Surrey Safeguarding Adults Board

Annual Report 2013 – 2014

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Foreword

OUR VISION

We will all work together to enable people in Surrey to live a life free from fear, harm and abuse

In May 2013 I was pleased to be appointed as the Independent chair of the Surrey Safeguarding Adults Board. The year was to be one with significant developments for the Board. The Care Bill, now the Care Act, was being debated in Parliament and the Board was preparing for the welcome changes that would come when Safeguarding Adults Boards become statutory.

The Board has undertaken a number of Serious Case Reviews in response to safeguarding referrals. Two have been published within the period of this report and the Board's activity to ensure lessons are learnt is set out in detail further in the report.

The Board has been strengthening the developing relationships with other Boards and organisations in Surrey including the Health and Wellbeing Board, Healthwatch Surrey and the Clinical Commissioning Groups. It has also been a time for engaging with our neighbouring Safeguarding Adults Boards and national safeguarding issues to work together, sharing effective practice, to keep adults at risk of harm safe.

The Board spent time developing a vision and updated its strategic plan with contributions from users, stakeholders and member agencies in order to reflect the changing environment we operate in.

This Annual Report is important to me and for the Board. It represents a public demonstration of our achievements and supports the Board's accountability and transparency. In addition to this Report, the Board has a comprehensive website with quarterly newsletters on Board activity and national safeguarding news, highlights from the Board's meetings, a wealth of safeguarding materials, a training brochure and many other useful resources. The website address is: http://www.surreycc.gov.uk/protecting-adults-from-harm/surrey-safeguarding-adults-board

I am pleased to present this report on the Board's delivery of its strategic objectives.

Simon Turpitt
Independent Chair of the Surrey Safeguarding Adults Board

1 National Context

This year has seen significant developments in the national context of adult safeguarding as the government and agencies prepare for the Care Bill receiving royal assent and respond to the issues raised in the Winterbourne View Serious Case Review and Francis Report inquiry into the Mid Staffordshire NHS Foundation Trust. The Care Bill will place Safeguarding Adults Boards on a statutory footing for the first time and is welcomed for the increased priority being publicly demonstrated at the national level to safeguarding adults at risk of harm. The Care Bill received royal assent in late spring 2014 and will come into effect in early 2015.

Healthwatch England, the consumer champion for users of health and social care services, published their vision for rights in health and social care.

The Department of Health published several reports following the Francis inquiry into the Mid Staffordshire NHS Foundation Trust and published their report 'Winterbourne View: Transforming Care One Year On'.

The Health and Social Care Act 2012 established Health and Wellbeing Boards as a forum where key leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities. These Boards took on their statutory functions from April 2013.

In March 2013 the Association of Directors of Adult Social Services published revised Safeguarding Adults Advice and Guidance. The guidance identified the priority areas for safeguarding.

In May 2013 the Department of Health updated their statement on Adult Safeguarding setting out the policy on safeguarding adults.

In January 2014 the Association of Chief Police Officers, Association of Directors of Adult Social Services, the Local Government Association, NHS Confederation and NHS Clinical Commissioners jointly signed a pledge on adult safeguarding.

These are just some of the publications that Board members have needed to understand and respond to during the year.

2 Surrey Safeguarding Adults Statutory Return 2013 – 2014

Each year, Adult Social Care compiles data on safeguarding activity in Surrey and sends the information to the Department of Health. This is known as the Safeguarding Adults Return (SAR). This collection of safeguarding data is a new collection of tables that have been designed as a successor to the Abuse of Vulnerable Adults (AVA) Return. The SAR addresses various aspects of safeguarding, with particular regard to the details of the victim, the alleged perpetrator and the alleged offence.

This new Safeguarding Adults Return strengthens the information held nationally and locally on the incidence of abuse, supporting local authorities to reduce incidents of abuse and neglect, and to supporting them to respond appropriately when incidents occur. The data is now more focused on the outcomes of safeguarding activity, supporting local authorities to identify areas for improvement, and enabling the sharing of learning and expertise between councils.

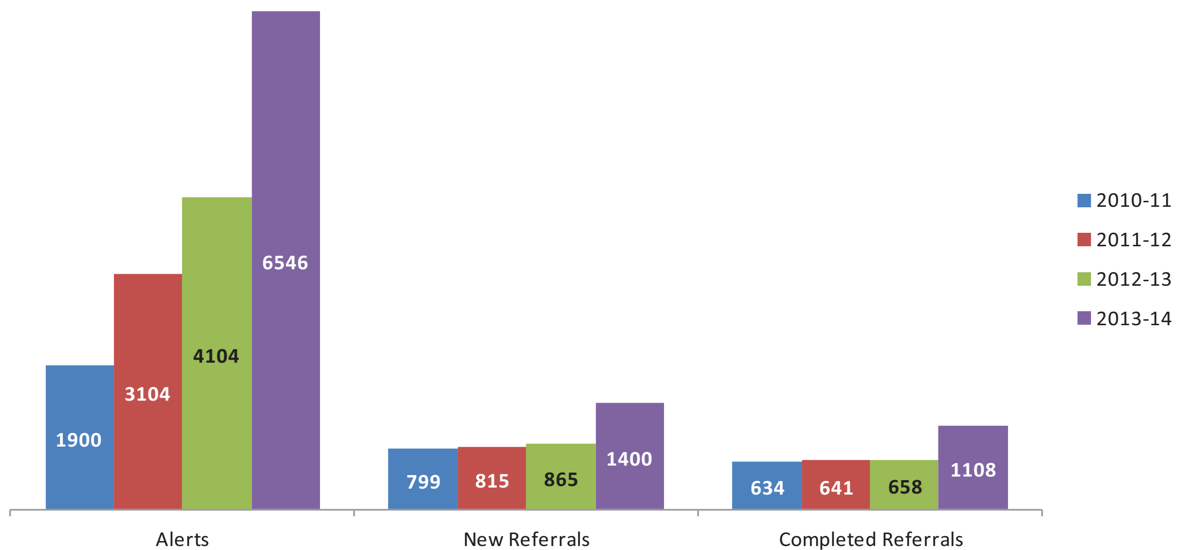
In autumn, the Department of Health will publish the national data from the Safeguarding Adults Statutory Returns and this will enable comparisons to be made between Surrey and other similar authorities.

Please see Appendix 3 for the definitions of terms used in the Safeguarding Adults Statutory Return.

2.1 Number of Safeguarding Alerts, Referrals and Completed Referrals

Safeguarding Alerts, Referrals and Completed Referrals			
	Alerts	**New Referrals**	**Completed Referrals**
2010-11	1900	799	634
2011-12	3104	815	641
2012-13	4104	865	658
2013-14	6546	1400	1108
% change between 2012-13 and 2013-14	60%	62%	68%

- The proportion of Alerts progressing to Referrals was 21% in 2013-14, the same as in 2012-13



There were large increases in concerns made by staff working for health services and the police with some increase in the numbers of referrals made by Adult Social Care staff.

Factors driving this increase in alerts:

The increased focus of agencies on training and application would reflect a stronger understanding and engagement with Safeguarding Adults procedures and therefore alerts. This increase should be seen as a good thing and is essential to have safeguarding concerns raised at the earliest opportunity to prevent issues from escalating.

In September 2013 the Board published a Serious Case Review that had received national publicity leading up to the report being made available and this will have increased awareness of safeguarding across the County.

How does the Board know that its alerts to referral are a true reflection of safeguarding activity and proportionate?

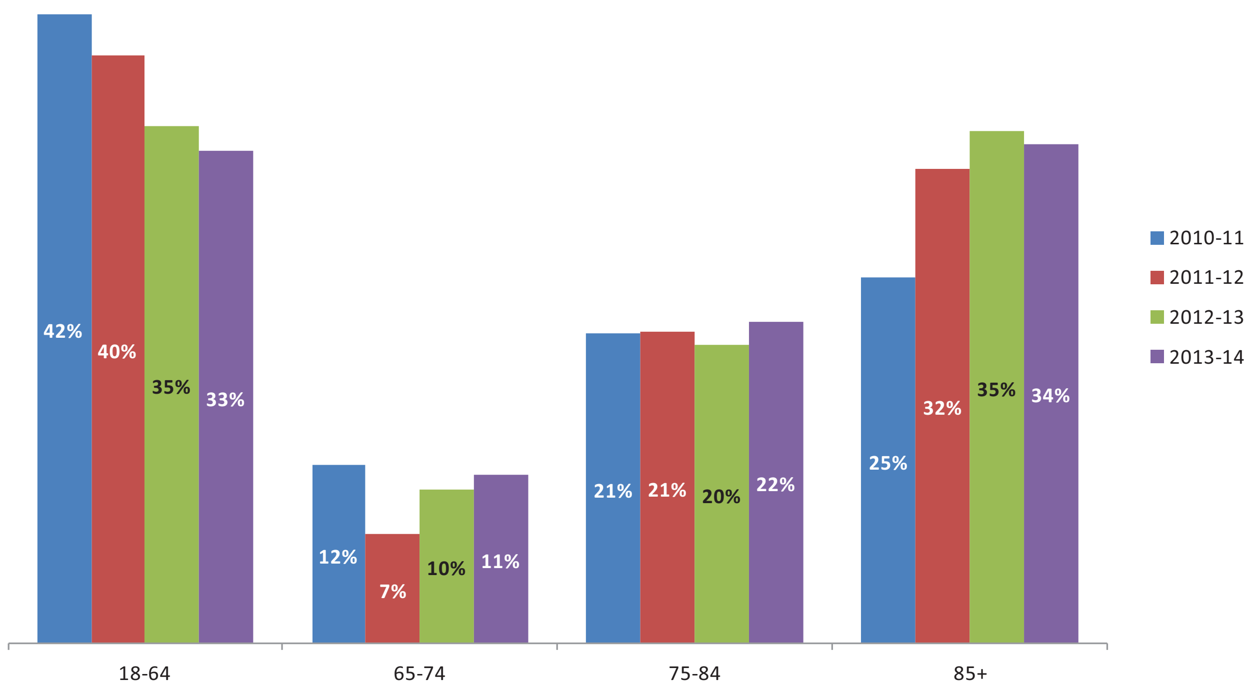
On 31st March 2014 Adult Social Care invited a Peer Review team to visit Surrey and as part of that review they were asked to look at the safeguarding alerts and referrals received by Surrey to identify and patterns or concerns. The review team looked particularly at the Abuse of Vulnerable Adults data and noted the low level of conversion rate from alerts to referrals as the Surrey rates are so different from comparable authorities. An audit of 120 cases that had been received as an alert but assessed as not meeting the threshold to become a referral was undertaken. This

found that only 2 cases needed to be changed to a higher threshold that meant they would be treated as a referral. Overall, the Peer Review team found the number of alerts that were assessed as meeting the criteria to become a referral was proportionate.

2.2 Safeguarding Referrals by Age Group

Safeguarding Referrals by Age Group				
	18-64	**65-74**	**75-84**	**85+**
2010-11	42%	12%	21%	25%
2011-12	40%	7%	21%	32%
2012-13	35%	10%	20%	35%
2013-14	33%	11%	22%	34%

Safeguarding New Referrals by Age Group %



- The 18-64 age group continued to show a steady decrease in the proportion of referrals, with a decrease of 2% between 2012-13 and 2013-14
- The 75+ age group has shown a small increase of 2% between 2013-14 and 2012-13 while the 65-74 age group has shown an increase of 1%
  For the first time in the last four reporting years there has been a small decrease (1%) in the proportion of referrals where the vulnerable adult was aged 85+

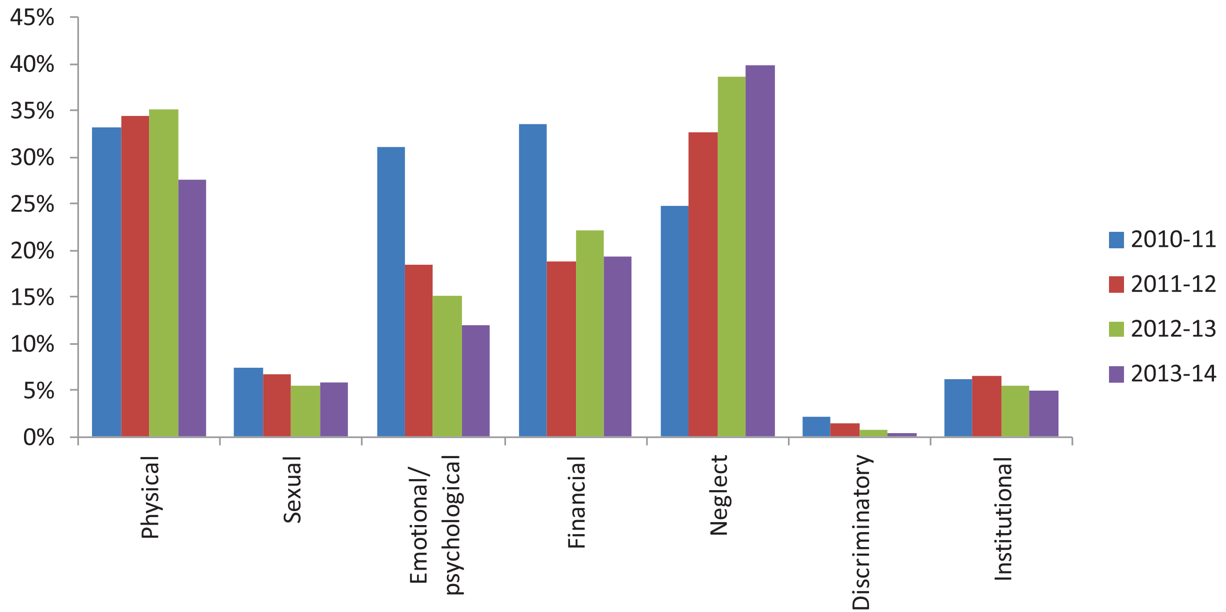
Factors driving these changes:

There is no discernible cause for these changes in referrals. The Board will continue to monitor the data and seek to identify trends that need to be addressed by actions.

2.3 Nature of Alleged Abuse

Nature of Alleged Abuse				
	2010-11	**2011-12**	**2012-13**	**2013-14**
Physical	33%	34%	35%	28%
Sexual	7%	7%	6%	6%
Emotional/psychological	31%	19%	15%	12%
Financial	34%	19%	22%	19%
Neglect	25%	33%	39%	40%
Discriminatory	2%	1%	1%	0%
Institutional	6%	7%	6%	5%

*Please note: multiple abuse types may be recorded from a single referral hence totals may be more than 100%



- In 2013-14 there was a 7% decrease in Physical abuse
- There was also a 3% decrease in both Emotional/Psychological abuse and Financial abuse
- There was a 1% increase in the proportion of Neglect reported
- The proportion of referrals with multiple abuse types recorded decreased from 23% in 2012-13 to 10% in 2013-14

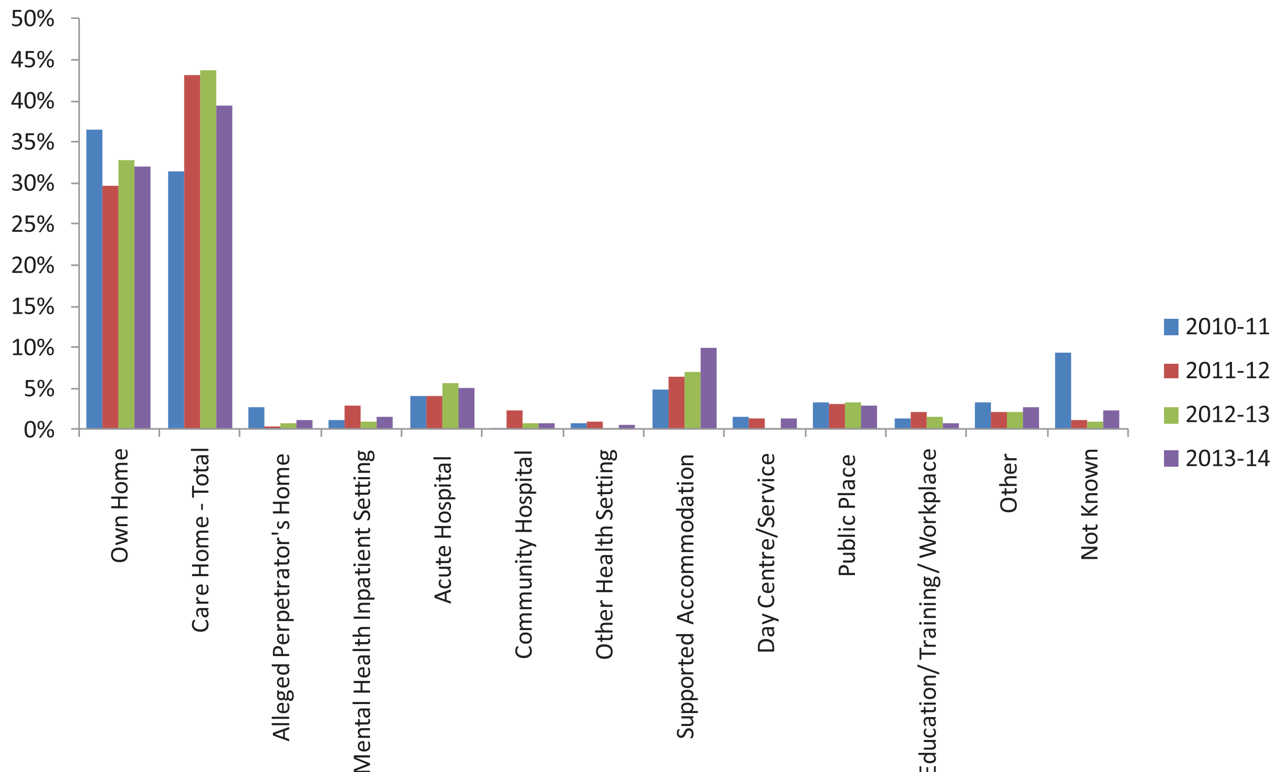
Factors driving these changes:

There is no discernible cause for these changes in referrals. The Board will continue to monitor the data and seek to identify trends that need to be addressed by actions.

**Please note the 2013-14 Nature of Alleged Abuse figures are not directly comparable with previous years. This is because the Safeguarding Adults statutory return 2013/14 uses different definitions for the categories of abuse from the Abuse of Vulnerable Adults statutory return (2010-2013) that was submitted the previous year.*

2.4 Location of Alleged Abuse

Location of Alleged Abuse				
	2010-11	**2011-12**	**2012-13**	**2013-14**
Own Home	36%	30%	33%	32%
Care Home - Total	31%	43%	44%	39%
Alleged Perpetrators Home	3%	0%	1%	1%
Mental Health Inpatient Setting	1%	3%	1%	1%
Acute Hospital	4%	4%	6%	5%
Community Hospital	0%	2%	1%	1%
Other Health Setting	1%	1%	0%	1%
Supported Accommodation	5%	7%	7%	10%
Day Centre/Service	2%	1%	0%	1%
Public Place	3%	3%	3%	3%
Education/Training/Workplace	1%	2%	2%	1%
Other	3%	2%	2%	3%
Not Known	9%	1%	1%	2%



- In 2013-14 there was a 5% decrease in the proportion of referrals alleged to have occurred in a care home. 90% of those alleged to have occurred in a care home were in a permanent residential or nursing care setting and 10% were in a temporary residential or nursing home placement
- There was a 3% increase in the proportion of referrals alleged to have occurred in supported accommodation

Factors driving these changes:

The increase with supported accommodation is an upward trend which is part of raising of awareness in this area and safeguarding generally. A significant amount of work has gone into raising Adult Safeguarding capability through more training and engagement in care homes and though there is a decrease in care homes as a location this could be a reflection of this but is hard to evidence

**Please note the 2013-14 Location of Alleged Abuse figures are not directly comparable with previous years. This is because the Safeguarding Adults statutory return 2013/14 has different definitions from the Abuse of Vulnerable Adults statutory return (2010-2013) submitted the previous year.*

3 Priorities

In 2012 the Board introduced a new three year Strategic Plan. The plan set out the Board's programme of activities in relation to each of the six national principles of adults safeguarding, namely:

- **Empowerment**
- **Protection**
- **Prevention**
- **Proportionality**
- **Partnership**
- **Accountability**

Underpinning each of these principles is a comprehensive, multi-agency training framework. Information on the courses is set out in the annual training brochure that is published on the Board's web pages.

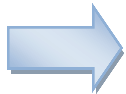
The Board and the Business Management Group agreed the Strategic Plan should be reviewed by Board members at the development day in December 2013 to take into account the significant national developments since the plan was drafted at the beginning of 2012. Following the discussions on that day, the Board agreed a new vision and key priorities to be taken forward from April 2014. A new three year Strategic Plan has been drafted, supported by an annual Action Plan. This has been agreed by Board members and made publicly available on the Board's web pages.

Below are the highlights of actions taken by the Board in this reporting year. The relevant action from the three year Strategic Plan is noted against each highlight. Some of the Board's actions were fully completed in the first year of the plan's implementation and those actions were reported on in the Annual Report for the previous year and have not been reported on here.

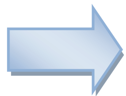
Throughout its work, the Board considers the views of adults at risk and their carers as of paramount importance. There are four User Led Organisations on the Board, namely, Action for Carers (Surrey), Age UK Surrey, Surrey Coalition of Disabled People and Surrey 50+. Their contribution is vital to set the priorities of the Board's work and to ensure the actions undertaken by statutory agencies meet the needs of adults at risk. Representatives from these User Led Organisations also sit on the four local Safeguarding Adults Groups and participate in Board events including the development day which began with a service user and a carer giving their experiences of the safeguarding process in Surrey. At the end of each safeguarding

investigation, the adult at risk is asked for their view on the safeguarding process and the responses are taken to the Board's Quality Assurance and Audit group for consideration and actions.

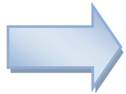
3.1 Empowerment



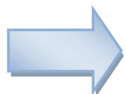
The Board's web pages have all been reviewed to ensure all the information is accurate, up to date and easy to find. Quarterly newsletters have been produced, widely circulated and made available on the web pages.
Strategic Plan actions 1.1 & 1.3



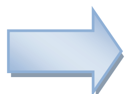
New publicity materials have been produced in the form of a credit card sized alert card and a postcard sized guide on how to respond to safeguarding concerns. Easy read safeguarding materials have been produced and distributed.
Strategic Plan actions 1.2, 1.3 & 1.4



The Board has researched the availability of easy read materials that support adults at risk including information from safeguarding, the police, the Crown Prosecution Service, voluntary organisations and health services. The availability of these documents has been promoted through the Board's newsletter to support adults at risk to keep themselves safe and understand what to do if they believe there is a safeguarding concern.
Strategic Plan actions 1.3 & 1.4

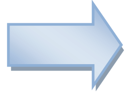


The Board's Multi-Agency Procedures, Information and Guidance are revised on an ongoing basis to reflect changes and include information on how to respond to human trafficking. The Board's newsletter carried further information and links to resources to help people find the right help quickly.
Strategic Plan action 1.4

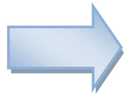


The Board's representative from Adult Social Care Safeguarding met with the Chief Executive from Surrey Independent Living Council to review the safeguarding information that is supporting Personal Assistants.
Strategic Plan action 1.6

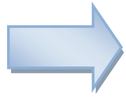
3.2 Protection



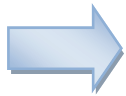
The Board's community reach has been strengthened with four local Safeguarding Adults Groups which have met quarterly and invited specialists from different elements of safeguarding to attend and raise awareness of priority issues. This has included speakers on: independent advocates, hate crime, financial abuse targeted at vulnerable adults, Deprivation of Liberty Safeguards, the Mental Capacity Act and legal responsibilities.
Strategic Plan action 2.1



User led organisations and organisations representing adults at risk have been integral members of the four local safeguarding groups. This includes Surrey Coalition of Disabled People, Surrey Independent Living Council, Action for Carers, Victim Support, Surrey 50+, Surrey Domestic Abuse Services, Age UK and Just Advocacy.
Strategic Plan action 2.2

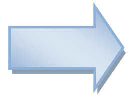


Board members had a substantive item on hate crime at their meeting in May 2013. Led by the Detective Superintendent who is head of Public Protection at Surrey Police, members increased their awareness of the on-going work following the published report 'Out in the Open'. Members agreed to raise awareness of this report within their own organisations, a link is now available on the Board web pages to the police web pages on hate crime and the local Safeguarding Adults Groups agreed to have an item on hate crime on their agendas.
Strategic Plan action 2.4

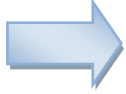


At the Board meeting in May 2013, members were keen to maintain robust implementation of responses to the Winterbourne View Serious Case Review. In addition, the Francis Report had been published and Board members expressed their commitment to ensuring the recommendations are in place across Surrey. Board members noted the issues raised in both reports addressed similar issues, including quality of care, appropriate staff training and supervision, focus on safe patient care, effective processes for patients, families and staff to raise concerns. The Board has agreed to establish a new working group specifically to embed the learning from the reports. The senior manager for commissioning services for people with Learning Disabilities has chaired this group and has reported progress to the Board.
Strategic Plan action 2.5

The Board has a Serious Case Review Protocol that sets out the process

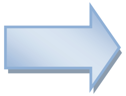


and responsibilities for agencies. During this reporting period the Protocol has been reviewed and updated.

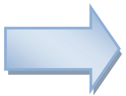


A Multi-Agency Incident Review process has been introduced. It is implemented when the Serious Case Review group decides that a notification does not met the criteria for a full Serious Case Review, but the group believes that there are lessons for agencies that could be learnt.

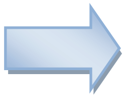
3.3 Prevention



Board members have continued to identify and learn lessons from national Serious Case Reviews (children and adults) and Domestic Homicide Reviews. This has been done through items in the Board's newsletter, the Policy and Procedures group and the local Safeguarding Adults Groups. A comprehensive list of recent, national adult Serious Case Reviews was included in the Board's newsletter published Winter 2013.
Strategic Plan action 3.1



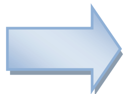
During the period of this report, the Board has published two Serious Case Reviews and one Domestic Homicide Review has been published by a Surrey Community Safety Partnership.
The recommendations in the Domestic Homicide Review were highlighted in the Boards newsletter and discussed at the local Safeguarding Adults Groups.
Strategic Plan actions 3.1, 3.2 & 5.16



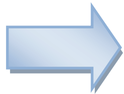
The Board's Policy and Procedures group has received updates on the development of the 'Keeping you Safe from Fire' project to ensure the work is continuing to achieve the aims envisaged at the start and that protection measures are proportionate.
Strategic Plan action 3.4

Board members have committed to undertaking an annual self assessment to review and benchmark their safeguarding practices within

their own organisations. Members undertook the self assessment in the previous year and received a report at the September 2013 meeting on issues and highlights that had been identified. Examples of effective practice were widely promoted by including them in the published the Board's newsletter.
In January 2014, NHS England circulated a new self assessment tool that can be used by Safeguarding Adults Boards. Members of the Surrey Board agreed to use the new tool, undertake a self assessment and participate in a 'Challenge and Support' event in the new year. This will support member agencies working together to put practices in place at the earliest stage to support the prevention safeguarding issues occurring.
Strategic Plan action 3.6



The senior manager for commissioning services for people with learning disabilities has joined the Board. In addition, managers from Adult Social Care Commissioning service have joined the four local Safeguarding Adults Groups to strengthen the existing arrangements between safeguarding and commissioning.
Strategic Plan action 3.8



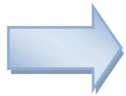
The Board has produced a Choking Prevention Policy following several incidents of choking resulting in harm to adults at risk and in response to the findings of a Surrey Serious Case Review regarding a person who died as a result of choking whilst in a care setting. It was produced by a multi-agency group comprised of individuals with specialist knowledge from Virgin Care, Surrey and Borders Partnership Foundation Trust, Clinical Commissioning Groups and Adult Social Care. The Policy has been made publicly available on the Board's web pages and has been widely circulated to Commissioners
Strategic Plan action 3.10

In November 2013 the Board put on an event for over 110 delegates on Surrey Serious Case Reviews and Domestic Homicide Reviews - pathways to robust reports and successful implementation of recommendations.
Attendees were from a broad range of backgrounds including safeguarding leads, commissioners, representatives from Clinical Commissioning Groups, Community Safety and importantly from User Led Organisations.
The event was opened by Simon Turpitt, chair of the Board. Speakers at the event were:

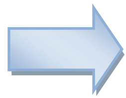
- Steve Cosser, Associate Cabinet Member for safeguarding,
- Claire Crawley, who leads on Social Care Policy at the Department of Health,
- Davina James-Hanman, the Director of AVA (Against Violence and Abuse).
- Professor Hilary Brown is the author of a Surrey Serious Case Review.
- Hilary Ross a solicitor with specialist expertise on corporate

compliance.
In addition, delegates attended two workshops on the key themes identified from recent Serious Case Reviews and Domestic Homicide Reviews. The themes were: Information sharing between agencies, Mental Capacity Act, Robustness of engagement with people who face barriers or who are reluctant to engage, Core competencies and staff training, Cross authority accountability, Commissioning the right services with the right safeguards and Court processes from the victims perspective including support.
Strategic Plan action 3.11

3.4 Proportionality



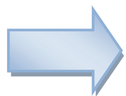
The Board's Multi-Agency Procedures, Information and Guidance have been considered and revised as appropriate by the Policy and Procedures sub-group at each meeting. Sections have been amended where needed and updated versions made available on the Board's web pages. The Board has ensured that the Procedures are proportionate and the least intrusive response appropriate for the risk that is presented including responding to user feedback
Strategic Plan action 4.2



The Board's training framework has been reviewed to ensure it includes indentifying and addressing risk. In addition, the training framework for 2014-2015 has been produced and the contents of courses include the issue of ensuring actions in relation to risk are proportionate.
Strategic Plan action 4.3

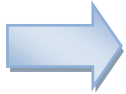
The Board has undertaken an Equality Impact Assessment on the new Choking Prevention Policy. This has ensured we have considered the impact of the policy on our communities and professionals to ensure any changes to practices promotes fairness and respect to people regardless of their characteristics and circumstances.
Strategic Plan action 4.4

3.5 Partnership

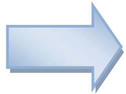


The Board's Local Safeguarding Adults Group in mid-Surrey undertook a project to increase awareness of safeguarding with General Practitioners (GPs). Working with the Safeguarding lead from Surrey Downs Clinical Commissioning Group, representatives from the Board attended the GP's sub-committee meetings to talk about the Board and distribute the Board's publicity materials.

Strategic Plan action 5.1

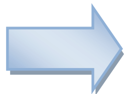


The Board has published and implemented a training programme that included a wide range of courses for staff and volunteers from all agencies.
Strategic Plan action 5.4

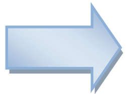


The Board's Quality Assurance and Audit group undertook a pilot in relation to undertaking multi-agency case file audits of safeguarding cases. This involved a multi-agency group assessing the file information available and hearing from staff involved in the cases. Agencies were given feedback on the good practice discovered and on practices that could be improved.
Strategic Plan action 5.8

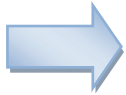
The Board established a multi-agency task and finish group to develop a protocol for agencies working with vulnerable adults who are at risk of going missing. The agreed 'Missing Persons Protocol' provides all parties with clear and concise guidelines as to their agreed actions to be taken when an adult receiving care services goes missing. The protocol has been placed on the Board's web pages.
Strategic Plan action 5.13



In December 2013 Surrey Safeguarding Adults Board produced a new Multi-Agency staff Competency Framework. The framework is a guide in developing and meeting each organisations individual responsibility for ensuring a competent workforce. It has been designed to be a working document that is simple to use in all organisations and can be used to evidence the right levels of training for all staff.
This supports the Association of Directors of Adult Social Services advice that training should be competency based to ensure that workers' practice meets consistent standards.
Strategic Plan action 5.14

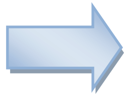


A task and finish group had been established with representatives from the Board and the five Surrey Prisons to take forward safeguarding in line with the national paper 'Her Majesty's Inspectorate of Prisons Expectations' (2012). This work came to a conclusion during this reporting year with all parties signing up to a Memorandum of Understanding on referral processes. A 'Prisons and Safeguarding' workshop event was held in October 2013 to support prison staff, Adult Social Care staff and Surrey and Borders Foundation Trust staff to work within the agreed safeguarding referral and care pathway. The Department of Health and an agency from outside Surrey had requested and been given a copy of the Memorandum of Understanding to help develop their work with prisons.
This action was a response to the publication of the national 'Expectations'. It supported all the key priorities of the Board and reflects the particularly strong partnership working of the Board.

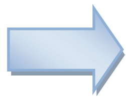


At the end of March 2014, Adult Social Care held a sector led Peer Review of safeguarding. Board members supported the process through attending focus groups and interviews with the Peer Review team. As part of the Peer Review, the team looked into the leadership of the Board. The Report recommendations will be considered by the Board, but generally found the Board was effective in its business and had areas of good practice.
Board member's engagement in the Peer Review of safeguarding supported the key priorities of partnership and accountability.

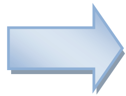
3.6 Accountability



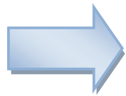
On 16 December members of the Board came together to agree the vision, strategy and action plan that will take the Board forward. At the start of the event, members were given a very personal account of safeguarding from a service user who is in receipt of direct payments and employs his own Personal Assistant. He had been involved in a safeguarding process and was able to give a description of the impact of being abused and how the safeguarding process supported him in achieving good outcomes. Safeguarding Board members also heard from a carer in relation to their experiences of the safeguarding intervention. The Board is appreciative that both people were willing to give up their time and speak so candidly about their experiences. They supported Board members to ensure the subsequent discussions put the experience of the service user at the very centre of Board activities.
The Board has now taken forward the agreed priorities and established the new strategy and supporting action plan. This will be monitored by the Board's Business Management Group and has been made publically available on the Board's web pages.
Strategic Plan action 6.3



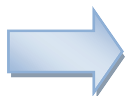
To support the development of the Board, members completed a feedback sheet on the structure, membership, agendas, accountability and impact of the Board. This has been used to provide assurance on the way the Board operates and will inform future developments.
This supported the key priority of accountability and was introduced by the new Independent chair.



The Board's Independent chair held meetings with the chairs of each of the four local Safeguarding Adults Groups to set the direction of travel and ensure synergy between the Board and local group's activities.
This supported the key priority of accountability and was introduced by the new Independent chair.



The Board's Annual Report for 2012 – 2013 was presented to the Surrey County Council Cabinet and to the Health and Wellbeing Board. The Annual Report has been made available in hard copies in each of Surrey's libraries and electronically on the Board's web pages.
Strategic Plan action 6.1



From January 2014, the Board started publishing highlights and key decisions from meetings on the web pages to improve openness and public information.
This supported the key priority of accountability and was agreed by Board members at the meeting in January 2014.

3.7 Challenges

The Board has faced a number of challenges whilst implementing actions from its plan. Engaging with some partner agencies has been difficult due to competing priorities and restructures. The Board needed both effective engagement and to be able to hold agencies to account for their delivery of safeguarding. Recruiting a new chair who is independent of any agencies on the Board has assisted overcome this challenge and it was noted attendance at meetings has improved during the year.

There remained the challenge of holding partners to account for their delivery of safeguarding. Board members completed a safeguarding adults self-assessment; however, those self-assessments were not subject to any form of scrutiny by other Board agencies. In January 2014 members agreed to change this process and take part in a 'Challenge and Support' event. The aim of this event, to be held in autumn 2014, will be to identify and agree what agencies are doing well, individual agency areas for improvement and how partners can work together more effectively. The outcome of this day will be incorporated into future actions.

The number of referrals received by the Serious Case Review group has put pressure on budgets and the availability of administrative staff for other Board work. To resolve the financial burden, the Board will be working with agencies to agree multi agency contributions to the Board's work. There are also plans in place to increase the support available to the Board when this funding is in place. In the meantime, improvements have been made to the support available for the persons involved in chairing or contributing to Serious Case Reviews and it is anticipated this will result in a more streamlined and effective process.

4 Surrey Safeguarding Adults Board Structure

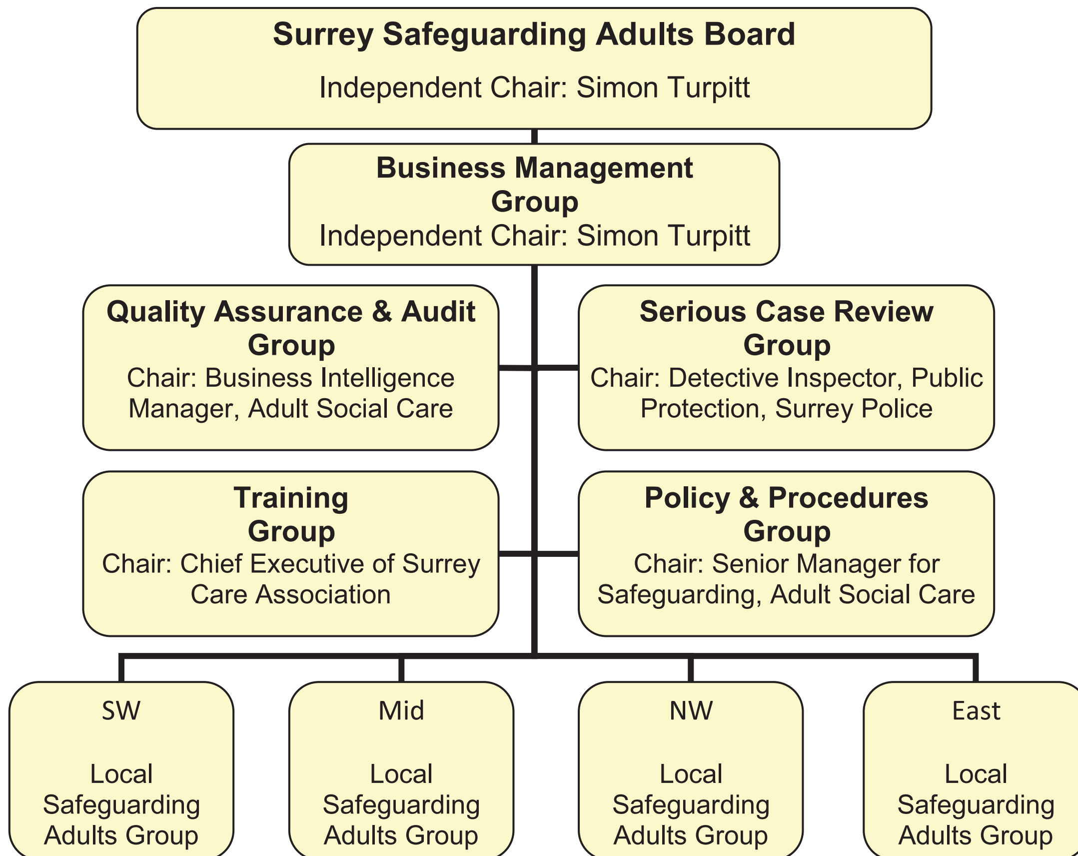
The Surrey Safeguarding Adults Board is a partnership constituted under the Department of Health guidance: 'No Secrets' (March 2000). The Board has an Independent Chair who chairs both the Board meetings and the Business Management Group meetings. The duty of the chair is:

- To provide independent leadership and strategic vision to the Board.
- To champion the promotion of diversity and equality in all Board activity.
- To ensure the Board operates effectively in exercising its functions as set out in "No Secrets" and other relevant guidance and meets all statutory requirements that may be placed upon the Board once made Statutory.
- To chair the Board meetings, the Business Management Group meetings and other meetings/events held by the Board as required.
- To monitor and challenge the effectiveness of safeguarding adults at risk across agencies.
- To ensure that there is a meaningful business relationship with other statutory Boards.
- To produce the Board's Annual Report and Strategic Work Plan.

The chair is assisted in this role by four sub groups, namely, Quality Assurance and Audit, Policy and Procedures, Serious Case Review and Training. In addition, the Board has four Local Safeguarding Adults Groups supporting the implementation of the Work Plan. An additional 'task and finish group' was established specifically to take forward the recommendations from the Winterbourne View Serious Case Review, the Francis Report and the Confidential Inquiry into Premature Deaths of People with Learning Disabilities.

The Board is currently fully funded by Adult Social Care. The funding covers the costs of the Independent chair, administrative support staff, Serious Case Reviews, conferences / events, training, publicity materials and meeting rooms.

4.1 Organogram



The Board meets three times a year. The Board's Terms of Reference are:

- To oversee the implementation and working of the Safeguarding Adults procedures, including publication, distribution and administration of the document
- The management of inter-agency organisational relationships to support and promote the implementation of the procedures
- To make links with other areas of policy and good practice guidance, including, contracting, care management and child protection within the statutory, voluntary and independent sectors
- To oversee the training strategy, and to maintain a strategic overview of Safeguarding Adults training
- To identify sources of funding required to implement the training and development needs associated with the procedures and to monitor the use of these resources
- To oversee the development of information systems which support the gathering of information necessary to carry out the evaluation of policy and practice
- To regularly review the monitoring and reporting of safeguarding adults concerns and investigations and to undertake a full review annually

- To make recommendations for revisions and changes necessary to the procedures, identified as a result of the monitoring process
- The promotion of multi-agency working in Safeguarding Adults, through formal events or information campaigns to ensure a wider professional and public understanding of adult abuse
- To support and advise operational managers working with abuse, through the local groups and sub groups
- To agree and maintain links with relevant corporate management groups
- Manage and support the work of the sub groups

The Board members are from:
User led Organisations: Action for Carers (Surrey), Age UK Surrey, Surrey Coalition of Disabled People, Surrey 50+.
Surrey Care Association
Clinical Commissioning Groups: Surrey Downs Clinical Commissioning Group (hosting adult safeguarding on behalf of Surrey’s Clinical Commissioning Groups.
South East Coast Ambulance Service
Five Acute Trusts: Ashford & St Peters NHS Trust, Frimley Park Hospital, Royal Surrey NHS Trust, Epsom & St Helier Hospital Trust, Surrey & Sussex Healthcare NHS Trust.
Central Surrey Health
Surrey and Borders Partnership NHS Foundation Trust
Virgin Care Community Health
First Community Health & Care
First Point: hard of hearing interpreting services
Chairs of each local Safeguarding Adults Group
District & Borough Councils – Guildford, Spelthorne and Tandridge
Surrey County Council (SCC): Strategic Director for Adult Social Care, Assistant Director for Commissioning , Assistant Director for Service Delivery ,Safeguarding Adults Senior Manager, Interim Assistant Directors for South West and East Areas, Senior Manager for Learning Disabilities Commissioning, SSCB Partnership Support Manager, Domestic Abuse Manager, Business Intelligence Manager, Quality Assurance Manager, Senior Lawyer, Associate Cabinet Member with nominated lead for adult safeguarding, Senior Trading Standards Officer, Surrey Fire & Rescue Service Area Commander.
Care Quality Commission South East Region
Surrey Police
Probation Service

4.2 Business Management Group

The work of the Board is supported by the Executive group, known as the Business Management Group (BMG) The BMG meets every two months. The Terms of Reference are:
To ensure there are effective governance arrangements for managing the Board business, including:

- Co-ordinating the development, implementation and performance management of the Board Strategic Work Plan.
- Ensuring the Local Safeguarding Adults Groups effectively deliver the Work Plan
- Receiving and responding to Management Information reports on the safeguarding process and on the effectiveness of the Board
- Monitoring Serious Case Reviews and notifications.
- Monitoring the Board budget.
- To ensure the Board develops in concordance with the national safeguarding agenda, including:
  Driving the national agenda forward at the local level
  Preparing the Board for becoming statutory

The BMG members are from:
Surrey Safeguarding Adults Board Independent Chair
District and Borough Council representative
Central Surrey Health
Surrey Downs Clinical Commissioning Group
Surrey and Borders Partnership Foundation Trust
SCC, Director of Adult Social Services
SCC, Senior Manager for Safeguarding
Virgin Care (representing Surrey Community Health providers)
Surrey Care Association
Surrey Police, Public Protection
Surrey Fire and Rescue Service
Royal Surrey County Hospital (representing all Surrey Acute Trusts)

4.3 Sub-Groups

The work of the Board is delivered at a strategic level through the four sub-groups.

- The Quality Assurance and Audit sub-group is responsible for assisting the Surrey Safeguarding Adults Board with developing, promoting and ensuring good quality safeguarding practice.

- The Policy and Procedures sub-group is responsible for reviewing the Multi-Agency Procedures, ensuring process and practice is sensitive to user and carer rights and promotes user and carer involvement; reviewing new national and local policy documents, guidance, legislation and outcomes from inquiries to consider their impact on the Board, the Multi-Agency Procedures. To make recommendations to the Board and consulting / communicating with partner agencies and engaging / involving other stakeholders as appropriate.

- The Training sub-group is responsible for developing, implementing, reviewing and updating the Board's countywide multi-agency training strategy for the protection of adults at risk of harm in line with the multi-agency competency framework; producing an annual training programme with the involvement of service users and carers; providing support, advice and engaging with organisations to promote the uptake of safeguarding training for their staff and volunteers; monitoring and evaluating the uptake and impact of the Board's safeguarding training and ensuring ongoing quality assurance.

- The Serious Case Review sub-group considers notifications received following a death, a life threatening injury or other serious incident involving an adult at risk where it is believed there have been failings, or there are suspected failings by more than one agency involved in caring for the adult (as defined by the Surrey Multi-Agency Safeguarding Adults Procedures). This is with a view to establishing what learning can be identified by implementing a review process. More information on Serious Case Reviews occurs later in this report.

5 Serious Case Reviews

The Serious Case Review sub-group is chaired by a senior Police officer from the Public Protection Unit at Surrey Police. The group considers notifications made following a death, a life threatening injury or other serious incident involving an adult at risk where it is believed there have been failings, or there are suspected failings by more than one agency involved in caring for the adult (as defined by the Surrey Multi-Agency Safeguarding Adults procedures). This is with a view to establishing what learning can be identified by implementing a review process.

The Board published all Serious Case Review Executive Summaries on their web pages.

Four Serious Case Reviews were already in progress at the start of this reporting period. Two have been published, namely the Serious Case Review into the circumstances surrounding the death of Gloria Foster and the Serious Case Review into the death of ‘Mrs S’. More information on these Serious Case Reviews is below.

The two further Serious Case Reviews will be published in the next reporting period.

During the course of this reporting period, the group has assessed four notifications as not meeting the criteria for a full Serious Case Review or a Multi-Agency Incident Review.

One further notification has been assessed as meeting the criteria for a Serious Case Review and the chair of the Board has been notified accordingly.

Four notifications have been subject to further enquiries to identify whether the meet the criteria for a Serious Case Review of a Multi-Agency Incident Review.

5.1 Serious Case Review – Gloria Foster

The Serious Case Review relating to the circumstances surrounding the death of Gloria Foster was published on 16 September 2013. The Board has undertaken the following actions to ensure the lessons identified in the Serious Case Review are learned:

- The full Serious Case Review and the Executive Summary have been made publicly available on the Board's web pages. The decision to publish the full report was made due to the national interest in this case.
- The Executive Summary and recommendations have been brought to the attention of all Board agencies and Local Safeguarding Adults Groups and has been on the agendas of all appropriate meetings.
- Relevant agencies have been requested to complete Action Plans in response to the Serious Case Review recommendations and report back to the Board on progress.
- The Board's Policy and Procedures sub-group has led in the preparation of multi-agency guidance on best practice in recording (Recommendation 3).
- The Board's Business Management Group has reviewed the Action Plans and members assured themselves that all agencies have completed the identified actions.
- The Board has required relevant agencies to conduct an audit of their Mental Capacity Act training and report back on their findings.
- The Board received a report on progress on the implementation of the Action Plans at the January meeting.
- The Business Management Group will be asking for agency's involved to provide an update in relation to the implementation of their Action plan.

5.2 Serious Case Review – 'Mrs S'

The Serious Case Review relating to the circumstances surrounding the death of 'Mrs S' was published on 31 March 2014. The Board has undertaken the following actions to ensure the lessons identified in the Serious Case Review are learned:

- The Serious Case Review Executive Summary has been made publicly available on the Board's web pages.
- The Executive Summary and recommendations have been brought to the attention of all Board agencies and Local Safeguarding Adults Groups and has been on the agendas of all appropriate meetings.

- The Board established a task and finish group to develop a Choking Prevention Policy. This was done at the earliest opportunity when the safeguarding notification was first made to the Board. The policy has been completed, adopted by Board agencies and made publicly available on the Board's web pages.

- Relevant agencies have been requested to complete Action Plans in response to the Serious Case Review recommendations and report back to the Board on progress.

6 The year ahead

The year ahead presents us with many opportunities and challenges. The Department of Health will publish for consultation the draft guidance that will accompany the Care Act and by April 2015 Safeguarding Adults Boards will become statutory.

In Surrey the Safeguarding Adults Board has been in place for more than a decade and has a wealth of experience to build upon. The statutory safeguarding clauses that are set out in the Care Act indicate that the Surrey Board will be in a good starting place from which to ensure compliance.

However, there will also be challenges for the Board. The arrival of the final guidance and regulations for the Care Act 2014 will result in a substantial review of the Board's Multi Agency Procedures in addition to other policies the Board has, such as choking prevention policy, missing persons protocol and the risk tool. All agencies are facing pressures on budgets but will need to reflect the importance of safeguarding adults by contributing financially to the Board. In addition, the Board will need to find ways of robustly holding its member agencies to account whilst making sure agencies feel confident to share any challenges they are experiencing.

All this work will need to be undertaken whilst ensuring agencies are preventing abuse and harm from happening, protecting and empowering adults when it has occurred and working in partnership to ensure the response is proportionate to the risk presented.

In the year ahead we as a Board will:

- Deliver against our annual plan.

- Aim to improve our working with other Boards both across Surrey and in areas around our borders to improve efficiency and stop duplication whilst improving communication.

- Continue on the path of making the Board ready for its role as a statutory body in April 2015 and implementing the guidance and regulations that will accompany the Care Act.

- Improve our assurance and impact as a Board to ensure learnings are embedded and best practice shared via the self assessment and 'challenge and support' event.

- Use Making Safeguarding Personal programme to help all member agencies ensure that the adult at risk of abuse or neglect is at the centre of what we do.

I look forward to leading the Board to achieve the vision:

We will all work together to enable people in Surrey to live a life free from fear, harm and abuse

Appendix 1 Highlights from Board agencies

Agencies represented on the Board were offered the opportunity to highlight their activities to support the delivery of the Board's Strategic Plan. The following submissions were received.

Action for Carers (Surrey)

Action for Carers Surrey represents the views of carers on the Surrey Safeguarding Adults Board.

Under Key Principle 2 Protection, our aim during the past year has been to ensure that the Board recognises the particular needs of carers in formulating their strategy and action plans. We have also assisted in the dissemination of Safeguarding Adult publicity materials to carers through our networks as part of the delivery of Key Principle 1 Empowerment.

In relation to Key Principle 3 Prevention, we have emphasised that carers may be vulnerable themselves to safeguarding concerns, particularly if they are caring for relatives with challenging behaviour. Operationally our own organisation has introduced a Safeguarding e-learning module for all new staff to complete early in their induction as well as continuing mandatory Surrey Safeguarding Adults Board training for all staff.

In relation to Key Principle 5 Partnership, we have encouraged a more joined up approach by the Safeguarding Board with the planning of service provision by both Adult Social Care and NHS providers to better meet the challenges for carers.

Age UK, Surrey

- We cascade newsletters and publicity materials to the Age Concern network.
- We have put safeguarding on all our internal meeting agendas and supervisions.
- Safeguarding training updates are taking place across the whole organisation
- A member of staff has been a member of the Training Sub Group during the year
- Awareness of safeguarding is being promoted to isolated groups, e.g. our Men in Sheds project.

Surrey County Council – Adult Social Care

In March 2013 ASC held a three day Peer Review of Safeguarding Adults looking at specific key lines of enquiry from the Local Government Association / Association of Directors of Adult Social Services Standards for Adult

Safeguarding. The review Team of six people was led by the Director of Adult Social Services of Buckinghamshire.

The Areas reviewed were:

- Leadership
- Delivery and effective practice/Performance and Resource Management
- Responding to Safeguarding Alerts
- Decision Making-
- Workforce

Three Locality and Integrated Mental Health Teams were involved in the Review.

The review included safeguarding case discussions with Adult Social Care Managers and Practitioners, focus groups for Service Users, Carers, Council Staff, Strategic Partners, other Partner Organisations and Providers organisations. In addition individual interviews were held with the Chief Executive, Interim Director of Adult Social Services, Lead County Councillor for Safeguarding, Chair of the Safeguarding Board, Senior Manager of Safeguarding and Adult Social Care Commissioners.

In order to capture wider views, a Survey Monkey was undertaken for partner agencies/members of the public and for Surrey County Council staff.

The outcome of the Review was the Peer Review team identified strengths of the Board including the appointment of an independent chair and a work plan that addressed all the aspects of the Care Act. They suggested actions for the Board to consider in the future including ensuring a balance between partner agencies contribution to the Board and consider how self funders access information on safeguarding.

In addition, Adult Social Care have supported the Board's strategic priorities as follows:

- Adult Social Care introduced a Safeguarding Competency Framework for all staff as part of the ongoing commitment to an effective workforce and continual improvement.

- The Adult Social Care Safeguarding training framework has been revised and new training in line with the competency framework, have been developed.

- Work has been undertaken for Adult Social Care staff to be located within the Multi-Agency Safeguarding Hub. The work of the Adult Social Care staff is expected to commence early in June 2014.

- Two corporate internal audits have been undertaken in relation to the quality assurance of safeguarding adults work and in relation to the implementation of the recommendations following the Gloria Foster Serious Case Review. Both audits have achieved good outcomes.

Surrey Fire & Rescue Service

- Surrey Fire and Rescue Service has invested in a range of training and continues to improve its capability and staff competence to support adults at risk by providing dementia training in order for them to live safer and longer in their communities. Staff training both in the recognition of people who are at risk and the different forms of abuse that exist, including the reporting process remains central to supporting our home fire safety initiatives.

- Surrey Fire and Rescue has also begun to embed Safeguarding into manager's job roles and ensured that managers with a responsibility for Safeguarding matters, either as part of service delivery or in terms of policy and procedural development receive the appropriate level of training.

- Surrey Fire and Rescue Service continues to work with partners to share information in order to provide the right level of service, at the right time in the right place. Our staff know what information to provide and where they can signpost people to get the right level of support that they need.

Surrey Care Association

Achieving Good Outcomes for adults at risk:
- Continuously promote good practice and raise awareness amongst providers. Share latest developments and encourage engagement at every opportunity.

Responding to Reported Abuse
- We aim to ensure that providers are appropriately trained and aware of best practice and confident in their application and involvement in safeguarding processes.
- We have provided two workshops specifically on this topic – "Responding Effectively to Safeguarding Alerts".

Leadership
- We provide regular updates for managers/owners at network meetings, conferences and events ensuring that they are aware and up to date in relation to best practice in relation to safeguarding.

Competent Workforce
- We were closely involved in the development of the competencies framework and have actively promoted their take up at meetings, events and in our communications.
- We were actively involved in the development of the Choking Policy and have actively promoted its take up at meetings, events and in our communications.
- We were actively involved in the development of the Missing Persons Protocol and have actively promoted its take up at meetings, events and in our communications.
- Safeguarding is a regular theme at all networking meetings, conferences and

events and within our member communications.
- We have provided Awareness Training Sessions, 2 Workshops for Managers on responding effectively to alerts, a conference on the practical application of the Mental Capacity Act / Deprivation of Liberty Safeguards.

Mental Capacity Act Awareness Level – 4 courses – 60 delegates
Safeguarding Awareness – 13 courses – 189 delegates
Deprivation of Liberty Safeguards an Introduction – 2 courses – 24 delegates
Deprivation of Liberty Safeguards for Managers – 2 courses – 27 delegates
Responding Effectively to Safeguarding Alerts workshops – 2 sessions – 40 delegates
Mental Capacity Act / Deprivation of Liberty Safeguards conference – 25 February 2014 - 40 delegates

Surrey Coalition of Disabled People

Representatives from Surrey Coalition of Disabled People are active members of the Board. Directors from the Coalition have attended each of the 3 Board meetings taking place this year and played an active role in the Board's Development day in December. We sit on the Board's Quality Assurance and Audit Group to ensure the voice of Service User's is heard in the group whose role is to assist the Surrey Safeguarding Adults Board with developing, promoting and ensuring good quality safeguarding practice. As an organisation we have our own Safeguarding Policy in line with the Board's policy which was reviewed and updated towards the end of 2013. We also attend the South West Safeguarding Adults Group where we support the group to understand safeguarding from the perspective of Service Users and in addition we learn more about safeguarding issues that we can then disseminate to other members of the Coalition.

This supports the following objectives and actions from the Board's Strategic Plan:
Key Principle 1: Empowerment - Presumption of person led decisions and informed consent
Surrey Safeguarding Adults Board Objective: To promote safeguarding in Surrey throughout partnerships, associations and agencies focussing on strong engagement with the voluntary sector and communications / publicity.
Key Principle 2: Protection - Support and representation for those in greatest need
Surrey Safeguarding Adults Board Objective: The views of service users and carers to become an integral part of activities undertaken by the board.

Virgin Care

- Virgin Care's Surrey Safeguarding adult lead chairs the North West Safeguarding Adults Group.
- Virgin Care attends and contributes to the Board's Policy and Procedures Group.
- The Surrey Safeguarding Adults Board newsletters are added to the Virgin Care, Surrey extranet and also disseminated through the Business Heads.
- Advocacy services promoted through Mental Capacity Act and safeguarding

training. Advocacy information is included on Virgin Care's internal extranet site.

- Serious Case Reviews are discussed at Virgin Care's safeguarding Governance groups. Serious Case Review and Individual Management Review (IMR) action plans brought to governance meeting for closure.
- Virgin Care has increased the number of trainers for Mental Capacity Act and has three trainers for The 'Prevent' agenda.
- Fire risk assessment form has been added to Virgin Care's internal safeguarding website, fire risks are discussed in safeguarding training and vulnerable patients are offered fire risk assessments.
- Virgin Care has participated in a multi-agency case review undertaken by the Board's. Quality Assurance Group.
- Safeguarding Governance meetings are held jointly with children and families services.
- Competency framework linked to safeguarding online training.
- Abuse of Vulnerable Adults data has been shared at Virgin Care's Safeguarding governance meetings.

Surrey Police

Surrey Safeguarding Adults Board Objective: To prevent harm being caused through learning lessons, identifying risks and implementing improvements in practice

- Surrey Police has been responding to the recommendations from the Equality and Human Rights Commission Disability Crime reports and implementing improvements in how people with disabilities are able to contact police, are responded to and supported through an investigation utilising a range of support agencies.

Surrey Safeguarding Adults Board Objective: To ensure in Surrey risk assessments are carried out to an appropriate standard in all cases and the risks are responded to in a proportionate manner

- Surrey Police is a key agency in tackling Domestic Abuse. Part of this process is an effective risk assessment using the nationally approved Domestic Abuse, Stalking and Honour Based Violence (DASH) risk assessment. In 2013 further bespoke training was provided by an external DASH expert to key supervisors on the correct use, review and assessment of the DASH risk questionnaire to ensure that all risks are recognised and responded to.

The Board's Serious Case Review sub-group is chaired by Surrey Police.

Appendix 2 Overview of adults at risk of abuse and neglect in Surrey

- Surrey has a population of just over 1.1 million people (census 2011). This is nearly 7% higher than when the previous census was undertaken ten years earlier.

- In Surrey, on average, people over the age of 85 years make up 2.7% of the population whereas in England they make up 2.2% of the population (census 2011).

- According to the Index of Multiple Deprivation (2010) Surrey is the fifth least deprived area in the Country.

- Life expectancy in Surrey is 80.5 years for men and 84.1 years for women compared to that for England which is 78.3 and 82.3 respectively (Joint Strategic Needs Assessment).

- This tells that the population in Surrey is older and wealthier than most other local authorities. This means there will be a high percentage of people who fund their own care rather than have care arranged for them by Adult Social Care.

The importance of safeguarding has been recognized by Surrey's Health and Wellbeing Board. They have identified safeguarding as one of their five priorities.

Age	Households
• 194,466 people in Surrey are aged 65 years and older. • The number of people aged over 65 years in Surrey has increased by 13% between 2001 and 2011 and the number of over 85s increased by 25.7%. *(census 2001 and 2011)*	• 84,143 people in Surrey are aged 75 years and older and live on their own. • 100,824 households have no one living in them under the age of 65 years. *(census 2011)*
Health	**Carers**
• 153,354 people said their day to day activities are limited by long term illness or disability. *(census 2011)*	• 108,433 people reported they provide unpaid care. • 18,474 of the people providing unpaid care do so for more than 50 hours a week. *(census 2011)*

Ethnicity	Dementia
• 186,717 people in Surrey are from ethnic groups other than white British. • English is not the first language for 64,831 people in Surrey. *(census 2011)*	• It is estimated that there are 15,551 people in Surrey with dementia; 15,258 people over 65 with dementia and 293 people with early onset dementia. *(Joint Strategic Needs Assessment data)*
Learning Disability	**Hate Crime**
It is estimated there are: • 3,788 people in Surrey aged 18 to 64 years that have a moderate or severe learning disability. • 4,391 people in Surrey aged over 65 years that have a learning disability. *(Projecting Adult Needs and Service Information)*	In 2013/2014 there were: • 473 hate crimes recorded in Surrey. • 43 of these were disability hate crimes. • 47 of these were sexual orientation hate crimes. *(Home Offices statistics)*
Physical Disabilities	**Domestic Abuse**
• 16,381 people in Surrey aged 18-64 have a serious physical disability. • 39,926 people in Surrey aged over 65 are estimated to be unable to manage at least one mobility activity on their own. *(Projecting Adult Needs and Service Information)*	• Data from Surrey Police tells us that between June 2013 and March 2014 there were 11,551 incidents of domestic abuse reported to the police (data from April and May 2013 is currently unavailable). *(Surrey Police data)*

Appendix 3 Surrey Safeguarding Adults Statutory Return – definitions

The following definitions are used in the Safeguarding Adults Statutory Return data:

Alert

An alert is defined in this return as a feeling of anxiety or worry that a vulnerable adult may have been, is, or might be, a victim of abuse. This would normally be the first contact between the source of the referral and the council about the alleged abuse. In Surrey, on receipt of the alert, initial enquiries are undertaken, the immediate safety of the adult at risk is put in place and a complete assessment of seriousness and risk is done. If the alert is assessed as not meeting the Threshold of Intervention as set out in the Board's Multi Agency Procedures then management of care is put in place and the case does not proceed to become a safeguarding referral. The Multi Agency Procedures are published on the Board's webpages and these set out the process in detail.

Referral

A referral is defined as a report of risk of potential abuse, harm or neglect which leads to investigation under the safeguarding process. The term referral in this context relates to safeguarding referrals, and not to referrals for community care assessments. Cases which do not meet the safeguarding threshold are not counted as a referral in this data.

Completed Referral

A completed referral is defined as when the active investigation has been undertaken and where the formal conclusion is recorded as one of the following:

- Substantiated – fully - This refers to cases where 'on the balance of probabilities' was concluded that all the allegations made against the individual or organisation were verified "on the balance of probabilities". Where allegations of multiple types of abuse are being considered against an individual or organisation then all will need to be proved for it to be defined as fully substantiated.

- Substantiated – partially - This refers to cases where there are allegations of multiple types of abuse being considered against an individual or organisation. Verification will be partial

- Investigation ceased at individual's request - This refers to cases where the individual at risk does not wish for an investigation to proceed for whatever reason and so preclude a conclusion being reached. Referrals which proceed despite this, for example where a local authority has duty of care to protect other residents in a care home setting or multiple individuals in supported housing, will not come under this definition.

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The burden of proof is consistent with the civil standard of proof required referred to in ‘No Secrets’ which is ‘on the balance of probabilities’.

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