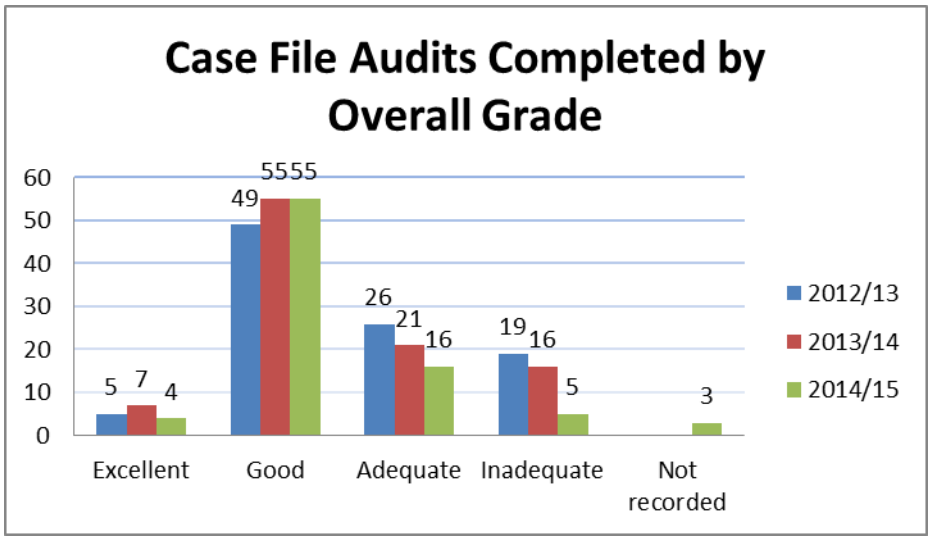
Case file audits
Total safeguarding adults case file audits undertaken April 2012 to March 2015.

104 case file audits of adults safeguarding investigations undertaken by Adult Services were carried out by WSCC in 2014/5. This included twelve cases that were audited as part of the Multi-agency case file audit process (further information below). Of these the majority of cases were graded as either 'outstanding' or 'good' with other cases highlighted areas where improvement could be made.

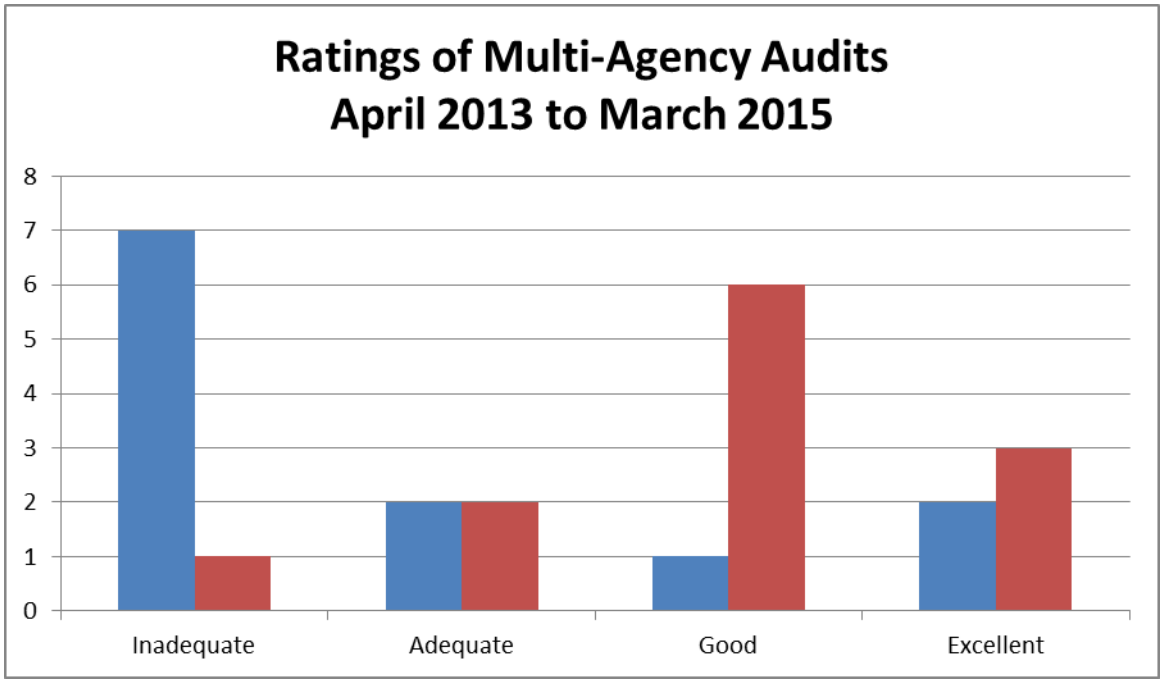
Fewer audits were undertaken in 2014/15 compared to previous years due to the focus on preparation for implementation of the Care Act.



Comparison of outcomes of all audits undertaken 2013 to 2015:



Multi-agency case file audits: took place in May and November 2014 covering twelve cases in total. Twelve Agencies were involved with a focus of undertaking audits of completed adults safeguarding investigation in which the agencies had been involved. The audits and multi-agency discussion of these cases take an in depth look at the quality and effectiveness of work undertaken with the adults and in partnership with other agencies. Good practice and any actions or learning are identified and disseminated across partner agencies and included in future development work and practice.



A summary report of the audit's findings and an action plan were produced and presented to the Adults Safeguarding Board. Although a relatively small number of cases are audited, this process has proved very effective in highlighting and sharing good practice and areas for learning and improvement for individual agencies and partnership working. The audits also provide an opportunity to reflect on work through a multi-agency lens.

Actions were completed for individual cases where appropriate and this also provides an overview of any areas requiring development and/or focus for training for agencies and organisations that could enhance or improve partnership working. The processes for multi-agency audits will be reviewed to ensure assurance and accountability of processes following Care Act implementation.

Up-dates from Partner Organisations:

This section gives you further information on safeguarding activity taking place within other partner organisations across West Sussex
Some common issues are highlighted in partners' reports and the themes and priorities from these are summarised below.

The Care Act 2014

All partners will focus on continuing work to fulfil the requirements of them set out in the new legislations to ensure this is firmly embedded across their organisations. The Care Act Guidance provided a framework for new Safeguarding Adults Procedures and agencies have been working together through task and finish groups to develop and embed these in everyday practice. The Board's task and finish and subgroups will enable continued interagency work regarding this. Partners will be asked to provide the Board with assurance that they are compliant with the Care Act.

Orchid View Serious Case Review

All partners have had been engaged in work to ensure the recommendations and learning from the review are implemented. Partnership working has been evidenced in all key areas and is planned to continue into next year and includes commissioners working closely together to identify better ways of working.
All agencies have noted learning from the events of Orchid View have informed improvements and revisions to their safeguarding policies and protocols. Arrangements are in place to ensure progress and developments will be fed back to families through an event planned for June 2015, one year on from publication of the review's report.

Prevent Strategy

The Governments counter-terrorist strategy CONTEST was reviewed in January 2015, resulting in key changes to the Prevent strategy regarding the approach to rolling out training and increasing levels of awareness.

Co-ordinating responses to issues of quality relating to health or care services and safeguarding concerns for individuals

Work is in progress focusing on the interface between quality assurance related and safeguarding related processes and procedures to ensure there is clear understanding regarding how these work together to prevent and safeguard people from harm.

Restructure

Several partners have identified the need to review organisational structures in light of the financial climate, to ensure efficiency and adequate resources to safeguard adults.

Designated Adult Safeguarding Managers - DASM

As part of Care Act Implementation all statutory partners identified an individual to take on the DASM role for their organisation – all DASMS

will continue to meet regularly to identify how their role will develop in the coming year.

Audits systems

The Safeguarding Adults Board Quality and Audit subgroup will continue to complete multi-agency safeguarding audits to ensure that organisational work around safeguarding continues to be focused on Making Safeguarding Personal and falls in line with individual organisational and Pan-Sussex procedures.

Adults Safeguarding Unit, WSCC:

Bev Morgan, Principal Manager, Adults Safeguarding Unit

General overview of the year:
The Unit provides support and quality assurance regarding practice in adults safeguarding work, advice regarding Investigations, independent chairing of case conferences for complex investigations and undertakes multi-agency development and partnership work, briefings, practice workshops and training. The Unit also works closely with adults safeguarding leads of partner agencies and contracts and commissioning; learning and development, service improvement teams and the Safeguarding Adults Board Team.

The Unit has been heavily involved in work to support the implementation of the Care Act in April 2015 for both the Local Authority and other partner agencies, while continuing to provide advice and support for complex safeguarding investigations; development related to Making Safeguarding Personal practice; and re-write of Sussex Safeguarding Adults Policy and Procedures.

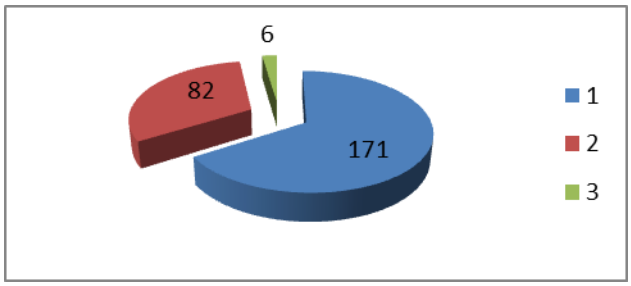
What has worked well / challenges: This has been a challenging year given high levels of demand on the Unit's time and resources. Preparation for readiness and compliance with the Care Act was achieved and included design and development of related practice guidance, tools, training materials and information, delivery of these and focused briefing sessions to operational teams. This challenge was compounded by the short time frame to complete this work as the final statutory Guidance was not available until late October 2014.
Alongside this the Unit continued to provide input to a number of large scale and complex adults safeguarding investigations, and on-going day to day support and advice for operational services and working age mental health teams. The new role of Designated Adults Safeguarding Manager for the Local Authority has been incorporated into the Unit's responsibilities, with a member of the Safeguarding Adults Unit in the post temporarily until March 2016 to undertake this function and develop related protocols and guidance. The Unit also provided input and support to the Orchid View Serious Case Review and Improvement Board; and the recruitment and establishment of the new multi-agency funded Safeguarding Adults Board Team, hosted by the Local Authority, and the Principal Manager, Safeguarding Adults supervises the Board Manager.

Key areas of work undertaken, developments and achievements include:

In addition to the areas above: briefings and workshops delivered to over 700 staff and managers in statutory and independent sector services, including input to a series of twelve multi-agency Care Act implementation Road Shows in March to May 2015 that were attended overall by over 1000 key staff and managers from independent, voluntary and statutory sectors. Monthly case file audits were suspended for the latter part of 2014/15 given Care Act implementation. The Unit continues to attend Multi Agency Risk assessment Conferences (MARAC) reviewing domestic violence cases where there are high levels of risk on behalf of Adults Services. This will require review given Domestic Abuse will be included as a category of abuse under the Care Act.

Safeguarding Meetings attended by the Adults Safeguarding Unit:
The Independent Chairs were involved in 259 Safeguarding Meetings from April 2014 to March 2015, representing attendance a minimum of one meeting per day for each Independent Chair throughout the year. Each meeting requires preparation time, and action post meeting. There are three meeting types: Strategy Meetings, Case Conferences, and Review Case Conferences.

Attendance at safeguarding meetings in 2014/15:



April 2014 – Mar 2015:
1) Strategy Meetings: 171
2) Case Conferences: 82
3) Review Case Conferences: 6

Attendance at safeguarding meetings yearly comparison:

Year	Case Conferences chaired	Review Case Conferences chaired	Strategy Meetings	Total input from Unit
2012/13	118	13	68	199
2013/14	103	6	134	243
2014/15	82	6	171	259

The number of attendances at Strategy Meetings has increased from previous years, as the focus of practice and the Unit's involvement has moved to earlier involvement in the safeguarding process, providing specialist advice and support for operational teams, to support a preventive approach, early intervention, and proportionate response to alerts and investigations. Case Conferences chaired predominantly were for Level 4 complex, high risk cases involving institutional abuse, and/or more than one adult at risk. Case conference requests have reduced as anticipated also in line with expectations of a more proactive and proportionate approach in adults safeguarding work.

Priorities for 2015/16:
Continued focus on embedding new legislation and on-going development and review of: local practice guidance and learning and development materials as national policy, guidance and practice develops; supporting Making Safeguarding

Personal outcomes focused approach in practice; input to systems development and recording tools (Frameworki, the electronic customer record in adults services); quality assurance in relation regarding day to day practice, case file audits and contribution to Safeguarding Adults Reviews; and multi-agency partnership work; and review of the role and responsibilities of the Safeguarding Adults Unit and Independent Chairs post Care Act implementation.

Bev Morgan, Principal Manager, Adults Safeguarding, WSCC

Adults' Services (West Sussex County Council)

Edward Armstrong, Adult Social Care Improvement and Quality Team, and on behalf of Tracie Thomas, Head of Adult Social Care

General Overview of the year:
Since the redesign of Adults' Services was activated in June 2014 there have been many changes to the way we work with West Sussex residents. One key example of this is that the majority of adult safeguarding cases are now first referred through our single point of contact known as CarePoint. Staff there separate incidents from alerts, gather relevant information and where suitable forward the cases onto the appropriate team for further investigation.

The on-going work to ensure implementation of the recommendations arising from the Orchid View Serious Case Review has been a high priority - as has the preparation for and implementation of the Care Act 2014 (from April 2015).

Headline activity data:
In 2014-15 there were 2522 contacts made to Adults' Services regarding potential safeguarding issues or concerns, of which 1595 were safeguarding incidents (these did not meet the threshold for recording as an alert) and 927 resulted in alerts - 886 of which were then taken to an investigation. This is in comparison to the 2996 incidents and alerts for 2013-14.

43% of the reported concerns were located in Care Homes and 60% were regarding an individual already known to Adults' Services.

There were 3 compliments received by West Sussex County Council Adults' Services regarding the Safeguarding of adults and 17 complaints, five of which involved the Local Government Ombudsman.

What has worked well:
Commissioning has set up the 'firefly' system – a system which is designed to support understanding of the quality and key information of the provider services which support adults in and from West Sussex.

Audits were carried out on 104 Safeguarding investigation cases and have evidenced that the majority of cases' work was either 'outstanding' or 'good' whilst highlighting other cases which required work.

The recording of Safeguarding cases has now been organised into a more streamlined process on the electronic recording system used by Adults' Services

(Frameworki). This has made case recording clearer for all, and will seemingly make next year's reports more accurate, and has saved considerable staff time.

Challenges:
Preparing for the implementation of the Care Act has taken up a lot of staff time in terms of learning and development which may have an impact upon business as usual activity.
During 2014/15 Adults' Services have faced challenged implementing some outcomes of the Orchid View Serious Case Review; for example Adults' Services took on the responsibility of sharing information with other agencies in order to spot any trends or patterns and be proactive in preventing serious Safeguarding cases. This has only just begun due to the challenge of formatting the information into a suitable format, and sharing it in a way which is respectful of confidentiality.

Making Safeguarding Personal has continued to be a challenge; many cases seem to have continued to be process led with investigating officers investigating every aspect rather than the separation of safeguarding and service quality. This is a challenge to the involvement of the individual adults and respecting the outcomes they want to see from safeguarding concerns. Work has and will continue to embed and build on Making Safeguarding Personal.

The team of the contact centre responsible for organising through Safeguarding referrals (CarePoint2) faces a great challenge sorting through all of their emails, including safeguarding referrals, which has led to some delays in triaging, separating incidents from alerts and initiating investigations.

As previously mentioned the recording of Safeguarding cases on the electronic recording system used by Adults' Services has been changed so that they are organised into a more streamlined process. However this has caused a disruption to the collating of data and has delayed the end of year report.

Development, achievements and work undertaken:
Preparation for the first stage of the Care Act 2014 has been met through staff training, the development of practice instructions and other tools and resources including new Frameworki (electronic recording system) episodes.

The production of a new Safeguarding episode on Adults' Services electronic recording system Frameworki to accumulate all information about a case in one place.

Work has been undertaken to ensure the recommendations arising from the Orchid View Serious Case Review are achieved and maintained.

Future plans and priorities
'Making Safeguarding Personal' workshops were run with staff in July 2014 aiming to improve the practice around investigations, so that outcomes of any investigations were less process led and more about what the individual involved in the investigation wanted.

Developing ways of ensuring work related to issues about the quality of services supporting adults are investigated by a separate team to Adults Services, who will continue to enquire into concerns where individual adults may be at risk of abuse.

The Contracts and Commissioning team is working closely with providers and partnership agencies and will be making a team for looking into enquiries concerning the quality of provider services, the 'firefly' system is a new recording system to observe the quality of care provider services and will also support this work. Continued partnership working between Adults' Services and the Contracts and Commissioning team will ensure that practice is as effective as possible in the safeguarding of adults.

We will carry out the implementation of the recommendations arising from the Orchid View Serious Case Review including the sharing of information with other agencies to spot trends aiming to prevent future cases.

Adults' Services will continue to ensure their staff attend Safeguarding training for basic awareness and for both enquiry officers and managers.

Awareness raising and publicity campaigns such as 'choosing care' will be run during the year in order to help prevent Safeguarding cases from occurring and Adults' Services will work in partnership with the Safeguarding Adults Board team to raise public awareness about what Safeguarding is.

There will be an aim to improve practice through audits, training and staff engagement.

Improvement work will be undertaken to provide easier access for the public wishing to raise concerns around the Safeguarding of adults

We will work with Children's Services to finalise a process regarding concerns involving domestic abuse towards individuals 16+. And to ensure work with domestic violence as a whole is embedded throughout the work undertaken by adults.

The participation in subgroups feeding information to the Safeguarding Adults Board will continue. WSCC will continue to support the board through funding, resources and attendance.

Our Quality Assurance and Management Board will continue to provide the overarching scrutiny and discussion forum for improving the quality of safeguarding work undertaken by Adults' Services.

Tracie Thomas, Head of Adult Social Care, WSCC

Brighton and Sussex Universities Hospital Trust

Joanne Henderson, Lead Nurse Safeguarding Adults and Caroline Davies, Deputy Chief Nurse on behalf of Sherree Fagge, Chief Nurse, BSUH.

General Overview of the year:

The Adult Safeguarding Team worked well with other partner organisations in readiness for 1st April 2015 and The Care Act 2014, and regular discussions about the changes to safeguarding and learning from cases as they occur.

Governance arrangements have been reviewed with the Deputy Chief Nurse to ensure they are fit for purpose and support a timely and proportionate response to all concerns.

The Head of Adult Safeguarding is on a 9 month secondment, so the Deputy Chief Nurse undertaken an interim management role within the team, this loss of a dedicated resource is a challenge. Expressions of interest across Kent, Surrey and Sussex, BSUH were not able to find suitable interim replacement.
Brighton and Sussex University Hospital's policy is currently being updated to ensure it complies with The Care Act. This will be approved on 07/07/2015. The pan-Sussex procedures are available for staff on the BSUH intranet.

In common with many acute trusts BSUH has faced significant challenges with regard to bed occupancy, patient flow and staffing over the winter months. Safeguarding concerns relating to the Acute Medical Unit, which has been exceptionally busy due to the operational challenges, has used the learning from these incidents to develop a 6 month improvement plan with actions for nursing, medical and operational staff. Positive changes have been made and on-going improvements continue to take place.

An overseas and national nurse recruitment programme is running. 350 nurses have been offered employment of which 106 are already in post.
The Learning Disability services have highlighted the difficulties for the transition of patients from child to adult services. People with a learning disability sometimes remain in the Royal Alexandra Children's Hospital (RACH) after the age of 18 years due to them remaining in education. This is agreed individually for each patient by their consultant. To develop a clear protocol is part of their work plan for 2015 / 16. The Learning Disability Liaison nurses and the Adult Safeguarding Team provide monthly training for staff in the RACH in relation to the MCA and DoLS.

The Adult Safeguarding Team continues to work closely with the Dementia Champion / Nurse Specialist. They provide joint training and support for staff in bespoke areas to implement the learning from safeguarding investigations, complaints and Serious Incidents.
The impact of 'Cheshire West' ruling has seen an increase in the need for DoLS authorisations. The Adult Safeguarding Team continues to deliver training and provide direct support to staff in clinical areas. For the period 01/04/2014 to 31/03/2015 Brighton and Sussex University Hospital applied 90 Deprivation of Liberty Safeguards authorisations.

Development, achievements and work undertaken:
Learning and Improvement:
The Adult Safeguarding Team, Dementia Champion and Learning Disability Liaison team in conjunction with Sussex Partnership were actively involved in the development and implementation of the Joint Health Economy 'Are you confident' training for the Mental Capacity Act and Deprivation of Liberty Safeguards. The programme was presented at the RCN Older Persons conference in March 2015 as a good practice example of multidisciplinary partnership education and learning.

A full time Safeguarding/Mental Capacity Act trainer has been appointed and continues to support the on-going delivery of the Joint Health Economy training as well as internal training for all clinical staff.

A draft template to improve the quality of documentation regarding capacity assessments and best interest decision has been developed. This is to be taken forward as an on-going piece of work supported by the medico legal team.

Both the Adult and Children's safeguarding leads have been working together to develop an action plan following the recommendations and learning from 4 Domestic Homicide Reviews.

Following the recommendations of a Serious Case review a new policy for the Observation of Adult Patients with Mental Health Problems has been developed. Training for staff will be implemented by the Safeguarding/Mental Capacity Act Trainer in conjunction with the Mental Health Liaison Team – Older People's Mental Health.

Governance:
A joint monthly Serious Safeguarding and Complaints Meeting has been implemented to review serious and complex cases, actions and learning. The meeting is attended by the Chief Nurse; Deputy Chief Nurse Patient Experience; Deputy Medical Director Safety; Head of Complaints; and the Lead Nurse Safeguarding Adults. This committee reports to the Trust Executive Safety and Quality Committee.
All directorates discuss Safeguarding as part of their Safety and Quality meetings. Learning from Safeguarding is shared at the Nursing and Midwifery Management Board. The Adult Safeguarding Team continues to work closely with Adult Social Care, often in discussion on a daily basis, and both organisations attend monthly joint case review meetings.
Monthly review meetings of all current cases in the Adult Safeguarding Team will commence with the Deputy Chief Nurse from July 2015. Attendance at the quarterly Safeguarding Committee has been reviewed to ensure senior nurse representation from all directorates.

Future plans and priorities
A programme for site and service reconfiguration is now underway. Initial changes include the Neck of Femur pathway from Royal Sussex County Hospital to Twineham Ward Princess Royal Hospital. Twineham have implemented a dedicated bay for patients with dementia. The Dementia Specialist Nurse and Adult Safeguarding Team have provided focused training for staff regarding The Butterfly Scheme and the Mental Capacity Act / Deprivation of Liberty Safeguards. Dementia Competences are in development for pilot on Twineham.
Richard Beard 3Ts Head of Communication and Engagement will present the hospital new build to the Best of Health Event for People with a Learning Disability on 25th June at The King Alfred Leisure Centre, Hove.

On-going work is planned to improve the data collection and monitoring of the use of Deprivation of Liberty Safeguards authorisations within Brighton and Sussex University Hospital, in partnership with the Local Authority.

Training is on-going for clinical staff regarding Adult Safeguarding and the Mental Capacity Act/Deprivation of Liberty Safeguards. Two members of the Adult Safeguarding Team have undertaken WRAP 3 (Workshop raising awareness of PREVENT 3rd Edition) training.
The PREVENT* training strategy is currently in development in conjunction with NHS England. PREVENT is the Government Counter-Terrorism strategy and is mentioned throughout our partner updates – more information is available here: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/97976/prevent-strategy-review.pdf

Sherree Fagge, Chief Nurse, BSUH.

West Sussex Clinical Commissioning Groups (CCG);

Crawley CCG, Horsham & Mid-Sussex CCG, Coastal West Sussex CCG

Alex Morris, Deputy Designated Nurse: Safeguarding Adults

General Overview of the year:
The Safeguarding Adults Team was transferred to Coastal West Sussex CCG in April 2014 and is a hosted service working across the CCGs in West Sussex. The team is managed by the Designated Nurse: Safeguarding Adults.

In September 2014 a Mental Capacity Lead Nurse funded with money from NHS England started a one year post. Their remit is to provide teaching and support to the West Sussex health economy, with a particular focus on primary care. With increased capacity it has been possible to provide an increase in health opinion and involvement in safeguarding investigations, supporting the local authority, individuals believed to be at risk of abuse and care providers throughout the safeguarding process.

Preparation for the implementation of The Care Act (2014) has generated a large volume of work for the Safeguarding Adults Team with their involvement being required to ensure that the CCGs are compliant with The Act, as well as being members in the West Sussex Safeguarding Adults Board implementation Groups. The team also presented at each of the Care Act Road Shows.

The Care Act (2014) clearly states that quality issues should not be addressed through the safeguarding process but sit with the providers, commissioners and regulators of care. A large piece of work is required to identify how this will be achieved is West Sussex.

To date multi-agency progress has been slow but this work will continue to develop through the work of the Quality Design Team in 2015-2016.

Development, achievements and work undertaken:
Bimonthly reporting to the Quality and Clinical Governance Committees for each CCG with additional exception reporting if required (Objective 2)

CCG intranet and public facing pages regularly updated with information about Safeguarding Adults, the Mental Capacity Act and Deprivation of Liberty Safeguards, as well as the work of the West Sussex Safeguarding Adults Board (Objective 3)
Safeguarding policies, procedures, strategy and assurance tool updated to reflect The Care Act (2014) (Objective 3)

Commissioning Intentions updated to reflect learning from Serious Case Reviews, Domestic Homicide Reviews, audits and other multi-agency work (Objective 3)
Successful integration of the Safeguarding Adults Team and resultant increase in capacity has been used to provide additional support for the CCGs and improved assurance for commissioned services (Objectives 3 & 4)

Participation in the West Sussex Multi-Agency Audit process (Objective 3)
Attendance at the West Sussex Safeguarding Adults Board, as well as all of the subgroups of The Board (Objective 4)

Mental Capacity Act and DoLS training offered to all GP Practices in West Sussex (Objective 3)

Future plans and priorities
To continue to develop the assurance process for safeguarding adults in commissioned services
For the Safeguarding Adults Team to provide opinion and Enquiry Officer support to safeguarding enquiries
To continue to provide training in safeguarding adults, the Mental Capacity Act and Deprivation of Liberty Safeguards to primary care
The Safeguarding Adults Team will continue to provide support and advice to the local health economy regarding the Mental Capacity Act and Deprivation of Liberty Safeguards
To continue to be an active member of the West Sussex Safeguarding Adults Board to ensure that it can work effectively
Continued attendance at the West Sussex Safeguarding Adults Board and subgroups
The Deputy Designated Nurse: Safeguarding Adults is to chair the Quality Design Team group which is tasked with developing processes for the monitoring of the quality, and sharing information about the health and social care services in West Sussex
Ensure that safeguarding is integral to the development, commissioning and on-going quality assurance of CCG commissioned services

Alex Morris – Deputy Designated Nurse Safeguarding Adults

West Sussex District and Borough Councils

Nigel Lynn, Chief Executive Officer – Arun District Council

General Overview of the year:
The main focus of the six District and Borough Councils in 2014/15 was the introduction of the Care Act and assessing how it would impact on service delivery.

Representatives from the District and Borough Councils attended both the Policy and Procedures Working Group and the Training Working Group.

The challenges for District and Borough Councils were largely to ensure that the authorities were Care Act ready and this is a process that has extended in to 2015/16. Whilst structurally compliant with the Act, the District and Borough Councils recognised the need to extend training to ensure colleagues were aware of changes brought about by the Act, particularly making safeguarding personal and the new categories of abuse.

All of the District and Borough Councils meet quarterly to provide updates and share best practice. Internally, each partner has Designated Safeguarding Officer meetings to ensure that the policies and procedures are being adhered to and operating effectively.

District and Borough Councils have raised concerns in respect of the ability of colleagues, often with limited contact with an individual, to assess mental capacity. There have also been challenges brought about by individuals who choose to hoard and how to improve our response to hoarding behaviours.

Development, achievements and work undertaken:
Information is sought using a range of media and across services. The challenge will make specific safeguarding feedback and gather information on individual cases to review outcomes and the impact interventions have made.

The District and Borough Council's co-operated with the SAB in providing information for the baseline audit.

The District and Borough Councils worked with the Adult Safeguarding Practice and Learning Development Manager to consider the training needs of the Councils. This will result in specific training for all Designated Safeguarding Officers in 2015. Best practice is shared across the group of Council's at regular Safeguarding meetings and when appropriate external speakers are invited to provide specialist information or advice.

Leaflets and other information are displayed and distributed through Council buildings and facilities. District and Borough Councils sign post all Safeguarding queries to the West Sussex County Council website for further information about Safeguarding Adults.

Future plans and priorities
Training has been booked in 2015 with the Adult Safeguarding Practice and Learning Development Manager.
The District and Borough Councils will integrate the requirements of the Care Act in to their e-learning modules and other training courses, including new Member inductions.

Nigel Lynn – Chief Executive, Arun District Council

Healthwatch West Sussex

Katrina Broadhill, Consumer Champion and Healthwatcher (Locality Manager)

General Overview of the year:
The Board implementation of an improvement board, in response to the Orchid View Serious Case Review, has demonstrated the commitment of the Board to pushing agencies to progress towards achieving the reviews recommendations. Healthwatch West Sussex acknowledge the challenges around making safeguarding concerns available to the public but will be pushing for such a system to be brought online in 2015.

The Care Act 2014 introduced a need to transform the way safeguarding is carried out from 1st April 2015 onwards, and agencies have worked steadily to implement the necessary changes. Healthwatch West Sussex aims to have a key role in evaluating, from the point of view of the individual at the centre of any safeguarding concern, whether the expectations of this new legislation are matched in reality (2015/2016).

Development, achievements and work undertaken:
It is fair to say that the Board has undergone major changes during this year, in order to meet the requirements of the Care Act and this will have had a significant impact on the business plan priorities.

Future plans and priorities
Healthwatch West Sussex will be seeking to work in partnership with the Safeguarding Adults Board to carry out consumer audits of the safeguarding process to evaluate whether the expectations of the Care Act 2014 legalisation are being met in reality. The feedback, any learning will be shared in order to support the Board to achieve successful outcomes for individuals at risk.

Healthwatch West Sussex's Annual Report 2014/15 is available for additional information.

Katrina Broadhill, Consumer Champion and Healthwatcher (Locality Manager)

Independent Lives

Sam Pegg, Care Services Manager and (Designated Adult Safeguarding Manager (DASM)

General Overview of the year:

Independent Lives is a registered charity promoting and supporting independence for disabled people in West Sussex. We help people set up and run their own care and support under the county's Direct Payments (DP) scheme. Many people use this form of Self-Directed Support to employ their own Personal Care Assistants (PAs). Our other services include: -
Lend a Hand, a home care service registered with CQC
Payroll services which supports PA employers
Recruitment Solutions, a PA recruitment service
BAS, a banking admin service handling DP money on behalf of customers
DBS checking service
Personal Health Budget support planning
Peer support groups and a member action/advisory group
Integrated advocacy service based in GP surgeries.

We work directly with disabled people across the range of physical, mental and learning disabilities, including acquired brain injury and dementia, and with children, young people and their families, working age adults and older people.

In 2014-15 we have worked with adult social care services to discuss and report safeguarding incidents and alerts effectively. Owing to the nature of our services we have different levels of involvement in safeguarding alerts. We investigate all safeguarding incidents relating to Lend a Hand, our domiciliary care service; and report all incidents and alerts arising through our DP support service to social services.
We have recorded, investigated and notified CQC of 4 incidents through our Lend a Hand agency during this period.
We have reported 7 incidents/alerts to social services from our DP support service. We do not routinely receive an update on the outcome of these alerts, however, and therefore have no record of whether they have been investigated as part of the Adult Safeguarding procedure or logged as an incident.

Development, achievements and work undertaken:
Independent Lives' Chief Executive, Philippa Thompson, has a place on the WSCC Safeguarding Adults Board. Independent Lives has contributed to WSCC's development of the new Safeguarding policy by attending the Quality and Audit Subgroup, and the Care Act Implementation Policy & Procedures Working Group. We are able to give the perspective of a charity governed by disabled people and carers. Our involvement also helps Independent Lives to keep abreast of safeguarding topics and ensure our own procedures and training reflects best practice.

Future plans and priorities
Independent Lives has updated its safeguarding policies and procedures to safeguard adults (and children) at risk in line with the Care Act 2014 as it is a legal requirement to provide a proportionate, timely and professional approach, co-ordinated across all relevant agencies and organisations, which is essential for the prevention of harm and abuse.
Independent Lives has appointed a Designated Adult Safeguarding Manager who writes a quarterly report on the number and nature of safeguarding alerts that have been made by Independent Lives and contributes to the Safeguarding Adults Board's annual report. In addition to this, Independent Lives has also appointed a Safeguarding Training Lead and a Quality lead for safeguarding.

Independent Lives has made a commitment to improve the safety and wellbeing of adults with care and support need and children. We are committed to informing our customers and other people that we regularly come into contact with about our policies on safeguarding and confidentiality. We publish information about our policies and practices on our website (www.independentlives.org) and explain the process to individuals starting on Direct Payments or with our care agency.
We will continue to invest in safeguarding and confidentiality training for all new staff as part of our induction policy and we provide annual refresher and update training for all staff.
It is our intention to continue to contribute to the development and co-ordination of safeguarding principles, practices and procedures in West Sussex through engagement with the Safeguarding Adults Board. Independent Lives also participates in a number of sub committees to the Board.
All attendees to the Board or subgroup complete a summary of the meeting and send it through to the Designated Adult Safeguarding Manager who will compile the information into the annual report.

Going forward, Independent Lives will be continuing to develop making safeguarding personal and offer safeguarding training to PAs of direct payment customers.

Independent Lives will also develop a Safeguarding factsheet for all Direct Payment and PHB customers so they are aware of the process and their rights around safeguarding by October 2015.

Kent Surrey and Sussex Community Rehabilitation Company Ltd

Kerrin Page – Outgoing Director (Assessment and Integrated Offender Management)
Paul Jones – Acting Director (Assessment and My Solution Rehabilitation Programme)

General Overview of the year:
2014 – 2015 has brought significant changes in the delivery of Probation services. Under the Government's Transforming Rehabilitation programme of change the previous Probation Trust structure was dissolved and reforms created a new public sector National Probation Service (NPS) and 21 Community Rehabilitation Companies (CRC). Through this the former Surrey and Sussex Probation Trust ceased to exist and the Kent Surrey and Sussex Community Rehabilitation Company Ltd (KSS CRC) was formed.

Following a period of national competition KSS CRC transferred ownership to Seetec on 1st February 2015. The opportunities created by this sale permits KSS CRC to redesign community justice provision offering the communities of Kent, Surrey and Sussex a bespoke, innovative, effective and efficient public service delivered through a private company.

Workloads and scope increase post-share sale with the inclusion of short sentenced prisoners in the statutory caseload. The Offender Rehabilitation Act 2014, charges KSS CRC with the new responsibility of 12 months post-release supervision for a cohort of service users typically presenting as chaotic and prolific. KSS CRC is now

required to effectively supervise this cohort, change their perceptions on sentencing where a short prison term is no longer the end of their punishment and adopt new practices with stakeholders in HMPS.

KSS CRC brand is built on clear and consistent delivery to service users based on a strong message of "My Problem, My Solution". This is designed to increase service user ownership of solutions, increase engagement levels and lead to faster desistance. The KSS CRC model is agile, flexible, innovative and comprehensive and applicable across the range of delivery contexts and service user characteristics

Development, achievements and work undertaken:
A significant development in 2014-2015 is in service user engagement through our commitment to work with User Voice. User Voice was the first user-led charity working in the Criminal Justice System and their Service User Council model is in place across the KSS CRC geography.
This is allowing much greater engagement with service users regarding the services we deliver, and they will have a vital role to play in shaping the future of criminal justice delivery in KSS CRC.

Future plans and priorities
The Business Plan for years 1 & 2 of the KSS CRC contract covers the Transition (1st February to 31st April) being the first 3 months to set up the Through the Gate offer and the Transformation process. It is the period in which KSS CRC will build My Solution Information System (MySIS) a Cloud based IT platform upon which the electronic infrastructure sits. The synergy achieved between KSS CRC and the parent company will enable the delivery of effective practice, drive efficiency through the harmonization of work practices and operations thereby increasing capacity in service delivery to improve the levels and quality of engagement with service users.

KSS CRC will concentrate on embedding its operating model through the service user's journey from court to rehabilitation via our core functions: Assessment, Rehabilitation, Intervention and Resettlement. We will develop a robust supply chain that adds value to our own offer. We will establish Integrated Offender Management as a standalone function, embedding partnership working at the core of our business. We will evidence our work so we can show a demonstrable reduction in crime as a result of putting the service user at the heart of their own solution. And we will tell the probation story: that rehabilitation can and does work when a service user owns the problem as well as the solution.

Kerrin Page – Outgoing Director (Assessment and Integrated Offender Management)

Queen Victoria Hospital NHS Foundation Trust (QVH)

Jo Thomas – Director of Nursing and Quality

General Overview of the year:
The safeguarding agenda has grown on a national level within the last 12 months, particularly with the introduction of the Care Act (2014). Within QVH, Adult Safeguarding continues to have an extremely high priority and this puts the Trust in

a good position when further changes and guidance is delivered nationally. In many aspects, QVH is already meeting the needs of the change in legislation, in that a new full-time safeguarding lead will soon be in post, the Trust already offers full support and engagement with the Local Safeguarding Adults Board and has clear pathways for raising concerns.

Development, achievements and work undertaken:
QVH are in good position to respond to the changes introduced by the Care Act, as they already have a strong Adult Safeguarding agenda, with regular input from Board level. An open culture has been developed which encourages staff to report concerns and ensures they get the support to manage such concerns. Within the next month, the Trust Lead for Safeguarding will change, with a new employee recently appointed. The Board has taken an extremely positive step by changing the role into a full-time post (the position was previously a dual-role, combining Practice Development duties) This will provide the new post holder with the time to take the role forward and ensure safeguarding practice continues to progress at QVH.

The QVH Adult Safeguarding Policy continues to be based on the Sussex Multi-Agency Policy for Safeguarding Vulnerable Adults. This ensures our policy is supportive of the needs of our patients and provides a sound structure to the work we do. The policy helps to raise awareness and sets out a clear structure for reporting concerns for staff that may have either direct or indirect contact with vulnerable adults.

Future plans and priorities:
QVH plans, following the recruitment of the new post holders, to consolidate the work already started within the safeguarding agenda. Training delivery and compliance will be a priority, ensuring all areas of the organisation takes the agenda forward.

South East Coast Ambulance Service NHS Foundation Trust (SECAmb):

Jane Mitchell: Safeguarding Lead

General Overview of the year:
South East Coast Ambulance Service NHS Foundation Trust (the Trust) is committed to promoting and safeguarding the welfare of all vulnerable people; recognising that everybody has the right to be protected from harm, exploitation and neglect within the context of the law and personal civil liberties. During 2014/15 the Trust has undertaken a review of its safeguarding arrangements and the safeguarding team has seen an increase in capacity during this period. Referral rates have continued to rise with an overall increase of 18% from 2013/14 across the whole Trust area. Unfortunately it is not possible to break down the reporting figures by local authority area due to data entry challenges, however, it is anticipated this will be addressed during 2015/16.

Development, achievements and work undertaken:

Appointment of a full-time Safeguarding Support Officer adding resilience and capacity to the safeguarding team

Re-introduction of a Domestic Abuse (DA) pilot in Sussex with increased DA awareness training across the whole Trust

Successful pilot for an on-line reporting process across the whole Trust

The additional capacity in the team has enabled the Trust to have a greater presence at the local Safeguarding Boards which has the benefit of ensuring that the Trust continues to play an active role within each local area.

The Trust undertook a Domestic Abuse (DA) project in 2012/13 which ended due to the cessation of short term project funding. However, with the support of the Office of the Police and Crime Commissioner, and associate commissioners in East Sussex County Council and West Sussex County Council, additional funding was secured enabling the project to be re-introduced from December 2014 for a twelve month period, and expanded to cover the whole of Sussex (previously this was restricted to West Sussex and Brighton and Hove). As a result, all areas of the Trust have benefitted from DA training and the post-holder has secured referral pathways to specialist DA organisations across Sussex (with signposting to the national helpline in non-pilot areas) and made direct contact with a number of patients identified through the referral process.

The Trusts on-line referral process was successfully piloted in Kent during 2014 and subsequently rolled out to all staff across the Trust from April 2015. Improved clarity of concerns and data being gathered will enable greater scrutiny of demographics and ensure that training needs can be identified and mapped to enable targeted training to be delivered in future.

A significant backlog of data entry for vulnerable person (VP referrals) due to legacy departmental capacity issues made reporting and analysing referrals for the year challenging. This has since been rectified at the end of Q4 and into Q1 2015/16.

Lack of capacity within the team during the first half of the year meant it wasn't possible to properly engage with local safeguarding boards across the region. This has improved following the appointment of additional staff in the team.

Understanding how the 111 service differed from the 999 service provided across the Trust and the unique challenges faced by staff that do not see the patient with regards to making referrals was a core requirement.

Future plans and priorities

The safeguarding team will continue to roll out the electronic reporting across all Trust sites (including both 111 sites) leading to improved monitoring and analysis of the information being gathered.

The DA pilot will continue as per the commissioned plan, including project review and evaluation to assist the development of business case proposals for its sustained continuity beyond December 2015.

The team will continue to work with 111 to improve the understanding of safeguarding referral requirements and referral data analysis.

A significant volume of safeguarding and DA reporting metrics have been agreed with lead commissioners for reporting where possible during 2015/16.

In partnership with learning and development colleagues, the team will progress the delivery of MCA training to all clinical staff in accordance with the Trusts key skills plan (including application of capacity assessments, obtaining consent to treatment and use of control and restraint techniques) supported if appropriate by a tier of Mental Health expertise available to operational staff.

Jane Mitchell - Safeguarding Lead – Southeast Coast Ambulance NHS Trust

Surrey and Sussex Healthcare NHS Trust

Julie Chivers/Fiona Crimmins – Safeguarding Adults Leads

General Overview of the year:
This has been an exceptionally busy year for Adult Safeguarding at Surrey & Sussex Healthcare NHS Trust. There have been 271 concerns raised in total. Broken down, 237 alerts were raised by Surrey & Sussex Healthcare NHS Trust regarding concerns in the Community; this has increased on last year's figure of 214. A further 34 alerts, (a decrease from 37 in 2013/14), were raised regarding care patients received whilst being a patient in the Trust. Of these, 16 were raised internally; this has decreased from last year's total of 22. There were 105 concerns raised regarding West Sussex patients equating to 40% of all activity.
The CQC visited Surrey & Sussex Healthcare NHS Trust in May 2015, they were satisfied that the Trust were meeting all the standards for Safeguarding.

What has worked well:
The Team are delighted to convey that Julie Chivers has joined the Safeguarding Team in September 2014.
There is constant communication between the Safeguarding Team and the Trust Social Care Team; there are regular weekly meetings in place for information to be shared regarding any concerns raised or investigations that are on-going.
As stated above, activity continues to be on an upward trend with a total 271 raised for the previous year.
The Safeguarding Team have worked closely with partner agencies to ensure that the Trust was prepared for the implementation of the Care Act.

Challenges:
The Trust tries to send a representative to as many external meetings as possible but as Surrey & Sussex Healthcare NHS Trust covers two counties, it can be difficult to attend all meetings.

The Safeguarding Team are working with the Education Department to see how training can be increased compliance is sitting at 54.7% for the year.

With the changes to the thresholds of Deprivation of Liberty Safeguards (DoLS), it has been challenging and time consuming for Trust Staff, though this has eased since the introduction of new paperwork.

With the DoLS teams stretched, it has also been difficult to ensure that all DoLS were reviewed by the DoLS Team within an appropriate timescale

Development, achievements and work undertaken:

Safeguarding Investigations
Through investigations completed during this time period, where possible the Trust has involved the patient, their Carer's and their families. Through the investigation and safeguarding process, their views have assisted with incorporating and improving service delivery. This has assisted with learning and raising awareness of the Safeguarding agenda across the Trust.

Paperwork
Since the introduction of the Care Act 2014, the Safeguarding Team have introduced a new safeguarding concern form, the initial feedback has been good as it is easy to use and this will be circulated.

Training
Safeguarding Training sits on the Trusts Mandatory and Statutory Training (MAST); this is for all staff to attend on a 3 yearly basis. The Team also facilitate mandatory training for the Consultants. Over the last year, the Team have joined the Maternity Training programme.
All training includes attitudes and behaviour when interacting and or caring for patients / relatives or visitors to the Trust. MAST training incorporates the Mental Capacity Act, Deprivation of Liberty Safeguards, PREVENT, Types of Abuse, including Domestic Abuse, FGM and Allegations made against staff. This session is considered to be set at level 2 and is for all staff (clinical and non-clinical). All training is evaluated; this also allows participants to comment on the learning.

Future plans and priorities
Training
This is an on-going priority for the Safeguarding Team and the Trust, particularly in light of the implementation of the Care Act 2014 on 01/04/2015. The Act has made Adult Safeguarding statute in law and heralds a new way of working. The Safeguarding Team will highlight the introduction of this and the changes that have occurred within Adult Safeguarding ensuring compliance across the Trust.
Training will continue to highlight and promote the importance of the Mental Capacity Assessments and Best Interests Process and ensure clear guidance is in place and accessible for all staff. Further training days are already in the process of being rolled out with a view to have MCA & DoLS training days on a continuous programme for the year ahead.
MCA & Consent training has been introduced to the Consultant Training Programme for the coming year. To assist with this, the Safeguarding Team will continue to work in partnership with the Learning Disabilities Liaison Team in highlighting the importance of the Mental Capacity Assessments and Best Interests process.
Prevent Training for all staff - The Trust has two trainers for Prevent. As Prevent is to become statute on the 01st July 2015, the Trust is looking at key staff who could also undertake the role as a Prevent trainer. This will assist with the roll out of the training and give assurance that the Trust is compliant with training (85%) as set by NHS England. The Prevent Lead from NHS England was invited to present to the Trust Executive Board in June 2015, as Surrey and Sussex NHS Health Care Trust are geographically located close to a priority area.

Deprivation of Liberty Safeguards (DoLS)
Due to the recent change in the threshold for Deprivation of Liberty Safeguards applications, the Safeguarding Team must ensure that there is a robust reporting

system in place and support for staff completing the application. This will include clear guidance and support for staff. The creation and publication of an information leaflet for patients and their carers regarding DoLS.

Risk & Compliance
The Team plan to roll out a robust audit programme for the Adult Safeguarding Team in relation to DoLS applications and concerns rose.
The Team will continue to develop strong links with the Tissue Viability Nurse, the Complaints and Patient Safety & Risk Departments to ensure that safeguarding is considered at all times when investigating a complaint or a patient safety issue.
The Safeguarding Team will continue to raise awareness around Domestic Abuse and introduce direct links with the local MARAC (Multi Agency Risk Assessment Conference). The Team will continue to raise awareness around Female Genital Mutilation and assist to ensure that a robust reporting system is in place.
With the Trust migrating to NHS.net later this year, the Safeguarding Team plan to move to electronic reporting of concerns, this will ensure immediate notification to both Social Care and the Safeguarding Team enabling a timely and appropriate response.

Julie Chivers/Fiona Crimmins – Safeguarding Adults Leads

Sussex Community NHS Trust (SCT):

Jennie Harmston, Head of Safeguarding Children and Adults

General Overview of the year:
SCT completed an independent review of safeguarding across the Trust during July/August 2015. The 24 recommendations were taken to the Board and accepted for implementation. SCT has provided additional resources including a senior post, Head of Safeguarding, reporting to the Chief Nurse.
The Chief Nurse has Director level responsibility for Safeguarding. SCT have strengthened the Governance arrangements with a Safeguarding Steering Committee chaired by the Chief nurse and reporting to the Trust Wide Clinical Governance Group. There is an Adult Safeguarding Delivery group to ensure operational services are informed and embed safeguarding in preparation for the Care Act 2014.

Development, achievements and work undertaken:
Sussex Community Trust delivers Level 2 training for all staff as part of their mandatory training programme and this has been revised to include Adult Safeguarding, Prevent and MCA/DOLS.
There is also bespoke level 3 training for MCA/DOLS offered in various localities 2015/6 using personalised case studies.
During July 2014 Sussex Community Trust commissioned an independent review of the robustness of the safeguarding arrangements in both adults and children. The 24 recommendations were approved by the Board. This resulted in the implementation of all the recommendations from the independent review actions for 2015/16 including strengthening the governance arrangements.
The Head of Safeguarding is supported by a team of three specialist nurses in adult safeguarding. Additional resources have been identified to strengthen the team.

SCT has been engaged with the Boards work in preparing for the Care Act through attendance and support at sub committees. All the policies and procedures are Care Act compliant.

Future plans and priorities

Implement a 5 year safeguarding strategy including children and adults across the Trust.

Effective response to safeguarding concerns and work in partnership during enquiries.

There is bespoke level 3 training planned for 2015/6 dates identified and specialist teams targeted

Increase the attendance of the adult safeguarding training

Offering bespoke safeguarding supervision to staff undergoing care home closures, serious incidents, serious case reviews and cases which are traumatic for staff

Develop a programme of audits of cases to ensure safeguarding is made personal

Develop a data collection process to benchmark

Jennie Harmston – Head of Safeguarding Children and Adults

Sussex Partnership NHS Foundation Trust (SPFT) West Sussex Locality:

Vincent Badu – Director of Social Care and Partnerships

General Overview of the year:

In 2014/15 we continued to undertake safeguarding activity in adult mental health on behalf of the local authority as a part of the section 75 agreement that establishes integrated health and social care provision. We have an established structure to support this with a West Sussex management and quality assurance group meeting regularly and bringing together managers and safeguarding leads. In addition we have a Trust wide governance structure and provide regular reports including data reports to our Quality Committee. An annual safeguarding report is presented to the Trust Board.

We worked closely with local authority and other key partners in preparing for the implementation of the Care Act 2014 including a significant number of staff attending local authority and in-house training. We have a strong commitment to Making Safeguarding Personal and this underpins the approach to training and practice post Care Act.

A comprehensive and independent internal audit of safeguarding was undertaken by Baker Tilly and completed in October 2014. The report covering both Adult and Children's Safeguarding gave an overall rating of amber/green and concluded that " the Trust Board can take reasonable assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied and effective"

During 2014/15 we addressed concerns about our integrated Adults and Older Peoples ward at Langley Green Hospital that had been highlighted, primarily about the care of older people, by the safeguarding process. We worked closely with the local authority, the CQC and the CCG to address these concerns. The issues raised through safeguarding were addressed robustly through an action plan monitored by the CQC. We subsequently significantly improved our process with regards to Adult

Safeguarding at Langley Green Hospital with support from local authority safeguarding leads. This included the provision of additional training and improving data systems.

In 2014 we were selected to be one of two Mental Health Trusts nationally to host a project led by AVA (Against Violence and Abuse) Stella to improve our policy and practice with regards to Domestic Abuse. A Trust wide steering group has been established with representation across all care groups. Initial training sessions have been provided and a training plan is being developed including a specific induction slot. A new and comprehensive Domestic Abuse policy has been drawn up and is currently at the committee approval stage.

The CQC inspection of services in January 2015 provided positive feedback around the systems we have in place to support safeguarding of vulnerable adults. As part of the visit inspectors spoke to staff across local services to test their knowledge and understanding and found a good level of assurance. Further work is required to raise awareness of MCA and DOLS and to ensure information about staff accessing and completing mandatory Safeguarding training is more robust. Actions around both these areas are being taken forward as a priority as part of our improvement plans. The "My Learning" learning management system has now been introduced to support completion and recoding of all mandatory training for our staff.

A new Social Care Lead Professional role has been created in the integrated service with a specific brief to lead on adult safeguarding.

Development, achievements and work undertaken:

Engaging with customers and using their feedback to inform and improve the work we do: we have extensive processes in place for getting feedback from people using our services including complaints, the PALS service and the Friends and Family Test. Regular reports on patient experience are reported to the Quality Committee and the Board. There is a robust process for learning from Serious Incidents.

Understanding the effectiveness of the Board's safeguarding arrangements through robust scrutiny arrangements including using key performance indicators, together with scrutiny reports from partner Boards (including the new NHS Commissioning Board): we have worked closely with the SAB to ensure compliance with the Care Act 2014. In this respect we have adopted the new Sussex Safeguarding Policy and Procedures, and the new multi-agency Information Sharing Protocol. Briefing papers have been presented to our key internal governance committees and to the Trust Board. Our Sussex Partnership Safeguarding Adults Policy is being updated to ensure Care Act compliance to reflect the new local policies and procedures.

Develop a culture of learning and improvement, co-ordinating and using the available information alongside the experiences of patients, customers and carers:
Our safeguarding management group regularly reviews safeguarding practice and quality. Adult Safeguarding is part of the Induction training for all staff supported by e learning modules at levels one and two. Staff in the integrated service are also able to access the safeguarding training provided by WSCC and this has included

extensive training with regards to new roles and responsibilities as outlined in the Care Act. Trust wide training is provided in relation to MCA and DOLS. In addition we have taken part in the Joint Health Economy project which provided further training re: MCA and DOLS Sussex wide.

Establishing robust and stronger scrutiny, overview and challenge of each other as Board partners but also about the provision in the County: we are an active member of the West Sussex SAB and its subgroups and have also taken part in Safeguarding Adults Reviews, Multi-agency Safeguarding Reviews and Audits.

Future plans and priorities
To ensure compliance with the Care Act 2014
To embed the principles of Making Safeguarding Personal into safeguarding practice
To raise staff awareness in relation to domestic abuse, self-neglect and modern slavery
To raise staff awareness in relation to the Prevent Duty and the Channel process
To improve data collection and reporting particularly in relation to our service
To develop more integrated systems for recording and monitoring safeguarding concerns and MCA work linking to the new Sussex Partnership clinical recording system – Care notes that are not integrated with the local authority.

Vincent Badu – Director of Social Care and Partnerships

Sussex Police Specialist Investigation Branch – West Sussex:

Detective Chief Inspector Richard Bates – Head of Adult Safeguarding

General Overview of the year:
Over the last year, Sussex Police have invested in experts to work alongside serving officers and staff to create a vision for our new local policing model. One of our challenges is financial. We have already had to make savings of around £50 million and further savings of £57 million may be required over the next four years. But we also know that policing has to adapt to changing demands. Sussex has long been a safe place to live and work – levels of reported crime, including burglary and vehicle crime have fallen considerably over the last 10 years. However, reporting of other crime types, including domestic violence and abuse and sexual abuse, have increased suggesting that victims may be more confident in reporting to police.

To ensure that we can continue to provide an effective response these serious crimes, including working with partners to support those who have experienced or been impacted by them, we have undertaken a major piece of work restructure our Public Protection teams. This has involved the creation of single Safeguarding Investigation Units (SIUs) in each Division, combining the previous Child Protection, Adult Protection, and Anti-victimisation teams. During the final phase of this work, the SIUs will take on responsibility for the investigation of all reports of Rape and Serious Sexual Offences, while the creation of a Complex Abuse Investigation Unit (CAIU) will improve our ability to manage larger, more complex, investigations.

Each of the force's three Safeguarding Investigation Units is headed by a Detective Chief Inspector (DCI) reporting to the Head of Public Protection, Detective

Superintendent Paul Furnell. This central line management enables us to share good practise and encourages consistency. Each of the SIU DCIs also holds a force-wide portfolio - DCI Richard Bates is responsible for the Brighton and Hove SIU and is also Head of Adult Safeguarding.

In addition to our organisational change, Sussex Police developed a Domestic Abuse Improvement Plan following the HMIC audit last year. The objective of this plan is to set out a vision and ambition for Sussex police to provide an effective service and response to victims of domestic abuse, and recognising that to do this requires a sustained, robust and dynamic approach from the organisation and our partners. Most of the actions and recommendations have been completed. However we will continue to monitor the progress of these.

One of many key focuses for 2014 – 2015 is raising awareness of Harmful Practices, this includes: FGM, HBA, Force Marriage and Modern Slavery. We have already carried out a considerable amount of work in accomplishing this, such as training and awareness events. These have been challenging areas of business to tackle due to the lack of people within the communities willing to talk about the cultural practices; however with the correct approach this has improved

Development, achievements and work undertaken:
A representative from the force Public Protection Branch has attended the Safeguarding Adults Board and relevant subgroups throughout the year.
The force has developed a domestic abuse training package for front line officers. This is to help officers get a better understanding of positive action and safety planning. We are half way through the roll out of this course; positive feedback has been received so far.

We have developed police operations to provide an enhanced response to Domestic Abuse over key times of the year. Operation Cureen was run over the period of the World Cup in June – July 2014 and Operation Ribbon was run over Christmas, New Year, and Easter. With the support and active involvement of partners, these operations enabled us to provide effective police response to reports of domestic abuse, whilst also improving the support we were able to offer to victims and survivors.

Sussex Police introduced the Single Combined Assessment of Risk Form (SCARF) in August. This has replaced the Vulnerable Adult at Risk (VAAR) form and once completed by an officer or member of staff will be forwarded to the relevant Local Authority. The Vulnerable Adult section of the form implemented several of the recommendations from the VAAR audit. Positive feedback has been received about the new form. The new form avoids any duplication and double keying and allows officers and staff the opportunity to provide more information about the adult at risk. The Policy and Audit Team undertake regular dip checks to ensure the forms are being completed and sent to partner agencies.

Last year Sussex Police introduced Operation Signature (scam mail fraud) and Operation Edisto (courier fraud) as the force's operational response to identify and support vulnerable, and often elderly, victims of these types of fraud within Sussex. There is a section on the SCARF for Operation Signature so referrals can be made and we also have a dedicated Police Constable within the Economic Crime Unit who solely focuses on this Operation. Information about Operation Signature is available

for victims on the Sussex Police internet page. The Public Protection branch also takes part in Safeguarding road-shows organised by the local authorities to raise awareness of these crimes and the support available to victims.

Sussex Police have taken steps to raise awareness of Harmful Practices within the force and in the local communities. This includes updates to our intranet pages and training of both specialist officers and front line officers. We have also organised awareness events at universities and colleges which received excellent feedback.

Future plans and priorities
We will review the force's Safeguarding Vulnerable Adults policy and procedures to ensure that it aligns with the new Care Act.

The Care Act establishes a new role of Designated Adult Safeguarding Manager (DASM). DCI Richard Bates is the DASM for Sussex Police and will be working with DASMs from our statutory partners to develop this role and embed it into our safeguarding approach. Work will also be undertaken to raise awareness of the new act amongst officers and staff, particularly specialist officers and new officers.

The domestic abuse training is to be completed and we will continue monitor actions from the Domestic Abuse Improvement Plan.

Sussex Police will continue to raise awareness of Harmful Practices. We recognise the importance of raising this awareness amongst our officers and staff as well as our local communities. We will also ensure our force policy is aligned with the new legislation.

Detective Chief Inspector Richard Bates – Head of Adult Safeguarding

West Sussex Fire and Rescue Service (WSFRS):

Alistair Evans – Community Risk Manager and Safeguarding Lead

General Overview of the year:
Our part in safeguarding the people most at risk in the community continues to develop.

Safer Communities, Community Fire Safety Officers (CFSO's) prevention team and the fire services operational crews have carried out over 4,500 High Priority (people most at risk), Home Safety Visits (HSV) for people in their own home; this meets the national and county objective of supporting 'independence later in life' agenda, with safeguarding as the foundation of this work.

The feedback from Social Care from concerns raised has definitely improved over the year, it's so important to those making the referral and their learning, although we acknowledge the demand on the service, and there is a stronger multi-agency coordination in working with those most at risk.

The new Care Act with its rapid development and implementation has impacted our plans from last year to deliver an e-learning safeguarding package to staff.

However the Care Act is seen as an extremely positive step forward clarifying the scope of safeguarding and will shape our plans for the future.

The increase of 10-20% increase of referrals for HSV's to Safer Communities year on year has resulted in a significant increase in the number of safeguard concerns.

The new Sussex Control Centre (SCC) with the joining together of ESFRS and WSFRS which is now managed by ESFRS, with different ways of working in procedure and process in safeguarding has been challenging, but the outcome resulted in keeping procedure the same with a slightly improved simpler process.

Development, achievements and work undertaken:
Operational crews raised 108 safeguard concerns to Carepoint 1, and the CFSO's have raised a further 210, the majority of the concerns have been self-neglect; dementia, hoarding, frailty, mobility aids, attendance allowance, in addition to cases of harm or abuse.

We continue to look at how we maintain high standards and best refresh, train staff in safeguarding, with the growing number of referrals from MARAC's, Police and Worth services for DV cases, dementia services and hospital discharge team. With the implementation of the new Care Act the Safeguard Lead has attended many multi-agency forums, meetings and training to help us in our support of staff and the delivery of new training.

The Safeguard Lead has completed e-learning training for Frameworki (FWI) and now has read only access to FWI this is helping WSFRS to access, assess, review cases and helps our safeguard learning following fire incidents and our HSV's prevention work .

The CFSO's have completed a bespoke dementia and self-neglect awareness training. The new Care Act road show has been attended by a number of WSFRS staff so far.

The Safeguarding Aide Memoire for operational crews has been reviewed jointly by Social Care, Well-being and Education department and the Safeguard Lead, with a number of improvements and amendments in light of the new Care Act and updated on the Computer in the Fire Engines (MDT).

The HSV which is the development of the old Home Fire Safety Checks focus is person centred 'Making Safeguard Personal' the scope has expanded and now includes CFSO's/crews looking at wider issues where there are indicators of significant risk- slips trips and falls, social isolation, well-being, health concerns, security and impact of installation of hospital equipment (O2, airflow mattresses…etc.), mobility scooters…

Future plans and priorities
The Safeguard Lead is booked to attend the Train the Trainer – Safeguarding Adults; this will aid the development of new safeguarding tools and training.

A safeguarding training refresher update for crews has been planned starting June 2015 this will involve visiting every watch and day crewing station to bring in the key messages from the new Care Act – Making Safeguard Personal, issues around

consent, an awareness on - the three key tests in the Care Act, the six key principles, scope of safeguarding and recording/reporting process.

Our future plan is to continue to have a part in multi-agency safeguarding adults reviews (SAR), safeguard forums and training.

A risk rating matrix is being developed for those most at risk from a fire service perspective which will have safeguarding at its roots.

The defining and allocation of key safeguarding roles within the new Directorate is under way.

Alistair Evans – Community Risk Manager and Safeguarding Lead

West Sussex Partners in Care (formerly West Sussex Forum):

Rosemary Pavoni – Chair, West Sussex Partners in Care

General Overview of the year:
Once again the excellent work that is undertaken by the majority of the independent sector has been over-shadowed by the tragic events of Orchid View. As a result of the recommendations of Orchid View report, the CQC, since 1 April 2015 have a more robust inspection process to ensure that all care providers meet the new Fundamental standards and are measured against the new key lines of inspection.
At the same time as the new Fundamental Standards were implemented, the new Safeguarding procedures and the Care Certificate (an induction programme for all new members of staff to the care sector) were introduced, making it a really challenging time for the sector that have had to learn their new responsibilities whilst maintaining good practices.
In March 2015 WSCC and the NHS withdrew their £50 thousand grant to what was then West Sussex Forum at a time when the care sector desperately needed the support of a local care association and as a result West Sussex Partners in Care was launched, funded only by membership.
Working with West Sussex County Council, WSPiC has strived to highlight the excellent work that is undertaken within the sector (including the West Sussex Care Accolades) to restore the trust into the sector that has been sadly lost by recent events and the media's poor publicity.

Development, achievements and work undertaken:
WSPiC have continued to work closely with the statutory sector and have strived to support the care sector throughout the recent turbulent times. This has been achieved by:
Launching the new care association under the banner WSPiC in order to fully represent and support the sector
Raising the profile of excellent care, and the staff who provide it by the Care Accolades 2014
Holding four Manager's Forums in the year (we now have 100 attendees) to keep manager's informed of all the changes
Holding two very successful seminars on the implementation of the Fundamental Standards

Liaising with the statutory training providers to ensure that they fully understood, and were able to provide the training that was needed to meet the care provider's new legal responsibilities.
Introducing a website and newsletters to keep care providers informed of all pertinent information.

Future plans and priorities
West Sussex Partners in Care continue to work very closely with the West Sussex Safeguarding Board as it is in everyone's best interest ensure that the most vulnerable people in our community get the excellent care to which they are entitled.

WSPiC Training Board will continue to meet with WSCC and other statutory training providers to ensure that the training needs of the sector are adequately met in order that they fulfil can their responsibilities. WSPiC are the driving force for the Train the Trainers model of training to ensure that training can reach as many staff as quickly, economically and consistently as possible.
We will continue to provide information to our members by our website and newsletters as well as holding seminars on topics that are of value to the sector at these challenging and evolving times

Rosemary Pavoni - Chair

Western Sussex Hospitals NHS Foundation Trust (WSHFT):

Annie Blackwell, Trust Lead for Safeguarding Adults

General Overview of the year:
This has been another busy and challenging year in terms of both safeguarding casework and preparatory work for the implementation of the Care Act 2014. Some cases continued to be very complex and length investigations which took longer than the agreed timescales. However, there have also been cases were good information gathering on receipt of an alert meant that a full investigation was not required.

Challenges:
Delivery of safeguarding training has continued to be a challenge, but an additional resource was provided at the end of 2014 which has resulted in training numbers increase from 72.2% in June 2014 to 85.3% at the end of March 2015.

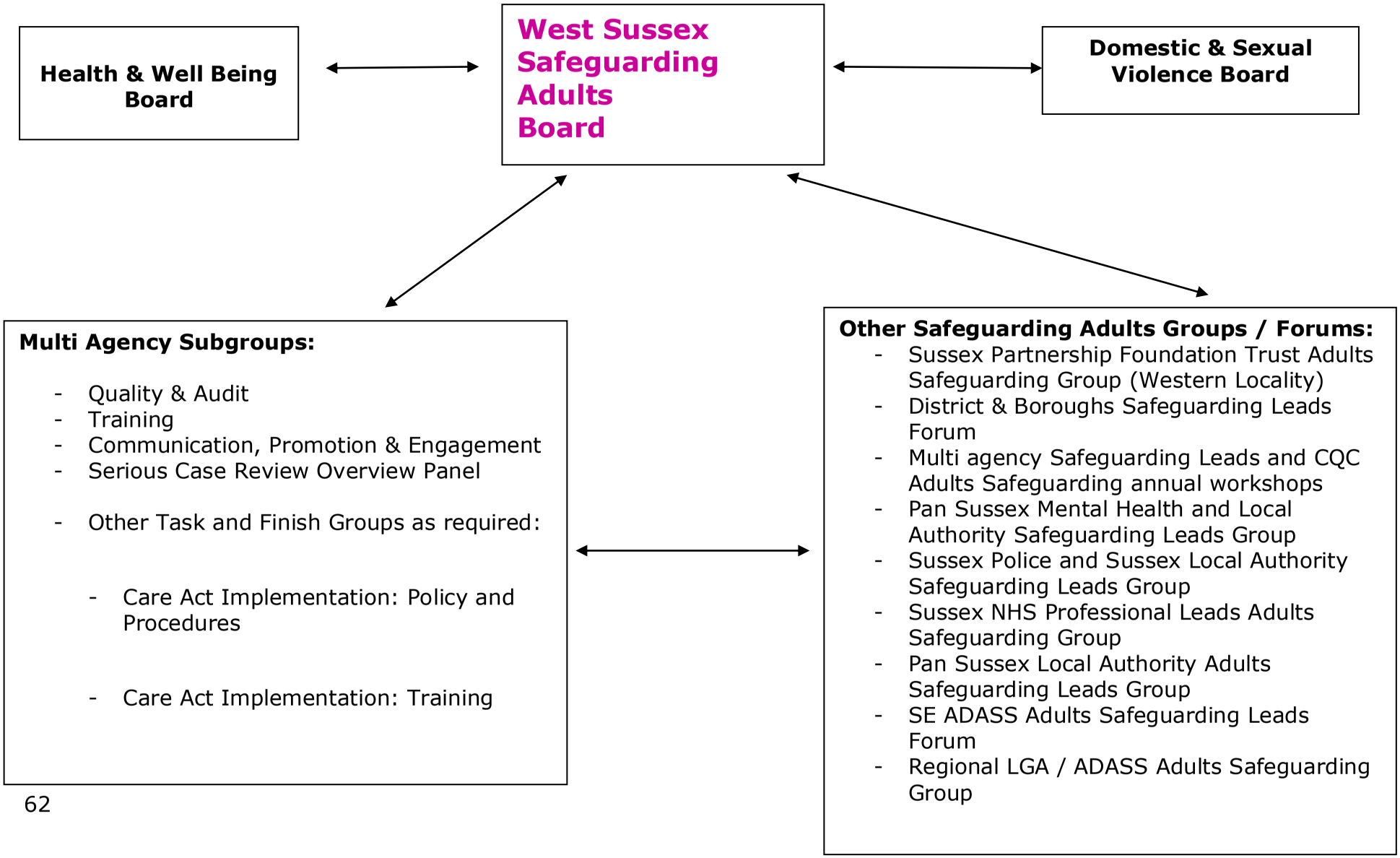
Another challenge for Trust staff has been the increase in the number of Deprivation of Liberty Safeguards (DoLS) referrals that have had to be made to the local authority. During 2014-15, 85 patients were referred to the DoLS team compared with 30 for the period 2013-14.

Development, achievements and work undertaken: Inter-agency working, both with WSCC and the CCG has continued to work well, with information sharing and assistance being provided for external safeguarding cases.

Future plans and priorities:
The organisation's future priority areas are as follows:
To recruit into new posts and expand the safeguarding team
With this additional resource, to increase the amount of face to face training available, both in formal sessions and ad hoc sessions at ward level
To ensure that the Safeguarding Team and Matrons attend the Enquiry Officer Training
To participate in a research project being undertaken by one of the clinicians into "**Patterns of radiological fractures in those at-risk of elder abuse"**
To consider, via Trust's Adult Safeguarding Operational group how service users can be represented at safeguarding meetings within the Trust
Continue to be actively involved in the multi-agency audits

Annie Blackwell, Trust Lead for Safeguarding Adults

Safeguarding Adults Board and Subgroups Chart (March 2015):



West Sussex Safeguarding Adult Board
Business Plan date: 2013-15

The task of safeguarding adults continues in a challenging climate of organisational change and pressure on resources. In these circumstances there is a test for us all to ensure that the essential work of the Safeguarding Adults Board is maintained and is effective.

Our vision as a Board is concerned with keeping adults in West Sussex safe. We aim to do this by coordinating our work to this end, challenging one another to do better and being a driving force which provides leadership and scrutiny of how well we work together to fulfil this vision.

Our Business Plan for 2013-15 reflects five strategic priorities:-

- Engaging with customers and using their feedback to inform and improve the work we do
- Understanding the effectiveness of the Board's safeguarding arrangements through robust scrutiny arrangements including using key performance indicators, together with scrutiny reports from partner Boards (including the new NHS Commissioning Board)
- Develop a culture of learning and improvement, co-ordinating and using the available information alongside the experiences of patients, customers and carers,
- Establishing robust and stronger scrutiny, overview and challenge of each other as Board partners but also about the provision in the County
- Raising awareness of safeguarding with the general public

As we work together to deliver our vision, I want to acknowledge the commitment and contribution that partners across the county make and continue to make in delivering our plan in the year ahead.

Judith A Wright
(Outgoing) Chair of the West Sussex Safeguarding Adults Board
December 2014

West Sussex Adults Safeguarding Board Work Plan 2013 / 2015

Business Plan Objectives: 1. Customer feedback

Ensure the Board obtains regular and systematic feedback from adults at risk and uses that information to improve service delivery. Engage with customers and use their feedback to inform and improve the work we do

1: Success Criteria: The Adult Safeguarding Board has listened to the views of adults who are persons at risk and who have experienced the safeguarding process and Board members have taken positive action as a result.				
What will we do?	**Who will do this and when?**	**Outcome**	**Evidence / update**	**RAG Rating**
1.1 Agree a specification for consultation in conjunction with the County Council Research Unit in Public Health.	Research Team /Adults Safeguarding Unit	Agreed approach and methodology	Specification agreed	Green
1.2 Devise a questionnaire in conjunction with people who use services	Adults Safeguarding Unit	Questionnaire produced which is fit for purpose	Questionnaire produced, consulted on and refined	Green
1.3 Questionnaire distributed to every adult at risk going through the safeguarding process	Operational staff / Safeguarding Adults Unit	People have the opportunity to comment on their experiences – phased approach to enable review of questionnaire following feedback	Distributed to all adults / their representatives at conclusion of level 3 and level 4 investigations. Available as printed copies and on internet Return of questionnaires limited – questionnaire to be revised to reflect feedback & incoming Care Act prior to rolling out more widely	Amber

1.4 Research staff collate responses and interview those willing to do so	Research Team / Safeguarding Adults Unit	Collation of feedback.	Bank of evidence to inform practice	Amber
1.5 Feedback to staff, training, and changes to processes as a result	Research and Safeguarding Team	Update to practice guidance, / Procedures where indicated and reflected in adults' experiences	Practice improves as a result Making Safeguarding Personal approach included in all practice guidance and Procedures	Amber
1.6 The Board will have an overview of the views of people and how changes can be made to practice as a result,	Quality and Audit subgroup	People's views will be heard and inform agency policies, procedures and training	Reports will be presented to Board, notes will evidence this. Training will include information about the findings. Customer reference group developed – priority area for incoming Safeguarding Adults Board team	Amber

Business Plan Objectives: 2. Performance

Understanding the effectiveness of the Board's safeguarding provision through robust scrutiny arrangements including using key performance indicators, together with scrutiny reports from partner Boards (including the new NHS Commissioning Board)
2: Success Criteria: The Adult Safeguarding Board is assured that there are quality assurance processes in place, identifying whether adults in the County are safe and that practices and procedures are changed and improved as needed.

What will we do?	**Who will do this and when?**	**Outcome**	**Evidence**	**RAG Rating**

2.1 Agree a set of multi-agency performance indicators for regular reporting	Board members / Quality Subgroup	Agreed key Performance Indicators (PI) and methodology	Key PI's agreed	Amber
2.2 Collect and collate agreed multiagency QAF data to identify benchmarks for future analysis and use	Quality and Audit subgroup	Report to quality and audit subgroup	Quarterly reports to Board and Annual report evidences this Quality Assurance Officer recruited to support subgroup and delivery of this work	Amber
2.3 Regular reports from agencies who present their agencies activity in regard to safeguarding at each Board	Board members	Agencies will provide a presentation to relevant Board meetings throughout the year	Notes of Board meetings will show agency participation	Amber

Business Plan Objectives: 3. Learning and improvement

Develop a culture of learning and improvement, co-ordinating and using the available information alongside the experiences of patients, customers and carers
3: Success Criteria: The Adult Safeguarding Board has learning and development framework, the adult safeguarding workforce is informed and equipped to carry out effective safeguarding work. There is on-going learning and improvement to practice in safeguarding

What will we do?	**Who will do this and when?**	**Outcome**	**Evidence**	**RAG Rating**
3.1 Regular multi-agency audits to review specific cases and put in place changes to practice, policy and procedures as a result of learning from those cases	Adults Safeguarding Unit/ Board representatives	A programme of multiagency reviewing of cases results in reports, smart action plans and learning is promulgated	Reports to Board	Green

3.2 Single and multi-agency training is informed by the findings of quality audits including Serious Case Reviews and national reviews	Board members and training subgroup	Local training is current and includes findings from local and national findings	Reports of training delivered and attendance reported to the Board via the Training sub-group	Amber

Business Plan Objectives: 4. Governance

Establishing robust and stronger scrutiny, overview and challenge of each other as Board partners but also about the provision in the County

4: Success Criteria: The Adult Safeguarding Board has maintained and strengthened its governance arrangements to ensure effective scrutiny, monitoring, challenge and strategic direction through effective structures and working arrangements. The Board has reviewed the Constitution, structure and business support with updated Terms of Reference for all subgroups, each led by a Board member and with the Board receiving sufficient financial support to do its business				
What will we do?	**Who will do this and when?**	**Outcome**	**Evidence**	**RAG Rating**
4.1 Agree a revised Constitution.	Chair and Board members	Renewed Constitution and all Board members will have signed roles and responsibilities document,	Manager will have 100% signed copies of roles and responsibilities document	Amber
4.2 Agree chairing and Terms of Reference for subgroups	Board chair And subgroup chairs	Agreed chairing and Terms of Reference	Board notes will record this – incoming Safeguarding Adults Board team provides business support to groups and work plans delivery	Amber
4.3 Board members make financial contributions to ensure the Board is able to conduct its business	Board members June 2014	Structure and support to effectively deliver the work of the Board	Financial arrangements in place and reported to the Board	Amber

effectively				
4.4 Recruit an independent chair for the Safeguarding Adults Board team	Board members	Independent chair provides challenge, objectivity and guidance for the Board	Independent chair recruited. Board notes and Strategic Plan reflect presence of scrutiny, challenge and strategic direction	Amber

Business Plan Objectives: 5. Communication and Engagement

Establishing permanent and sustainable awareness of safeguarding with the general public

5: Success Criteria: The Adult Safeguarding Board has formalised and enduring mechanisms and a regular campaign in place for raising the profile of safeguarding with the general public				
What will we do?	**Who will do this and when?**	**Outcome**	**Evidence**	**RAG Rating**
5.1 Explore opportunities for publicity campaigns.	Proms and Comms Group	Opportunities will be identified	Reports to Board	Green
5.2 Prepare material that can be used in a variety of media	Proms and Coms Group	Material will be available	Material available	Amber
5.3 Carry out a series of campaigns each year	Proms and Coms Group	Raised public awareness	Reports to the Board Incoming Safeguarding Adults Board team supports this	Amber

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