2022/23 Annual Report

Essex Safeguarding Adults Board

1. Chair Foreword

Dear Reader

It gives me both pleasure and pride to introduce our Annual Report for the period April 1st, 2022, to March 31st 2023. This again, has been a very busy year for the Essex Safeguarding Adults Board, dealing with change and challenge as well as success, never forgetting our purpose to try and ensure that our residents of Essex live a life free from abuse and neglect.

We have had a huge agenda to work through this year and I would like to share just some of the achievements we have attained, as well as some of the challenges we have faced. This year, of all years, (post the significant impact of Covid-19 on our population, services and staff), was going to focus on 'Recovery,' which we have done, but we have paralleled this with delving into the new challenges we have faced, where safeguarding risk had to be reduced and managed, as well as developmental areas that our Board were clearly committed to move forward with.

In returning to 'business as usual' we moved forward with Safeguarding Adults Reviews, consequently publishing 6 Reviews and have developed associated 'Lessons Learned' and recommendations for prevention and action, planned for improvement across our safeguarding partnership. Work commenced on thematic analyses and we shared two reviews with the Domestic Abuse Board, as joint Safeguarding Adults Reviews/Domestic Homicides (awaiting outcomes from the Home Office), and most importantly, always working very closely with families, and or, their representatives, maximising our approach to making safeguarding personal.

This work led to pro-active partnership working with the Coroner's Office and our legal advisors, and we developed a draft Coroner's Protocol, now being tested and shared with Children's Arrangements to widen work parameters for 'an all-age' conversation about moving ideas forward jointly. We have kept a watching brief on Prevent and governance of Channel Panel, noting the connections with adult safeguarding and people with care and support needs who may be at risk.

We have started work on updating our website to increase accessibility and improve efficiency, broadening our reach to raise public awareness, making the site more straightforward for public use. Partners from the Disability Forum at Healthwatch have been supportive to us in reaching this goal. We have also posed the prospect of developing a Risk Register to capture risks facing ESAB and adults in the community, with clear links between risks, issues and what the Board faces.

Chair Foreword (cont.)

Regionally, our Policy documents (shared with Southend and Thurrock) have been updated. 'Missing' (a direct link to the 'Alan' Safeguarding Adults Review recommendation) is a staff handbook and guide on how to develop safeguarding policy for our Providers. We have updated our 'one-minute guides' on Hoarding, Missing and Modern Slavery and endorsed the Essex Care Home Covid-19 Report, with primary contributors being Essex Care Homes, reviewing the impact of Covid-19 on the sector, its residents and its staff and how partnership working can be improved to 'future-proof' the sector given the likelihood of a future pandemic. The most notable outcomes reported from the sector was the deep level of camaraderie; the single desire to help people to live and the very genuine and sincere focus on residents and their families. The Care Homes, families and the many additional contributors and supporters of this report, are owed heartfelt thanks for their significant contributions to lessons learned for future prevention. This is testimony to the true partnership that exists in Essex and its communities.

We have maintained a watching brief on the tragedy of suicide across our County, supporting the Health and Wellbeing Board and Public Health, becoming active members of the Suicide Prevention Partnership Board to maintain our awareness of the current situation, data and the obvious links with adults at risk and safeguarding.

When we welcomed guests from the Ukraine into our country, Support Pathways were put into place by partner agencies which were robust, and from a safeguarding perspective - a very successful and well organised venture. From February 2022, there were at least 1028 sponsors who offered their homes, with 2326 Ukrainian guests registered on the scheme, 1100 of whom moved to Essex. The process was streamlined, with considerable support for guests and hosts, and no safeguarding concerns warranted a Section 42 safeguarding enquiry.

From July 1st, 2022, we saw our Clinical Commissioning Groups replaced by new NHS structures, involving three Local Authorities, three Integrated Care Systems (ICS)and twelve districts - with a focus on safeguarding and quality throughout the transition. There is both enthusiasm and interest from our partnership in supporting these models to succeed, where adult safeguarding services are robustly maintained to deliver their duties, aligned with ESAB. Suffolk & North East Essex (SNEE) ICS; Mid & South Essex ICS and Hertfordshire & West Essex (H&WE) ICS were the resulting structures, with safeguarding assurance sought by ESAB throughout and senior executive members attending ESAB from all of the three new statutory agencies.

Essex Partnership University Trust (EPUT) crafted their Patient Safety Strategy with "safety first, safety always" as their mantra, looking at therapeutic environments; the culture of learning; patient risk and experiences and the well-being of staff. ESAB maintained good, supportive contact with EPUT, whilst seeking their assurance about patient safety.

Chair Foreword (cont.)

Following the Channel 4 Dispatches programme (October 2022), EPUT also aimed at building a sense of assurance, and the restoration of confidence. ESAB partners constructively supported EPUT's work, via leadership meetings, communications and scrutiny of improvement plans, where 'Lessons Learned' were of key importance, with patient safety, privacy and dignity as major priorities.

We sought assurance from the East of England Ambulance Service Trust who had worked to amend safeguarding referral pathways; supporting Multi-agency Risk Assessment Conferences across the region and completing a patient survey of people who had experienced a safeguarding referral. In the same year the Trust achieved a 90% compliance rate in safeguarding training. ESAB also offered support to HM Probation Service in North Essex owing to issues raised by the inspection of their services, where areas going through the unification process had been impacted by workload and recruitment issues. Probation assured ESAB about the importance of the Probation Prioritisation Framework, linking for example the risk of serious harm to ensuring assessments are robust and of a good quality.

The Care Quality Commission (CQC) were invited to ESAB to share an Annual Update for 2022/2023 advising that between September 2022 and March 2023, 84 risk based inspections had taken place in social care providers based in Essex, with 50% of services rated as 'good' along with the news that the Local Authorities Assessment and Assurance programme will be going live in April 2023 to focus on working with people, providing support and ensuring safety and effective leadership.

The ESAB Safeguarding Strategy for Essex ends in March 2024, and work started on a consultation to develop the new strategy early in 2023, with voices of those with lived experiences, and their carers being integral to the process. We participated in Essex County Council (ECC)'s Peer review to look at CQC 'preparedness', experienced a substantial increase in social media interest, coupled with high numbers completing their safeguarding training. Our budget for 2022-23 was kept at the same level as previous years, with early plans to utilise some of our current reserves, explore contingencies and not request uplift in partner contributions, in line with the financial pressures experienced by all of our partners, highlighting that it is unlikely that a budget uplift will not be anticipated until 2024/25. All in all, as mentioned a busy and forward-looking year.

I hope the following pages add to my introduction, but I must add two matters here of great importance to me – firstly what you will learn on the following pages has been brought about by the commitment and dedication that exists in Essex to true partnership working, supported by a Safeguarding Adults Board that has developed mature and trusting relationships - and secondly, a huge thank you to these people – particularly to the small and fastidious team that support this Board.

Deborah

Deborah Stuart-Angus BSc (Hons) CQSW Cert.Ed. Dip.App.SS

2. Index

2. Index (cont.)

2. Index (cont.)

2.1 Overview of Content

Within this annual report we will provide an overview of the following areas:

1 The impact of the Essex Safeguarding Adults Board (ESAB) and how we have sought assurance and accountability from our partners.

2 How ESAB met its adult safeguarding strategic priorities from April 2022 until March 2023, and what members have achieved.

3 The findings of Safeguarding Adults Reviews (SARs), which have concluded in the reporting year, implementation of lessons learned and our ongoing SARs

4 ESAB's safeguarding activity deployed through our Sub - Committees.

5 ESAB's income and expenditure.

6 ESAB's strategic priorities and Business Plan for 2021-24.

3. About ESAB

ESAB is a statutory Board, committed to safeguarding adults in Essex, who have care and support needs, to live safely - free from abuse and neglect.

We work to assure that local safeguarding arrangements and our partners, act in accordance with our multi-agency safeguarding adult policy and procedures. ESAB collaborates with the wider strategic partnerships across Essex, to ensure that where safeguarding responsibilities are spread across organisations, there is a clear understanding of where responsibility lies, and that a robust joined-up approach, is in place. Safeguarding works best when people and organisations work together to prevent harm and try to remove risks that can bring about abuse, and or neglect.

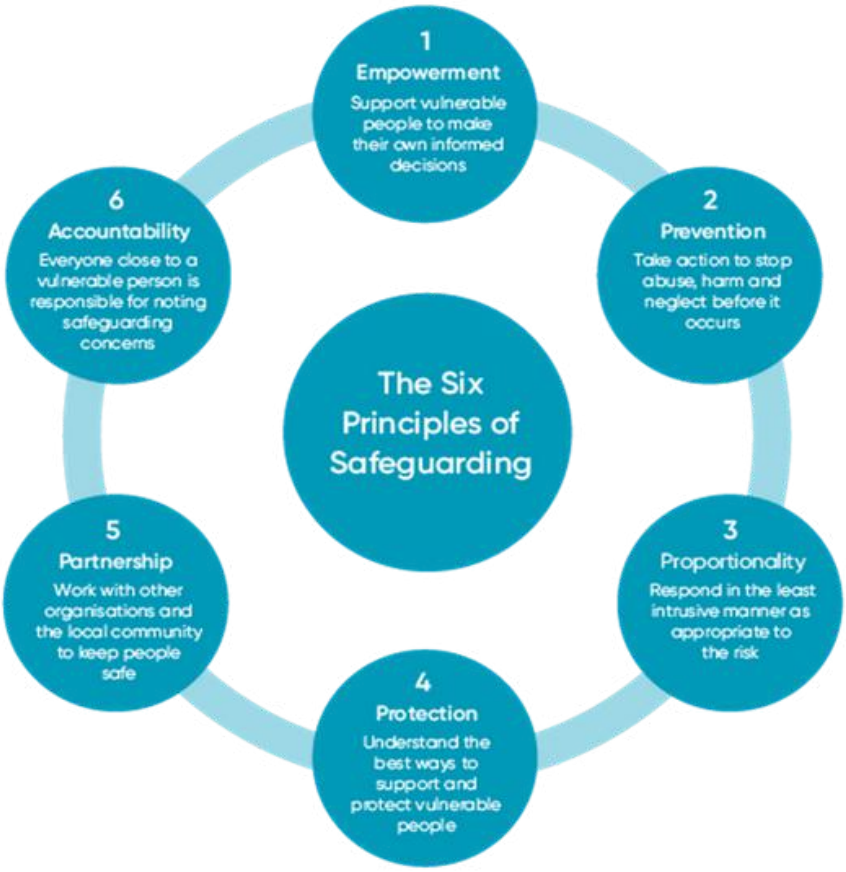
Our core duties are to:

1. Develop and publish a strategic plan setting out our priorities and how we will meet our objectives
2. Publish an annual report detailing how effective work has been
3. Commission Safeguarding Adults Reviews (SARs) for any case which meet the lawful criteria to do so, or commission a SAR on a discretionary basis, where it is deemed that learning for the organisations involved, can be gained

ESAB's priorities are prevention, learning and quality in relation to our aforesaid statutory obligations. Aspects of what Safeguarding Boards can implement are:

- Provide strategic direction for how organisations safeguard adults at risk across our partnership
- Develop and review multi-agency adult safeguarding policies, procedures and guidance
- Monitor and review the implementation of the safeguarding strategy, policy, procedures and our delivery
- Promote and deploy multi-agency safeguarding training (where a budget allows)
- Undertake Safeguarding Adults Reviews (SARs), share lessons learned from outcomes with partners (and nationally), and develop and monitor action plans for practice improvement; hold partners to account, proffer challenge and gain assurance of the effectiveness of safeguarding arrangements.

These duties and priorities are linked to the six core principles that all safeguarding boards should work towards, these being:



Since January 2020, ESAB has been chaired by our Independent Chair, Deborah Stuart-Angus. The Board is supported by a full time Board Manager, a Safeguarding Adults Review Officer, a Business Support Officer, and a Senior Communications Officer.

In early 2023 budget year, the Board officer team will be expanded to include a Practice Development Officer*

Meet Our Team

DEBORAH STUART ANGUS
INDEPENDENT CHAIR

Deborah is a senior executive, having led strategic safeguarding partnerships for several years. Her background stems from directing adult social care's strategic safeguarding across mental health; older people and transition services. She has also directed a local authority trading company, delivering county wide learning disability services, and founded a learning and development company, specialising in adult safeguarding. She has held several Chair roles in the South East since 2015 and is an active member of the National Chairs Executive.

MICHALA JURY
BOARD MANAGER

Michala is the ESAB Board Manager, having worked within safeguarding in Essex for over eighteen years. She brings a wealth of knowledge and experience to the Board and is committed to safeguarding the most vulnerable adults in our society.

JAMES BUTLER
SAFEGUARDING ADULTS REVIEW OFFICER

James is an experienced executive, programme and project support officer who undertakes and manages all Safeguarding Adults Reviews (SARs) for the Board. James has extensive expertise in local government, safeguarding and project management.

PATSY RUTLAND
BUSINESS SUPPORT ADMINISTRATOR

Patsy is the Board's Business Support Administrator, responsible for coordinating all of the administrative tasks the Board and its members have. Patsy has intensive knowledge of all things safeguarding and is meticulous with the gatekeeping of safeguarding processes.

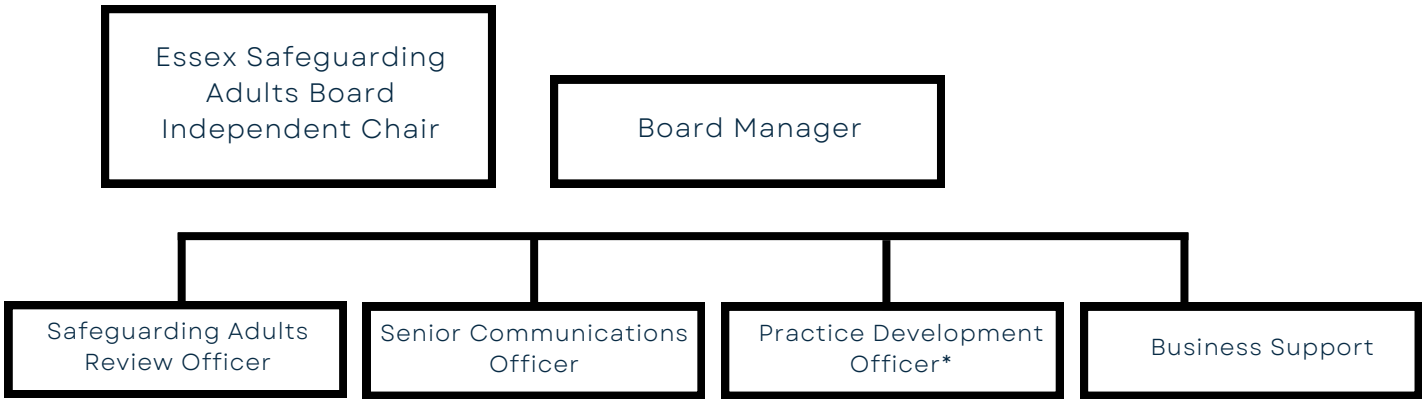
SONIA CARR
PRACTICE DEVELOPMENT OFFICER

Sonia leads the learning and development of the Board's various training programmes including Designated Safeguarding Adult Lead and Safeguarding Adults Basic Awareness training. Sonia has over a decade's experience working within safeguarding in local government.

CHANEL HARRIS
SENIOR COMMUNICATIONS OFFICER

Chanel leads the communications and marketing for the Board's activities. She runs all of the Board's social media pages and connects with partner agencies and professionals to update on all safeguarding adult activities in Essex.

ESAB STAFFING STRUCTURE



*position filled May 2023

4. Our Partners

The Essex Safeguarding Adults Board is made up of core statutory partners and multi-agency partners:

ESSEX POLICE

ESSEX COUNTY COUNCIL

NHS ICB

ESSEX FIRE & RESCUE

SOUTHEND, ESSEX & THURROCK DOMESTIC ABUSE BOARD

ESSEX CARE ASSOCIATION

ESSEX HOUSING

ESSEX CHIEF EXECUTIVE OFFICERS FORUM

SAFER ESSEX

EPUT

Additional partner details can be viewed in the Appendix on page 55.

5. Strategic Plan

ESAB continue to deliver against the priorities of the ESAB strategic plan - 2021-2024. This document gives direction to our partners and shares with the people of Essex, what we want to achieve and how we plan to deliver. Our strategic delivery aims are detailed in our Business Plan, which is reviewed quarterly by ESAB Executive Group and rated against our progress.

Vision

Our vision is to ensure that Essex Safeguarding Adults Board (ESAB) works in partnership and collaborates with our partners, to make sure that adults at risk of abuse and or neglect, are able to live safely, with the rights and freedoms of citizenship.

Mission

We will work together with our partners, to seek and gain assurance, with effective and transparent processes, to ensure that adults at risk of abuse or neglect are supported to live safe lives through delivering against the priorities of prevention, learning, awareness, quality and holding each other to account.

The vision and mission statement is taken from the ESAB Strategic Plan.

Our Priorities:

Priority 1 – Prevention & Awareness

We will improve the awareness of adults at risk within and across our communities and partner agencies, and we will work to prevent abuse and neglect.

Priority 2 – Learning

We will be open and transparent, sharing lessons learned from safeguarding practice and promote the development of an up to date, competent and skilled shared workforce.

Priority 3 – Quality

We will assure our own work, learn from experience, and set up processes to give insight into our ongoing commitment to continuously improve safeguarding practices.

Work started in early 2023 to review the Strategic priorities for 2024 – 2027, which will include the Business plan and revised objectives. A consultation review is being undertaken initially with ESAB partners, which will be followed by a wider consultation with professionals and the people of Essex.

6. Essex Safeguarding Adults Board

ESAB has met a total of seven times during 2022 – 2023. Four of these meetings have been the standard quarterly meetings and a further three have been extraordinary meetings to review and ratify six Safeguarding Adults Reviews (SARs) and one SAR/Domestic Homicide Review (DHR). Further details on the reviews ESAB have undertaken can be found under section 11.2.4

6.1 Impact and Challenge for ESAB during 2022-2023

- Development of the ESAB Coroner Protocol: Joint working with the Coroner's Office enabled this Protocol to be developed, enhancing how we work together. This is of particular importance given our lawful duties in relation to Safeguarding Adults Reviews, bringing clarity to our shared expectations, and how we manage complex processes. This protocol was implemented in June 2022.

- The ESAB Risk Register: This was reviewed during 2022-2023 with ongoing work taking place through the lens of how ESAB agree to define risk for the Board. One area of likely inclusion on the new version will be risk to services, to take into consideration the increase in referrals for Safeguarding Adult Reviews. This will include ongoing cost implications and any issues appertaining to capacity of multi-agency partners who help to undertake this statutory function of the board. Another area for consideration will be will be the new police, health, social care and NHS initiative: Right Care Right Person, which may have an impact on services across the Board Partnership, however until this is implemented the full impact will not be known. The final version of the new Risk register is expected during the 2023/24 year.

- Guests in our country: ESAB continued to request and receive quarterly updates on people and families from Ukraine and other areas, who are living in Essex, ensuring that safeguarding services were effective and active, across our partnership.

- NHS changes and the introduction of Integrated Care Boards: this year we have worked with the challenge of three new structures within the NHS, replacing the previous Clinical Commissioning Groups and moving to Integrated Care Boards (ICBs), set within Integrated Care Partnerships (ICP) and the Integrated Care Systems (ICS). Essex has one of the most complicated pathways in the country, given that it links with three different ICB's; ICP's and ICS's. All three ICBs are now fully represented at ESAB. Close working, collaboration and new learning has helped partners to understand how the new systems work and the Chair sought continued assurance about consistency and alignment with ESAB's strategic safeguarding priorities. This included governance and accountability being identified to ESAB, requiring extensive exploration with our NHS partners.

- Essex Partnership University Foundation Trust (EPUT): ESAB has proactively sought safeguarding assurance and accountability input from the Trust, via regular updates and scrutiny of the Patient Safety Strategy, given the Government's Private Inquiry announcement in 2021. Additional assurance requests were sought by the Chair, from the organisation, following the Channel 4 Dispatches programme in October 2022, to establish what additional improvements were being made. ESAB have offered to help to support EPUT and our Chair has met with their Chief Executive and the Director of their Patient Improvement Strategy, on several occasions.

- Care Home Covid Review: in Autumn 2022, Essex County Council (Adult Social Care) published the Care Home Covid Review, looking at the impact of Covid-19 on Essex Care Homes during two national lockdowns. This report was endorsed by ESAB at its meeting in July 2022, and shared widely across partner agencies in Essex, to maximise learning. Following presentations at a number of partnership meetings and the Suffolk and North East Essex ICP, it was requested that the Report be submitted to the UK Covid-19 Inquiry, with recognition to Essex County Council as the commissioners of this report and Deborah Stuart-Angus as author and reviewer.

- SET Suicide Prevention Board: ESAB connected with this Board during 2022/23 and requested regular suicide data updates given the links with adult safeguarding, to which their Chair agreed. ESAB are now represented at the Suicide Prevention Board, which enables cross sharing of information to take place between the two boards and learning from Safeguarding Adults Reviews to be maximised. Connectivity also enables themes and trends gained from safeguarding adult learning to be identified and shared. It is also clearly defined that the governance of the Suicide Prevention Board sits with the Health and Wellbeing Boards across Southend, Essex and Thurrock. The report outlining this partnership can be accessed here.

7. Statutory Partner Contribution

7.1 Essex County Council

The vision in Essex adult social care is to enable every adult to live their life to the fullest, and we believe that ensuring adults with care and support needs (who may be at risk) are empowered and enabled to stay safe, is a vital part of achieving this vision. ESAB is key to achieving this goal, in addition to full membership of the ESAB and its Sub-Committees, we fully support the ESAB safeguarding adult strategy and the key priorities it set out:

1. Prevention and Awareness
2. Learn from experience and enable professional competence
3. Assure our work and continuously improve our safeguarding practice

Our contribution seeks to reflect to the delivery of these priorities.

Prevention and Awareness

Sadly, too many people still experience abuse and neglect and there is no room for complacency. During 2022/23 we had 18,546 safeguarding concerns reported to us, compared with 17,055 the previous year, an increase of 9%. This is in line with the national trend which has shown an increase in safeguarding concerns since 2014. Of the safeguarding concerns received 4,558 met the threshold for Section 42 safeguarding enquiries (24.6% of the total concerns raised).

In the cases where the Section 42 duty is not triggered because the concern does not meet the threshold, we will do whatever we can to support adults to feel and be safe, including signposting them to other sources of support for a non-statutory safeguarding response - where this is appropriate.

85% of the adults we safeguarded in the reporting year - reported that they felt that their outcomes had been met. During the year we continued to provide safeguarding adults training for our staff and managers and additional 'lite-bite' safeguarding sessions for front line staff, who also accessed training on the newly created practice expectations guidance, relating to safeguarding and the Mental Capacity Act.

We delivered a safeguarding masterclass to our Adult Leadership Team and presentations to the Essex Care Association conferences.

We have also continued to offer Mental Capacity Act training twice monthly and safeguarding adults training to partners such as the Police and Prison Service in Essex.

7.1 Essex County Council (cont.)

Learn from experience and enable professional competence

We are proud of our workforce who respond effectively when an adult is at risk of abuse or neglect, ensuring their practice always keeps the adult at the centre of an enquiry by ensuring their wishes and outcomes are understood and respected, while seeking to build their resilience and promote their independence.

We have created a subgroup of our Practice Governance Board that examines the learning from Safeguarding Adults Reviews and ensures that this is shared across our workforce and picked up in any reviews of practitioner guidance and training.

Despite the Government's decision to delay the Liberty Protection Safeguards Scheme we have we have continued to focus on preparation for the Scheme's eventual implementation. We have identified the need for additional Best Interests Assessors and have commenced Best Interests Assessor training for 40 staff.

We believe that our providers play a key role in promoting and developing an effective safeguarding culture and we take a proactive approach to working with them on quality improvement and safeguarding.

We have continued to provide support for the provider market post Covid-pandemic and have created a strong approach to discussing and sharing the findings of our Provider Assessment and Market Management audits. We have worked with our statutory partners including the Care Quality Commission sharing risks and safeguarding concerns with them as part of our regular safeguarding and quality partnership working model.

Our Serious Concerns Review Group meets weekly to ensure that concerns are well managed and providers are supported to improve the quality of their service and in so doing remedy areas of concern. This approach enables us to ensure that we are taking prompt, proportionate and appropriate action when required to ensure the safety of residents and adults. While at the same time doing all we can to avoid disrupting established care arrangements that are relied upon by the adult and their family.

During 2022/23 we supported 56 providers from a provider concern to a point where they had completed their improvement plans. Where improvements could not be achieved or sustained, we supported the transfer of 190 adults to new care providers while maintaining continuity of care.

Assuring our work and continuously improving our safeguarding practice.

We recognise the need to build an empowered and professional workforce, and, as part of that process, to learn from experience. In doing so we acknowledge the importance of looking behind the numbers, on the impact of our work - on the people who rely on our support.

This is achieved in a number of ways:

- through auditing case files that look at practice and legal compliance,
- hearing feedback from people after a safeguarding case has been closed,
- analysing complaints and engaging with the public
- having a robust training and awareness programme as set out above.

7.1 Essex County Council (cont.)

We have carried out Practice Diagnostics across all of our safeguarding teams using an appreciative enquiry model that seeks to boost innovation by analysing best practice, strategic planning, organisational culture, and initiatives.

In the context of our safeguarding teams we have focused on understanding the experiences of our workforce, hearing their reflections on their training and support and their reflections on learning from what has gone really well and what has not gone so well, by using the output to create a team action plan. This helps our safeguarding teams to really focus on the strengths and areas that could be improved, to get better outcomes for adults and carers.

The audit and diagnostic approaches described above complement each other. Audits tell us an in-depth story on practice issues whilst diagnostics give a bigger picture of what is impacting on practice - helping us to devise effective solutions.

Learning and development

Our practice hub and dedicated practice forums enable us to offer clear and supportive guidance to our workforce who are supporting adults and carers that are experiencing abuse, harm or neglect. We are proud of our Supporting Independence Discussions which enable a professional, round table discussion to develop creative, innovative, and person-centered plans, to assist adults to be as resilient and independent as possible. We have recruited a dedicated Principal Social Worker to ensure our focus on adult safeguarding practice is clearly led, having also delivered a number of reflective practice sessions across adult social care.

Key examples of this approach in practice during this reporting period are:

- Homes for Ukraine - preventative – ensuring accommodation was safe.

During this year we led and co-ordinated the implementation of the Government Homes for Ukraine Scheme in Essex. We swiftly created and implemented the welfare and safeguarding assessments of adults and children from Ukraine requiring support to settle in homes across Essex. This required very close and co-ordinated working with City, District and Borough Councils, Children's Social Care, Charities, local businesses and individuals as well as clear links with the Department for Levelling Up, Housing and Communities.

- Responding to significant Safeguarding Concerns

Following the broadcast of the Dispatches TV programme in October 2022 that highlighted safety and safeguarding issues in some Mental Health inpatient units in Essex, we commenced an organisational safeguarding response led by the Head of Safeguarding Adults and our Organisational Safeguards Team. Regular assurance meetings have been in place with the provider and we continue to monitor quality and safeguarding concerns relating to the inpatient settings and individual patients and work closely with our Board.

We have also worked with a number of care providers where there is significant high risk or large-scale safeguarding concerns ensuring the ongoing scrutiny from our Provider Improvement Team and our Serious Concerns Review Group to inform our support to providers and decisions to safeguard adults using these services.

7.1 Essex County Council (cont.)

- Safeguarding Peer Audit

In October 2022 our Safeguarding Adults arrangements were the subject of a Peer Audit carried out by colleagues from Hertfordshire County Council and the Local Government Association (LGA). Headline findings included the consistent approach to managing safeguarding concerns through to enquiries via our Triage team, strong leadership and a very effective co-ordinated response to provider safeguarding concerns. Areas for improvement included developing our co-production and lived experience work in our safeguarding activities. We are also keen to better demonstrate how we are making safeguarding personal.

Building on the findings of the peer audit we are working on a number of opportunities to revamp our training and development offer for our workforce and updated our safeguarding policy and assurance processes to better support and evidence best practice and good outcomes for adults in Essex.

Our priorities for 2023/24

We want to better evidence the impact of our safeguarding activities through our quality assurance processes ensuring we are hearing and evidencing the voices and lived experiences of adults. We will ensure our Practice Governance Board provides the essential link between audit, assurance, learning and practice improvements.

We want to improve the safeguarding adults processes at our front door and are looking at the use of technology to assist our partners to share safeguarding concerns with us via a portal.

We want to improve our training and development offer for specialist safeguarding adults skills and knowledge across our workforce, and will launch a new safeguarding adults training programme that is based upon competencies related to specific roles.

7.2 Integrated Care Boards

7.2.1 In July 2022, the seven Clinical Commissioning Groups (CCGs) that worked across Essex transitioned into three Integrated Care Boards (ICBs). For this report, the three Integrated Care Boards (ICB's) covering the Essex footprint completed a combined submission.

Below shows the change of the Health picture from CCGs to ICBs:

<table>
<tr><th>Essex Integrated Care Boards in Essex</th><th colspan="2">Previously known as:</th></tr>
<tr><td>Suffolk & North East Essex ICB</td><td>North East Essex CCG</td><td rowspan="3">These CCGs covered the Essex footprint of greater Essex.</td></tr>
<tr><td>Herts & West Essex ICB</td><td>West Essex CCG</td></tr>
<tr><td rowspan="3">Mid & South Essex ICB</td><td>Mid Essex CCG Castlepoint & Rochford CCG Basildon & Brentwood CCG</td></tr>
<tr><td>Southend CCG</td><td>This CCG covered Southend unitary authority only.</td></tr>
<tr><td>Thurrock CCG</td><td>This CCG covered the Thurrock unitary authority only.</td></tr>
</table>

The Designated Safeguarding Nurse role within the ICBs has continued in respect of safeguarding accountability and seeking safeguarding assurance from commissioned health services across the system. There are some locality-based differences in the safeguarding work delivered and planned for the coming year. The following provides an overview of work, directly linked to ESAB strategic safeguarding priorities that has taken place over the past year. The associated outline plan from the ICBs for 2023-2024, to delivering ESAB priorities.

7.2.2 Priority 1: Prevention & Awareness

- All three ICBs completed the ESAB staff safeguarding awareness survey and self-assessment audit.
- The ICBs supported safeguarding messages and campaigns, via their communications team by social media.
- Work took place in collaboration with the Channel Panel Chairs to ensure consistent ICB representation and sharing of knowledge at Essex Panel meetings.
- Raising awareness of Domestic Abuse in Primary care: A Multi-Agency Risk Assessment Conference (MARAC) information sharing agreement process has been developed with 50% of GP practices having signed up (Suffolk & North East Essex ICB only).

Going into 2023 – 2024, the ICBs will be concentrating on:

- Their plans to analyse the findings of the SET Safeguarding Adult Audit and staff safeguarding awareness survey and to set out future recommendations
- Continuing the development of the MARAC Information Sharing Agreement process, to ensure more GP practices sign up to it, and to encourage the roll out across Essex.
- Taking forward the Serious Violence Duties.
- Continued attendance at Prevent and Channel Panels.
- Review the updated Domestic Abuse Act and its implications for health.

7.2.3 Priority 2: Learning

- Continued work in relation to Liberty Protection Safeguards (LPS) and Mental Capacity Act (MCA), Deprivation of Liberty Safeguards (DoLS), with support for training, workshops and scoping exercises. Also additional support for the acute trusts around MCA assurance and improvement of standards following Care Quality Commission (CQC) visits and recommendations made (Mid and South Essex ICB).
- Bespoke MCA training sessions took place across the system for health providers in preparation for LPS.
- Specialist safeguarding training for adults and children was developed as part of the GP Training Scheme to enable Registrars to assume safeguarding lead roles at GP practices (Mid and South Essex ICB).
- Learning from Safeguarding Adults Reviews (SARs) and Domestic Homicide Reviews (DHRs) took place, providing assurance to ESAB on recommendations linked to SARs, working to ensure that themes and recommendations are embedded into working practice.
- Implementation of the outcomes of the Essex County Council - Essex Care Home Covid 19 Review report will be carried out.
- Learning and development research evaluation for both adults and children was held.
- GP training sessions and primary care forums took place.

Going into 2023 – 2024, the ICBs will be concentrating on:

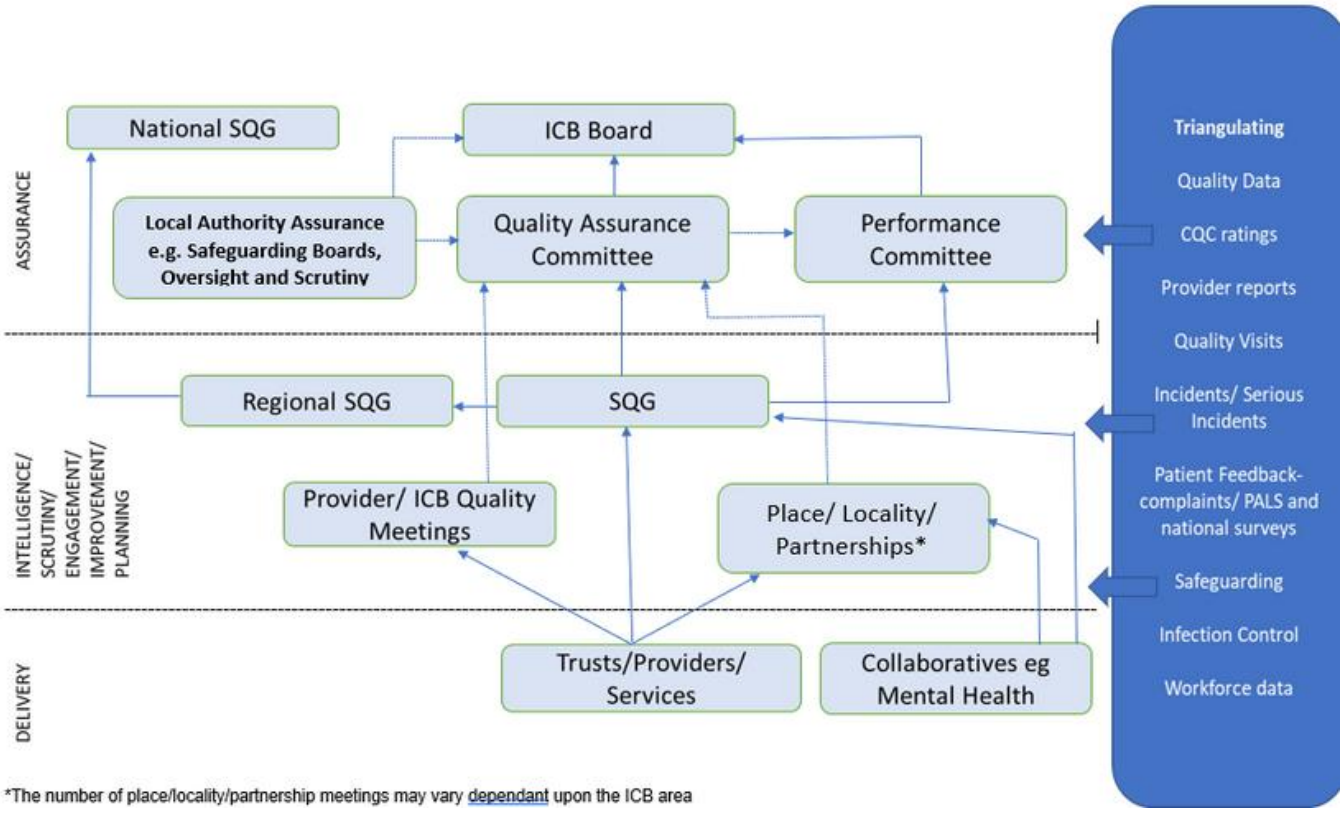
- Continuing to embed learning and recommendations from SARs and DHRs into health care practices, ensuring that the sharing of thematic analyses takes place collaboratively across the three ICB areas
- Additional MCA and GP training sessions for Primary Care.

7.2.4 Priority 3: Quality

- Participation in the SET self-assessment and staff safeguarding awareness survey.
- Developed the current Section 11 Safeguarding Assurance Framework
- Development of Essex wide LPS Implementation post and workstreams, linking in with all health providers, local authorities and Continuing Health Care (CHC), ensuring they are prepared and on track with implementation of LPS, when it occurs.

7.2.5

Below is a governance chart that shows the level of complexity that the ICBs now work towards and how this links to safeguarding, there may be some slight nuances between the three ICBs in relation to governance than shown on this diagram.



*The number of place/locality/partnership meetings may vary dependant upon the ICB area

7.3 Essex Police

7.3.1 Leadership and Structure

Safeguarding of people with care and support needs, is a priority for Essex Police, which is reflected in the police plan and enables delivery of ESAB's safeguarding adults strategic priorities. Essex Police Service has a wide range of oversight and governance of vulnerability, led by the Assistant Chief Constable for Crime & Public Protection (C&PP) and Criminal Justice. The ACC holds quarterly Public Protection Vulnerability Boards attended by C&PP and other Command areas, who report on activity, risks, and issues, the Head of C&PP Command is a Detective Chief Superintendent, supported by two Detective Superintendents leading on the areas: 'Proactive Investigations and Safeguarding and Partnerships' and investigations. Through this structure, safeguarding adults is championed throughout the organisation with thematic leads in key safeguarding areas such as mental health and missing people.

The Operations Centre is a central safeguarding hub and is the point of entry into Essex Police for all public protection partnership-related enquiries and referrals, linking the Essex Social Care Teams and Health Services. The Domestic Abuse Review Team (DART+) are responsible for risk assessing and safeguarding high-risk victims of domestic abuse supported by the Multi Agency Risk Assessment Conference route.

Staff and resourcing within Essex Police, who are fully engaged with ESAB are committed to collaborating with our safeguarding partnership. The service is represented at senior levels and support ESAB's delivery Subcommittees, where together with key partners, they review, and quality assure policies and recommendations to audit compliance and identify learning. We also have an Adult Triage function in the Operations Centre who work closely with our partners in relation to vulnerable adults in the community where S42 duty is triggered.

7.3.2 Activity, Initiatives and Operations

Due to the impact of COVID-19 in 2020, Essex Police have adapted their working practices which has enabled increased agile and flexible working. Utilising IT platforms such as Microsoft Teams has continued to ensure that Essex Police work effectively with partners to support vulnerable people. This has seen greater attendance at multiple meetings with different partnership agencies.
The centralisation of all secondary risk assessments for high-risk domestic abuse cases into the DART+ has provided a greater consistency across the Police Service, which has increased the accuracy and quality of risk assessments, together with timeliness in safeguarding activity.

7.3.2 Activity, Initiatives and Operations (cont.)

Essex Police have seen the introduction of a Domestic Abuse Problem Solving Team (DAPST) in 2021, geographically based across the County. Teams are led by a Detective Inspector and are responsible for working with repeat victims of domestic abuse with commissioned services, and tackle repeat perpetrators with a focus on the highest risk perpetrators being referred into the MAPPA process. DAPST are regular attendees at Level 2 and 3 MAPPA reviews when Domestic Abuse perpetrators are being discussed and work well with the statutory duty to cooperate across agencies.

Over the coming year Essex Police are moving from the Domestic Abuse, Stalking and Honour Based Violence(DASH) risk assessment model to Domestic Abuse Risk Assessment (DARA) which will enable enhanced risk assessments in all areas of domestic abuse including stalking, harassment and coercive and controlling behaviours.
Essex Police have developed a close working relationship with EPUT and Approved Mental Health Professional (AMHP) services to improve prevention, response, and investigation into cases where mental ill health is a factor. Essex Police co-chair the quarterly Concordat meeting. This is a multi-agency forum to discuss a whole system approach to mental ill health in the community, particularly when member of the community may reach a crisis point and needs to be detained under S135 and S136 Mental Health Act.

Essex Police have collaborated well with partner agencies, to reduce risk of serious harm where mental ill health is a key indicator. More recently Essex Police have invested in a Mental Health Partnership Team that oversees a 'partnership and prevention' model between agencies. Over the coming year the Police Mental Health Team will embed and work towards improved risk reduction through effective partnerships and ensure that people suffering with mental ill health receive the right support from the right agency.

8. Communications Data

2,588

This number is the combined audience across the ESAB social media and newsletter channels

17 Monthly and special topic bulletins sent out.

4 Partner campaigns on special topics including Dementia Awareness Week, Carer's Day, National Domestic Violence Awareness Month and World Elder Abuse Day.

164,522

This is a total number of engagements across ESAB Facebook content, which has sparked conversation and information sharing increasing ESAB brand awareness and visibility.

Our communication channels continue to experience steady growth in terms of followers and subscribers, and excellent engagement on topical posts. Campaigns for abuse types are organised into monthly categories and follow themes frequently advised by safeguarding partner agencies and charities. SAR recommendations are communicated with partners and developed into one minute guides for publication and ease of understanding.

9. Quality Data

Data supplied for this report has been provided by Essex County Council – Adult Social Care, during the 2023/2024 period it is expected that data from other statutory agencies will be included to provide a full picture of what is happening across Essex.

This is in addition to the quality/comms data in report below.

18,546
Total number of safeguards raised.

84%
of services in Essex are rated good or outstanding

4,558
Total number of section 42 enquiries

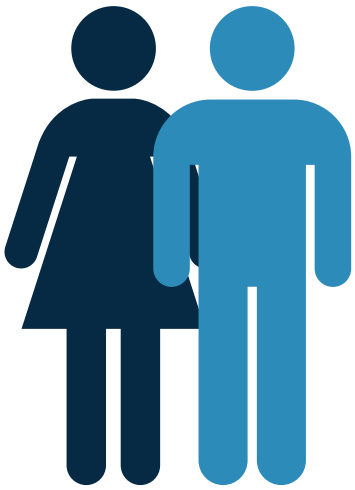
33
Different ethnicity groups identified

2/3
Almost two thirds of all alleged victims were over the age of 65

56%
of s42 enquiries were closed within 90 days.

0.76%
The population of Essex has grown by over 109,000 since census 2011.

20%
Increase in safeguard referrals raised 2021-22, up from 15,370.



There is still a disproportionate number of safeguards raised for females.

58% **WOMEN**

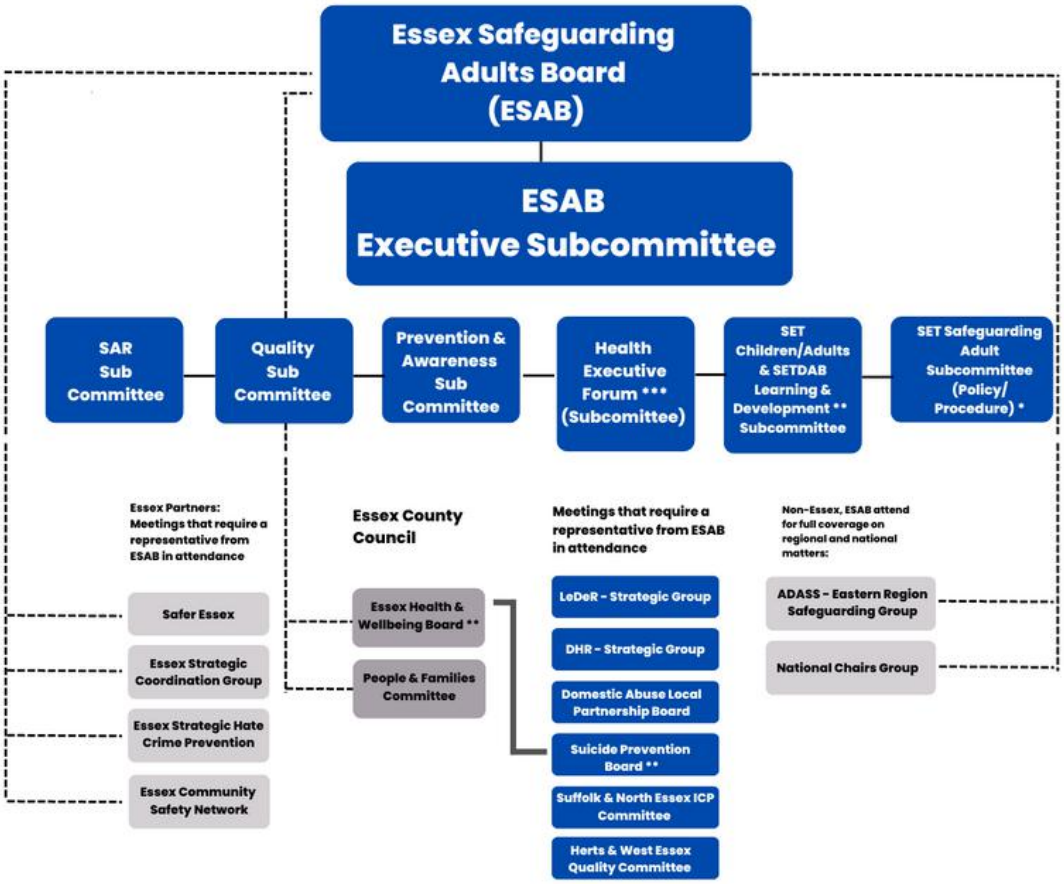
42% **MEN**

48%
of safeguard concerns raised were people known to services

58%
of safeguard referrals were raised by service providers

10. ESAB Structure

Below is the structure chart for ESAB, including meetings that ESAB officers or a representative are requested to attend.



*Joint committee with Southend and Thurrock SABs

** Joint Committee across Children and Adults covering Southend, Essex & Thurrock and SETDAB

***A forum where those responsible for the safeguarding of adults, children and looked after children in health services across Southend, Essex and Thurrock (SET)

11. Essex Safeguarding Adults Board (ESAB) Sub-Committee Overview

ESAB classifies all meetings under the main board as Sub-Committees although reference to these may change throughout the report given the nature of the Sub-Committee.

ESAB Executive Group (Sub-Committee)

11.1.1 The ESAB Executive Sub-Committee is made up of statutory agency partners who have met four times during 2022 - 2023. Over the year this Sub-Committee has reviewed the ESAB Business plan, redesigned the ESAB Risk register (work on which will continue into 2023 – 2024), completed a refresh of the ESAB Constitution (inclusive of Terms of Reference) and undertaken budget oversight, prior to final reports being presented to ESAB.

11.1.2 Additional ESAB partners are invited to the Executive Group as and when there is a need for discussions to support recommendations made to the main board, and over the past year Essex Probation, Essex Partnership University Trust (EPUT) and SET Suicide Prevention Board representatives have been invited.

11.1.3 Under the banner of the Executive Group, ESAB statutory partners have a bi-yearly meeting with the Essex Safeguarding Children's Board Executive sub-committee, to work together on issues that affect Children and Adults services. During 2022-23 three themes were jointly decided upon, which were:

- Transitions
- Think Family
- Suicide Prevention

The Executive Group work to ensure delivery of ESAB's Strategic Priorities 1, 2 & 3.

11.2.1 Safeguarding Adults Review Sub-Committee

11.2.2 The Safeguarding Adults Board (SAB) is lawfully responsible for holding a Safeguarding Adults Review (SAR), under Section 44 of Care Act 2014, and must hold a SAR if:

1. The person has died and ESAB suspects the death resulted from abuse or neglect (whether or not Essex County Council knew or were providing services, or not.
2. The person is alive but ESAB knows or suspects that they have experienced serious abuse or neglect; and
3. There is a reasonable cause for concern about how ESAB, its members or other persons involved worked together to safeguard the adult.

This is known as a mandatory SAR, however ESAB can also commission and arrange a SAR if they think that there is learning for organisations and it is deemed that a person has experienced abuse and or neglect. This is known as a discretionary SAR.

The purpose of a SAR, as stated in the statutory guidance is to, 'promote effective learning and improvement action, to prevent further deaths and serious harm'. The aim of a SAR is to ensure lessons can be learned from case findings, and for those lessons to be applied to action plans and organisational improvement strategies, in order to prevent similar risks of harm, neglect or abuse from reoccurring - and to improve systems delivery and practice.

11.2.3 The Safeguarding Adults Review Subcommittee has met on 12 occasions over the 2022-23 year. They hold responsibility for considering referrals received and for making recommendations to the Independent Chair if a Safeguarding Adults Review (SAR) is to be commissioned or not. If it is agreed by the Independent Chair that a SAR is to take place, the SAR Sub-Committee will commission an Independent Overview Report. Feedback on the progress of findings and outcomes are shared with to ESAB and the Executive Group on a quarterly basis and any issues of concern are regularly shared with the Independent Chair The SAR Sub-Committee are also responsible for managing contact with families; deploying ESAB's approvals and or critiques; managing publication plans; developing action plans for organisational improvement; ensuring media attention is managed and linking with the ESAB's other Sub-Committees to ensure that learning about SAR outcomes is shared and triangulated with the strategic safeguarding priorities of Prevention, Quality and Learning.

This Sub-Committee works to ensure that ESAB are achieving strategic Priorities 1, 2 & 3 via monthly review of the work plan.

11.2.4 Published Safeguarding Adults Reviews

In November 2022 ESAB published:

4 full SAR reports, 1 Executive Summary and 1 Learning Brief following ratification of 6 SAR reports by ESAB partners, which had been delayed in recognition of the demands faced by front line services and practitioners caused by the Pandemic details of which can be found in Appendix 2.

A total of 42 improvement recommendations were identified as part of the SAR reports, with five common learning themes identified, which were:

Theme 1: Challenges when working with those who experience Complex Needs

Theme 2: Improving Making Safeguarding Personal (MSP) and hearing the voice of the adult at risk

Theme 3: The importance of a shared approach to setting high standards in safeguarding practice and oversight from ESAB

Theme 4: ESAB's oversight of outcomes from partner's quality assurance of safeguarding systems

Theme 5: Improving interagency communications between Health and Social Care

Actions to address the recommendations linked to the themes is in the assurance monitoring stage. Further details on the themes are available via the ESAB website.

11.2.5 Safeguarding Adults Reviews: Referrals Over 2022-2023

17 SAR referrals were received over the 12-month period, two of which were also referred for a Domestic Homicide Review (DHR).

6 of the 17 SAR referrals were received late in the 2022 - 2023 financial year, with decision-making about escalation to take place early in the 2023/24 reporting year.

17 SAR Referrals Received

112% increase

The number of SAR referrals received from the previous year.

6 referrals

met the criteria for a S.44 mandatory SAR

2 referrals

were combined into one review SAR

2 referrals

were taken forward as joint SARs - DHRs.

Single Agency

Two of the referrals were agreed to be undertaken as single-agency reviews

1 SAR Case

remains open from 2021 - 2022, having been delayed due to issues beyond ESAB's control

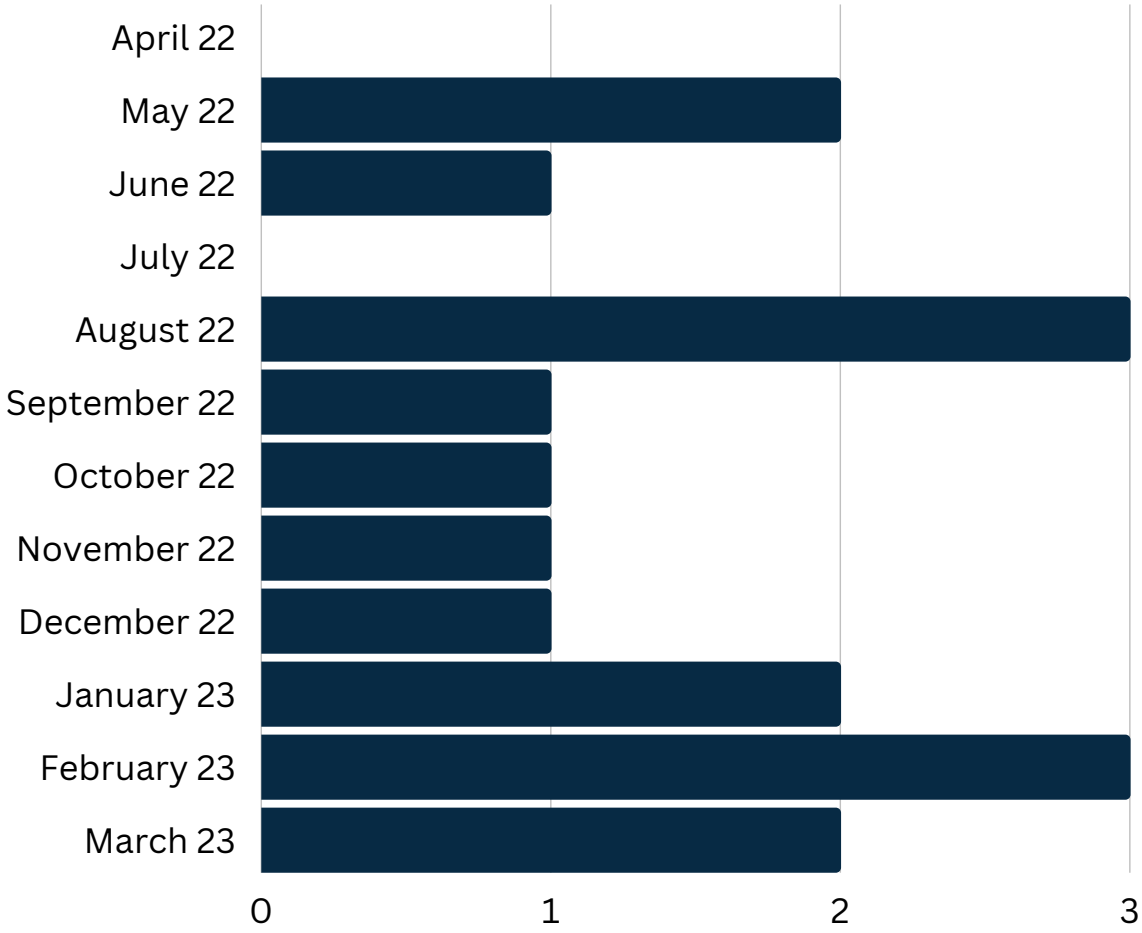
5 referrals

did not meet SAR criteria

6 referrals

were received late in the 2022 - 2023 financial year, with decisions about escalation to be made early in the 2023/24 reporting year.

11.2.6 Safeguarding Adults Reviews: Referrals Received By Month



11.3 Quality Sub Committee

11.3.1 This Sub-Committee has met three times during 2022 - 2023 to review and analyse safeguarding adult data from Adult Social Care (ASC) (data is accurate to 5 days prior to being reviewed). The group also reviews data linked to CQC reports from Mid & South Essex ICB and it is hoped this data can be replicated from Herts and West Essex ICB and Suffolk and North East Essex ICB during the 2023 – 2024 year. It is also expected that Essex Police data will be included in the dashboard early into the 2023-2024 year, to set out a holistic picture of safeguarding adults across Essex.

Healthwatch Essex became a member of this Sub-Committee in late 2022. Consideration will be given to analysis of information from Healthwatch about qualitative and quantitative data, to provide additional learning and insight for professionals and the general public across Essex.

The Sub-Committee, in conjunction with the SET (Southend, Essex and Thurrock) Safeguarding Adults Sub-Committee, developed and analysed the partnership audit and staff safeguarding adults awareness survey – both of which were undertaken at the same time. Both the audit and the survey had questions based on the application in practice of the six safeguarding principles in the Care Act. This was to enable parallel feedback information to be analysed, however a poor response rate prevented this.

11.3.2 **The actions below were developed as part of the audit report with partners requested to review and implement directly:**

ACTION: All to review external websites re accessibility and ensure it is clear what format information is available in, or there is a statement to say that it is available on request.

ACTION: All organisations to add a link to external facing websites to the relevant Safeguarding Board websites.

ACTION: Review information available in public facing areas and consider displaying up to date SET Safeguarding adult posters.

ACTION: Organisations to raise awareness of Making Safeguarding Personal.

ACTION: Consider how this information on how many adults attend safeguarding meetings could be collected e.g. can a tick box be added to electronic records to capture this.

ACTION: Organisations to encourage all staff to attend MCA training.

11.3.3 Similarly, a range of recommendations were developed following the staff survey findings:

Recommendation: Safeguarding leads to assure the Boards that the in-house intranet sites link to the Board website.

Recommendation: For the SET Safeguarding Adult Board to collate lists of training available to be shared across the partnership.

Recommendation: Safeguarding leads to promote SAB newsletters within the organisation.

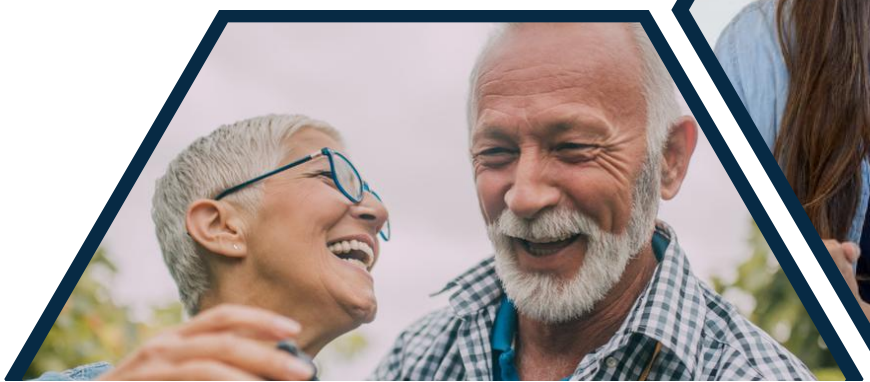
Recommendation: SABs to consider how to share the learning from reviews more widely.

Recommendation: Board partners to feed back to Boards on what they have done to share the learning and what impact this has had.

Recommendation: To develop an MCA basic awareness e-learning course across SET including what the MCA is, the key principles and examples of how this could be used in practice

Work on the next reiteration of the Audit will begin during the summer of 2023 alongside colleagues in the Southend and Thurrock Adult Safeguarding Boards, where the future of the survey will be considered.

This Sub-Committee works to ensure that ESAB are achieving strategic priority 3 via quarterly review of its workplan via its quarterly meetings.

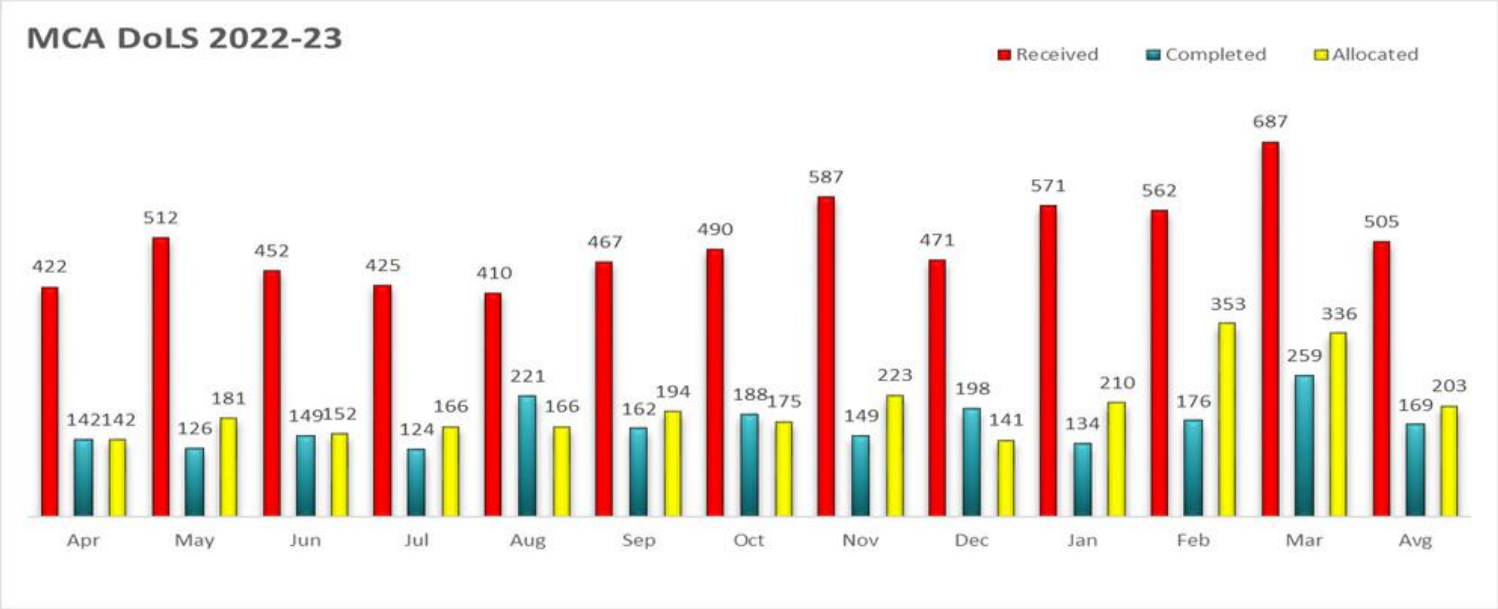


11.4 Deprivation of Liberty Safeguards (DoLS)

Although DoLS is currently a local authority role, the Sub-Committee receives oversight of the current figures in relation to this area within its dashboard report; below is data regarding DoLS collected by Essex County Council.

The backlog of adults waiting for an MCA DoLS to be started has remained around 3,200 throughout the past 3 years. The number of DoLS requests received each month in 2022-23 averaged over 500 per month, with a peak in March 2023 of 687 requests.

The number that have been allocated to workers in that same period averaged just over 200, with increases in February and March 2023 due to additional funding for a new agency secured. March 2023 saw the number of completed DoLS increase from around 160-170 to 259.



11.5 Prevention and Awareness Sub-Committee

Following a successful introduction during 2021 – 2022 leading to the much-improved communications and presence on social media, this Sub-Committee is currently on a hiatus to review its purpose, aims and objectives. That being said, previous members of the Sub-Committee have been engaged through the year to work on the development of a new ESAB website and logo both of which are expected to be delivered in mid-2023.

It is expected that the Sub-Committee will be reintroduced during 2023-2024 and include a training element as part of the scope of the meeting. When meeting, this group links to ESAB Priority 1.

11.6 Health Executive Forum (HEF)

11.6.1 HEF is primarily an information sharing forum for all health organisations across the Southend, Essex and Thurrock (SET) footprint. This Sub-Committee also covers children's and adults issues, with the update below linking to all areas.

Organisations who attend this meeting are able to bring details of current projects being undertaken or to discuss any issues within the system, whereby a solution is jointly agreed with actions to be addressed by individual organisations or as a Sub-Committee. HEF has a TOR and a delivery plan constructed of the priorities from ESAB and the Essex Safeguarding Children's Board, alongside national NHS directives and Essex initiated health projects, local to Essex.

11.6.2 During 2022-2023, HEF members have agreed and undertaken actions for the following:

- Implementing the A&E Notification and Assessment process across the Essex Acute Trusts
- Taking forward the Serious Violence Duties for ICBs
- Developing a SET Health escalation pathway for placement breakdowns or at risk of breakdown
- Implementing outcomes from the Essex Care Home Covid-19 Review
- Developing SET Female Genital Mutilation (FGM) pathway/service
- Preparation for the implementation of Liberty Protection Safeguards (LPS)

This groups works to ESAB priorities 1, 2 & 3.

11.7 SET Policy and Procedures Sub-Committee

11.7.1 This Sub-Committee covers Southend, Essex and Thurrock under the banner of SET, reporting to ESAB via the SET Policy & Procedures Sub-Committee (see organisational chart for reference) which devolved its duties to the SET Policy and Procedure Sub-Committee. This is an action that is replicated by the Safeguarding Adults Boards in Southend and Thurrock.

11.7.2 The SET Sub-Committee met four times in the reporting year; working across the multi-agency partnership and three Local Authorities, to provide a shared approach to adult safeguarding across Greater Essex.

11.7.3 During 2022 - 2023 the Sub-Committee reviewed and updated:

- Minor updates to the current version of the SET Safeguarding Adults Guidelines
- SET Guide to developing a safeguarding policy
- SET Staff Handbook
- SET 1 Minute Guide (Hoarding & Modern Slavery)
- SET Missing Protocol
- SET Managing and responding to Organisational Safeguarding Abuse Guidance
- SET Mental Capacity Action (MCA) and Deprivation of Liberty Safeguards (DoLS) Guidance

The documents above can be found via the ESAB website.

11.7.4 The Sub-Committee will continue to monitor policy and procedural updates, when required, in line with national legislation and local agreements, to include Liberty Protection Safeguards, pending the government release date.

This Sub-Committee works to ensure that ESAB are achieving strategic priorities 1, 2 & 3. via its workplan and policy schedule at its quarterly meetings.

11.8 SET Adult and Children's/SETDAB Learning & Development Group

This Group includes the Southend Essex & Thurrock Adult and Children's Board/partnerships and the Southend Essex & Thurrock Domestic Abuse Board and looks to identify joint learning between the seven boards/partnerships.

Until 2022/23 the SET element of this group was not a formal arrangement, however following agreement with Southend and Thurrock Children and Adult Safeguarding Boards, governance has now been put into to place and updated terms of reference agreed.

The Sub-Committee met four times throughout the year with a number of Task and Finish groups being set up to look at specific pieces of work; including development of joint guidance for professionals meetings (what they are and when they should be requested) and learning from Child Safeguarding Practice Reviews (CSPR), Safeguarding Adults Review (SAR) and Domestic Homicide Reviews (DHR). Both pieces of work will continue into 2023/24 with Joint learning sessions for partners being considered in relation to findings from all reviews.

This group works toward ESAB priorities 1,2 & 3 alongside the priorities of the other 6 boards/partnership highlighted in this section

12. ESAB Learning and Development Programme

ESAB continued to host its training programme on a virtual basis for 2022-2023 enabling continued cost reductions. A review was undertaken in September 2022 to look at the current programme and future target areas. ESAB Partners agreed that the Practice and Development Officer Post at ESAB (not fully covered for two years) should be filled, and a new Officer is expected to join us in May 2023.

Training Figures for 2022-2023 are listed below.

1,257 completions

Introduction to Safeguarding Adults e-Learning

314 completions

Safeguarding Adults Reviews e-Learning

429 completions

Adult Exploitation e-learning*

E-Learning training continues to be a popular method of training for a lot of delegates, with the figures for 2022-2023 reflecting this,

***Adult and Child Exploitation Awareness: 487 completed whole course with 429 completions for the adult module.**

Training Figures for 2022/23 (cont.)

166 delegates	attended the Designated Safeguarding Adult Leads (DSAL) training over 9 courses, with an increase of 24 delegates from last year, aided by additional DSAL courses put on to meet demand.
57 delegates	attended the Safeguarding Adults Basic Awareness (SGBA) training over 4 courses. An increase of 26 delegates from last year.
33 delegates	attended the Risk Taking, Unwise Decisions and Safeguarding (UD&S) training over 3 courses. An increase of 8 delegates from last year, aided by an additional courses commissioned

There were no course cancellations in 2022.

13. Think Family

During 2022 - 2023 ESAB, Essex Safeguarding Children Board and the Southend, Essex & Thurrock (SET) Domestic Abuse Board have continued to promote the Think Family podcast/video that was launched in December 2021; over the 2022/2023 period steady viewership has been maintained.

Both can be viewed via:

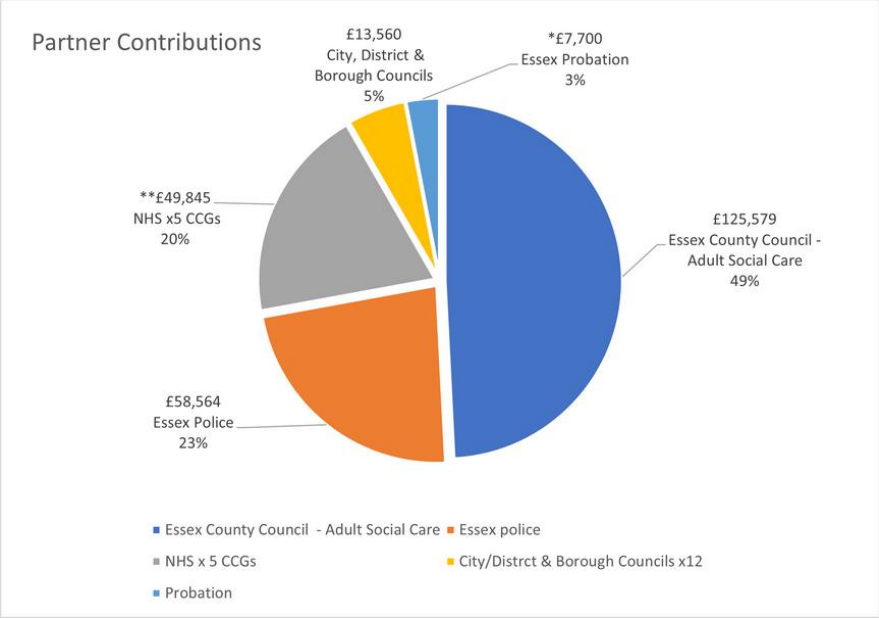
- Podcast
- Video
- Podcast transcript

Think Family means securing better outcomes for adults, children and families by coordinating the support and delivery of services from all organisations. When an individual first has contact with any service they should receive a welcome into a system of joined-up support and safeguarding together with coordination between adult and children's services. In order to achieve this, services must think about:

- The family network - learning who is involved in an individual's everyday life; working out links between people; maybe the use of genograms and people who are influential in the family circle who don't visit regularly.
- Cross-generational issues - where family relationships and dynamics have been affected, for example where dementia may have changed family dynamics or when aging parents are unable to continue caring for adult children, who have care and support needs.
- Best practice – such as ensuring there is an identified lead professional who co-ordinates agencies involved, especially where there are complex needs, supported by open and honest communication with the person you are working with, whilst listening to the family.

Appendix One: Income & Expenditure

Although ESAB finances are currently in a healthy position, it is known from financial planning that there is likely to be a request to the statutory partners to uplift funding over the next 2 years. This is to ensure that ESAB can continue to meet its lawful statutory obligations; meet the continuing increase in referrals for Safeguarding Adult Reviews; continue to provide help and advice for professionals/members of the public via its website and social media and continue to provide training for multi-agency partners members, all of which will has an impact on staffing for the ESAB Officer Team.



Partner Contributions

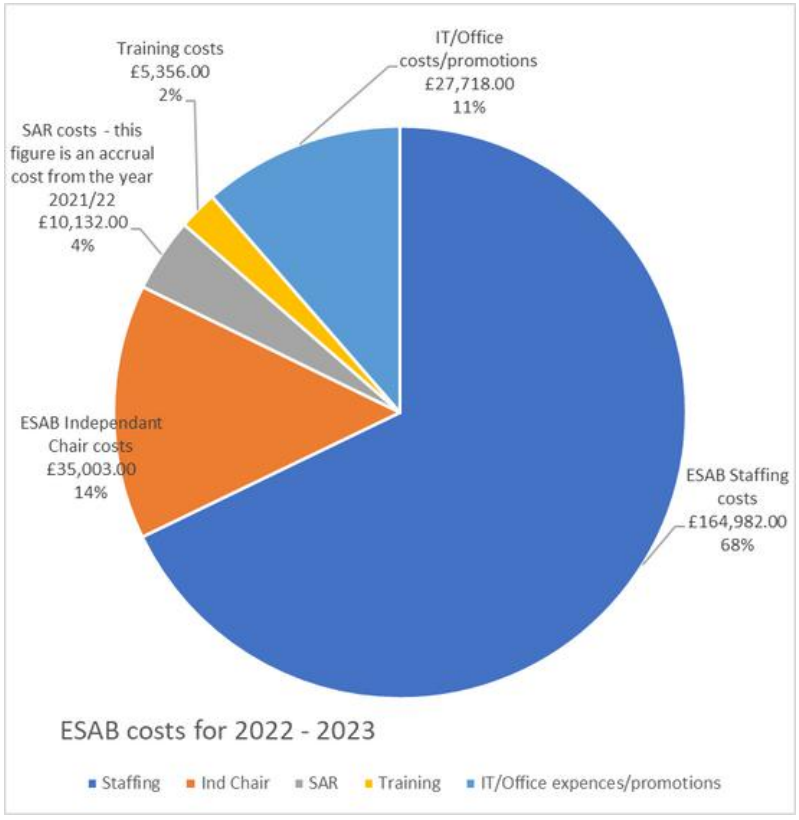
Partner contributions for 2022 – 2023 were: £255,248

*Essex Probation provided ESAB with a one-off funding for the 2022/23 financial year, this is not expected to continue into the 2023/24 year.

**The NHS figure above is based on the NHS CCG model that was in place until July 2022, as from April 2023, the NHS contribution will be based on the ICB areas model for Essex.

ESAB Board Costs

Training income for 2022/23 was £8,463



Appendix Two: Overviews of SARs Published

The SARs considered the deaths of six adults who were not known to each other and who died in different circumstances. The adults each had care and support needs meaning they were at risk, and it was deemed that agencies could have worked better together to protect those adults from harm, and or, abuse. A summary of each adult's circumstances is below.

SAR 1 - Learning Brief published under pseudonym

John was a 50-year-old male experiencing mental ill-health, alcohol misuse, poor physical health and mobility; he lived with his mother until his behaviours began to pose a risk to her. John was found deceased in his property having died from alcoholic liver disease.

Abuse type as identified by the Care Act 2014

Neglect and acts of omission

Self-neglect

SAR 2 – Full report published under pseudonym

Megan was a 28-year-old female with a history of emotional dysregulation leading to self-harm and substance misuse. Megan died while she was an inpatient in a mental health hospital.

Abuse type as identified by the Care Act 2014

Neglect and acts of omission

Sexual

Financial

The SAR reports including the recommendations, can be accessed via the ESAB website, where the themes can also be explored in more detail. Associated action plans will support the delivery of improvement for each agency concerned, where evidence-based outcomes will be monitored by ESAB.

Appendix Two: Overviews of SARs Published (cont.)

Abuse type as identified by the Care Act 2014

Neglect and acts of omission

Financial

SAR 3 – Full report published under pseudonym

Sonia was a 60-year-old female with mental ill-health and poor physical health and mobility, who lived with her brother who had care and support needs of his own. Sonia died from sepsis following poor mobility and leg ulcer management.

SAR 4 – Full report published under pseudonym

Lucy was an 87-year-old female with deterioration of physical health following a fall in her home which required a hip replacement surgery. Lucy died in hospital from aspiration pneumonia, with contributory factors of severe frailty, heart disease and hip fracture followed by surgery.

Abuse type as identified by the Care Act 2014

Neglect and acts of omission

Financial

Abuse type as identified by the Care Act 2014

Neglect and acts of omission

SAR 5 – Executive summary published under pseudonym

Miss J was a 20-year-old female with Emotionally Unstable Personality Disorder, who displayed self-harming behaviours; she was detained under the Mental Health Act and moved between various mental health inpatient settings. Miss J died.

Appendix Two: Overviews of SARs Published (cont.)

SAR 6 – Full report published under pseudonym

SAR themes identified

Neglect and acts of omission

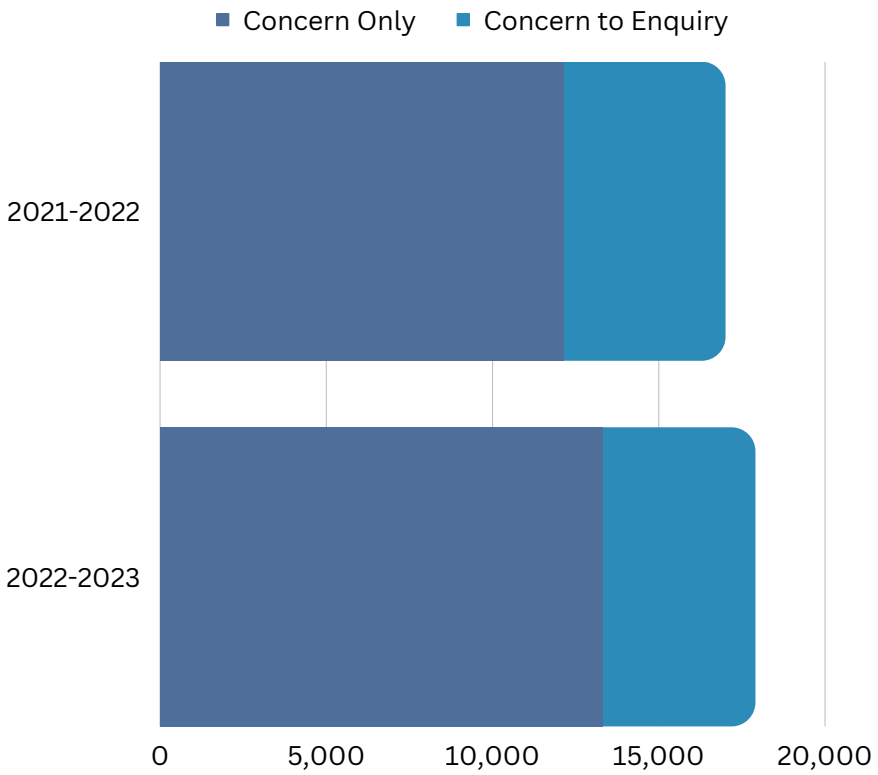
Self-neglect

Simon was a 55-year-old male with mobility issues, poor physical and mental health, experiencing alcohol use. Simon lived in a house provided by a housing association and after agencies lost contact with him, he was found deceased from natural causes related to his long-term medical history.

Appendix Three: Additional Data:

This data was produced and provided by Essex County Council - Adult Social Care.

How many safeguards are raised



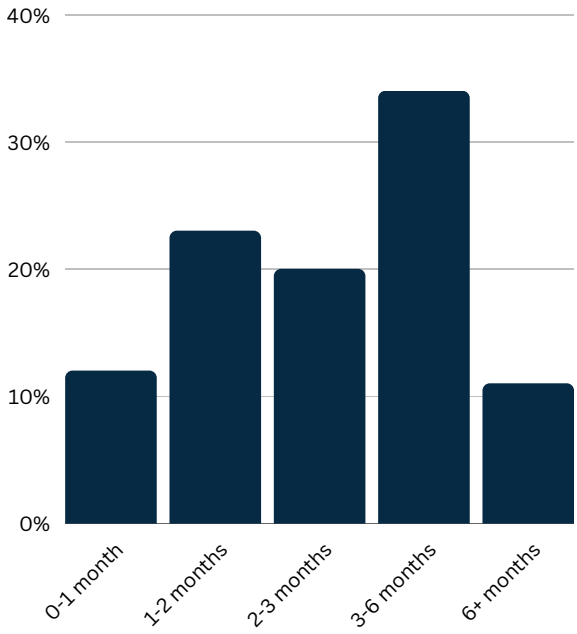
18,520 safeguarding referrals were raised in 2022-23, compared with 16,991 in 2021-22. This is a 9% increase on the previous year, but a 21% increase since 2020-21. To put this into perspective, this is an increase from 61 referrals received per working day in 2020-21 to 74 – with a peak of 132 received on 23 Jan 2023.

While the number of safeguarding referrals has increased, the proportion meeting the threshold has reduced. There are a number of factors that may impact:

- Volume of inappropriate safeguards has increased from 1,166 in 2021-22 to 1,871 (increase of 60%)
- Proportion of 'closed at concern' EPUT notifications (S42 enquiries undertaken by EPUT). ECC has a Section 75 agreement with EPUT for them to undertake their own enquiries.

A combination of these factors could increase the percentage that meet the threshold for S42 enquiry from 25% to between 28-36%. 'Concern only' relates to concerns that were raised but not acted upon, 'concern to enquiry' are concerns raised and progressed to enquiry stage.

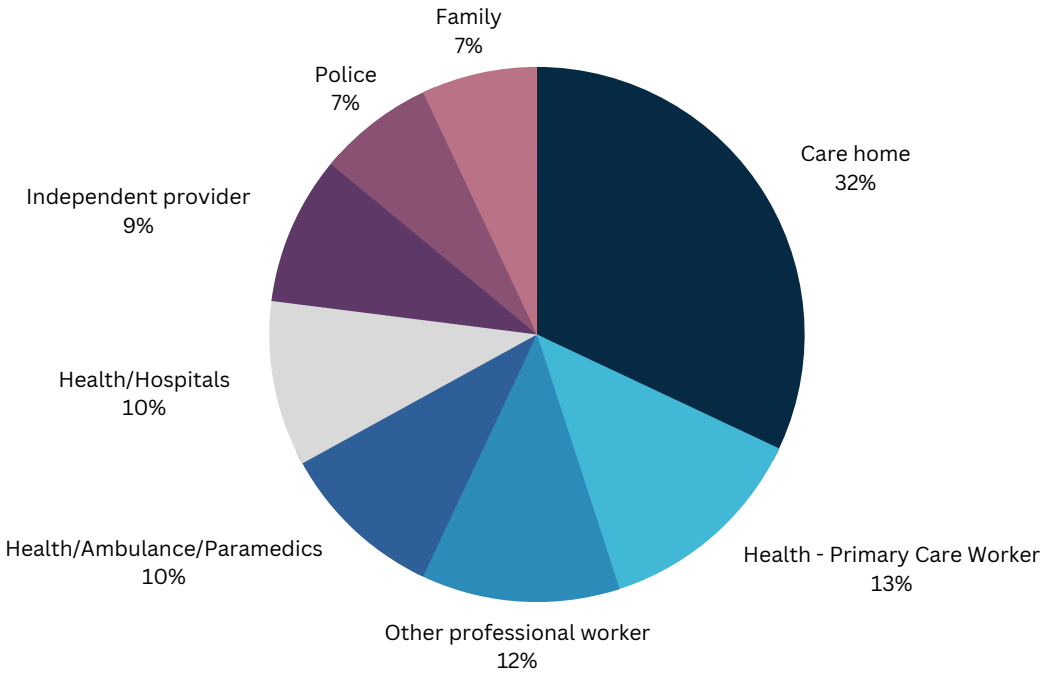
How long do Section 42 enquiries take to complete?



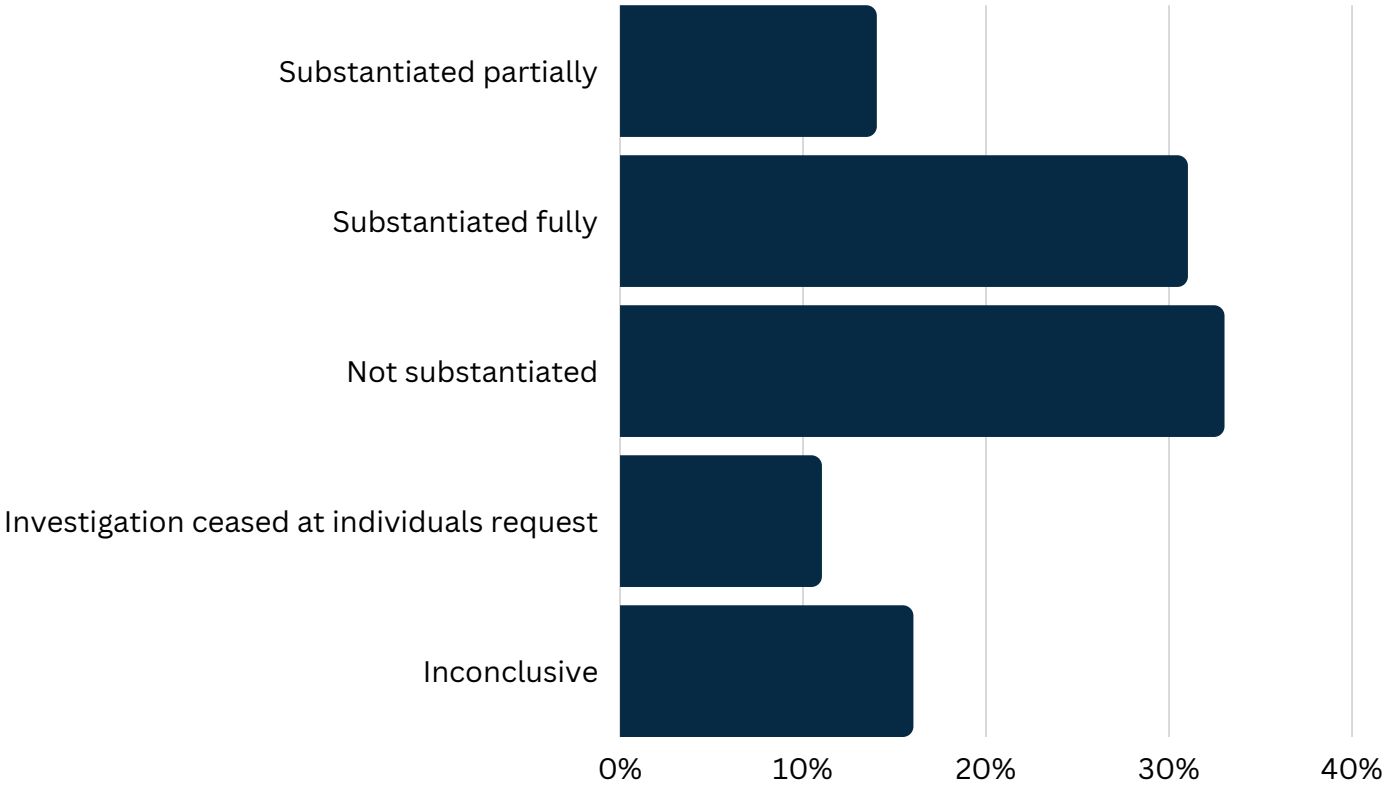
More than half of enquiries are completed and signed off within 90 days.

Who reports the safeguarding concerns?

32% of concerns are raised by care homes and 45% by health professionals.



What are the outcomes of enquiries?



45% of enquiries are substantiated in full or partially.

Appendix Four: MARAC Data

Taken from SET MARAC Performance – Quarters, 1, 2, 3 and 4 2022-23. This data is collected from Essex Police and should not be attributed to ESAB or Adult Social Care data.

8 **cases per day**

This year Essex MARAC has heard 1684 cases. This is a decrease from the previous year of 523 cases. When divided by the 52 weeks of the year MARAC is hearing on average 32 cases per week or 8 cases per day. This is however rarely the case because cases fluctuate over various times of the year.

1,373 police referrals

1,684 cases heard in total

311 partner referrals

The break-down of cases equates to 1373 Police referrals and 311 Partner referrals (figures relate to cases 'heard' and not for cases received and refused for a MARAC).

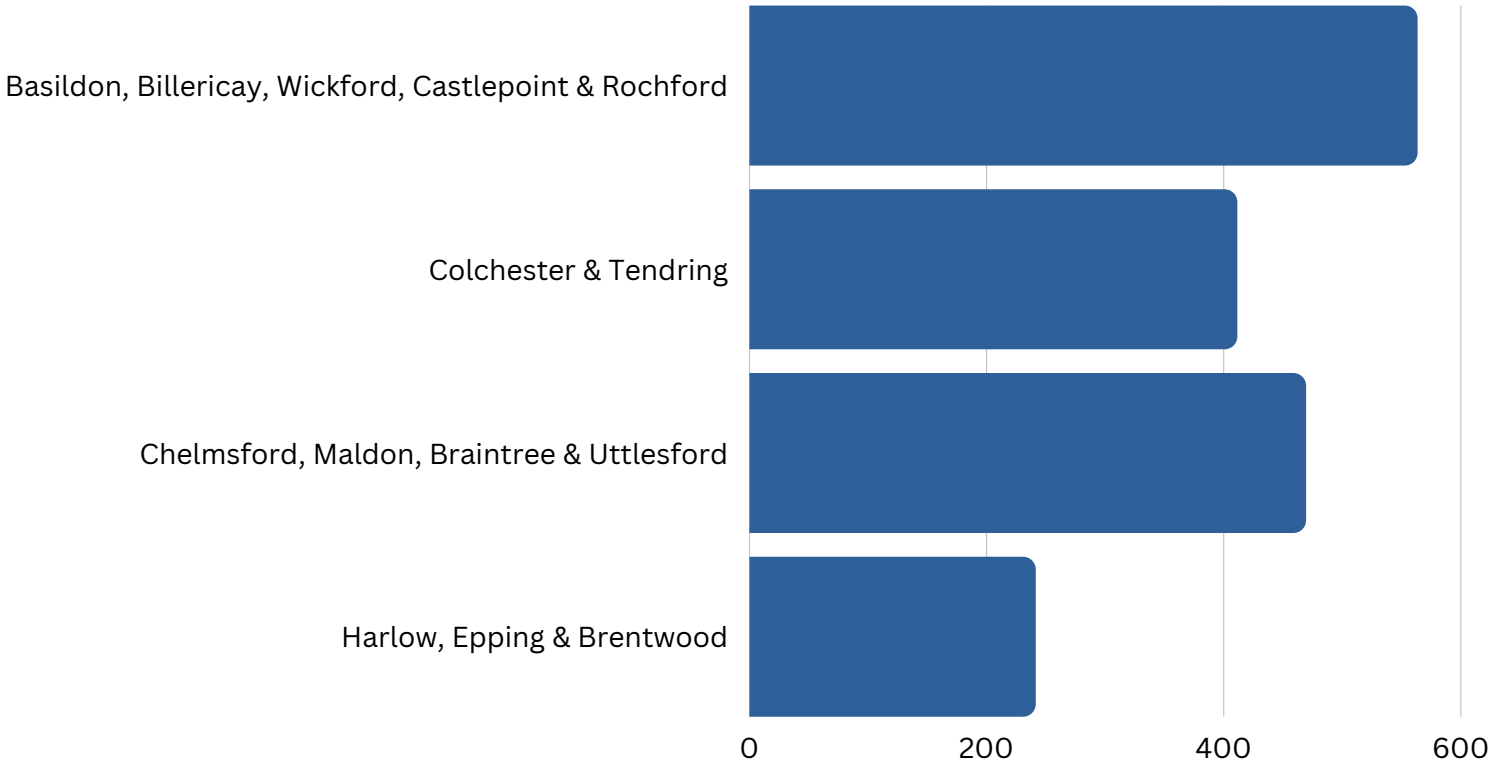
19% of referrals were from partner agencies - a drop of 13% compared to last year.

All cases heard over the last 12 months were heard within MARAC protocol timescales of 14 working days upon receipt.

Appendix Four: MARAC Data (cont)

Below is a graph detailing cases by area. Basildon remains the busier area followed by the North and Mid. The West (which covers Harlow, Epping and Brentwood) has always seen less cases presented to MARAC.

April 2022-March 2023 cases by area.



MARAC Data (cont.)

Cases recorded as having an element of stalking.

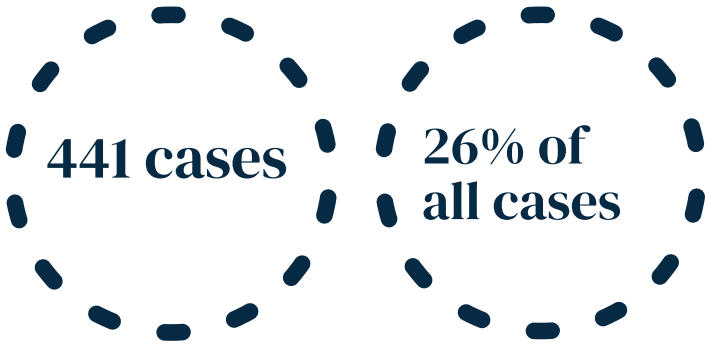
Essex MARAC collaborates with the Police on stalking and refers to a Panel called ESIP (Essex Stalking Intervention Panel), held every six weeks. Cases and investigations are scrutinised to ensure that everything possible is being done to try and gain a conviction and that victims are safeguarded. Cases heard at MARAC with a stalking element have increased from 24% last year, to 33% this year.

Honour Based Abuse Cases

Essex MARAC hear Honour Based Abuse cases on a separate day with a closed panel. The figure stands for 0.6% of cases heard at MARAC and this proportion has remained steady over the last 4 years

Cases recorded where Drugs and Alcohol are a factor for the victims

There has been an increase this year on the number of victims recorded as using drugs and alcohol from 17% to 26% and it is noted that cases are becoming more complex, many where there is joint dependency, contributing to abuse incidents.



MARAC Data (cont.)

Cases recorded as LGBTQ+

A further drop has occurred, over the last 12 months of cases being heard from the LGBTQ+ community which is disappointing. Further work needs to encourage reporting, as the numbers are exceptionally low.

5 cases

1% of all cases

Appendix Five: Essex Domestic Abuse Board Data

The Domestic Abuse data was provided by Essex Domestic Abuse Board covering the 2022 – 2023 year and should not be attributed to ESAB data.

The data portrays:

Gender

- 94.6% female
- 5% male
- 0.1% non-binary
- 0.3% not stated

Ethnicity

- 79% white
- 9% black, Asian and dual heritage
- 2% other ethnicity
- 10% not stated

Sexual orientation

- 83% heterosexual
- 1% gay/lesbian
- 2% bisexual
- 1% other
- 13% not stated

Appendix Six: Extended Partner Feedback

This section includes overviews of the work that has taken place across the ESAB extended partners throughout 2022 - 2023 and should not be attributed to ESAB data, information or feedback.

1. EPUT

Essex Partnership Trust is committed in supporting employees who are experiencing domestic abuse (DA), around their health, safety and wellbeing; supporting them to remain productive and efficient at work. In realising this commitment the organisation's Employee Experience Team and Safeguarding Team have developed a staff support pathway, to enable employees to access support both internally and externally via a number of specialist organisations.

The staff support pathway is informed by the Domestic Abuse Toolkit which has been developed in partnership with Alpha Vesta, a specialist domestic abuse consultancy. This toolkit aims to create awareness about domestic abuse and demonstrates the support any employee can access if they are experiencing it. This toolkit provides guidance and support for all employees including line managers, HR colleagues and the Safeguarding Team.

The launch of the toolkit was supported by a programme of training events delivered by Alpha Vesta commencing in June, for line managers, to raise awareness and to provide advice and guidance on their role and responsibilities in supporting an employee experiencing domestic abuse and on undertaking a workplace risk and needs assessment and action plan. As this initiative progresses forward, this training will also be delivered as part of the EPUT Management Development Programme.

1. EPUT (cont.)

Domestic abuse awareness raising across the organisation has also been achieved through webinars delivered by a variety of organisations such as, ManKind (specialising in men escaping abuse), Galop (the LGBT+ anti abuse charity) and Karma Nirvana (working to end honour-based abuse in UK) and national and regional awareness raising weeks.

The organisation has also developed an identified page for Domestic Abuse on its website with access to the pathway and toolkit but also additional resources for support and information such as podcasts, webinars, safety information and sources of specialist organisations that can be accessed for support. A fast action button for rapid exit from the site has been built into the function of the page.

At EPUT we want learning to be an 'Always Event' where we all have a responsibility to seek improvement, learn from mistakes or good practice and adopt positive changes to provide safe and excellent care. The EPUT Culture of Learning (ECOL) represents our commitment to excellence and our willingness to learn from the experience of others. The concept allows us to identify and share learning through safe, effective and constructive pathways, ensuring this learning is embedded and sustained at all levels within the organisation.

The framework will enable us to achieve the Safety First, Safety Always Strategy outcomes. In July 2022, the Lessons Team was formed, which consists of a Head of Shared Learning, Learning Lessons Analyst, Lessons Facilitator and Database Manager. The Lessons Team work with all teams across the organisation and Subject Matter Experts to innovatively consider how learning can be shared and embedded within practice. Some key highlights of successes over the last year are as follows:

- A desktop icon has been launched on all computers across the Trust. The Culture of Learning desktop icon will automatically take colleagues to the Culture of Learning intranet page, to ensure this is visible, easily accessible and user-friendly. This has received very positive feedback.
- The Lessons Team have developed a process entitled Safety and Learning Command (SALC) Call whereby when new and significant learning events are discussed with senior managers across the organisation to ensure the knowledge is widely known and aware. An agreement will be made in this meeting as to what actions can be taken to ensure the learning is cascaded, and also where the information needs to be shared.
- Culture of Learning folders have been delivered and socialised to all inpatient units for them to store 5 Key Messages, Lessons Identified Newsletter and other key sources of learning information in.
- The Learning Collaborative Partnership Group (LCP) has been introduced and has been running since July 2022. This enables Subject Matter Experts to consider learning themes, good practice and significant events within their areas of work and share this across the organisation.
- The Lessons Team have successfully held Learning Matters: Your Monthly Insight sessions since January 2023. In April 2023, the Lessons Team and Safeguarding Team provided a live session around Safeguarding and Professional Curiosity. The sessions are recorded and promoted pre and post event to encourage engagement.

2. Essex Chief Executive Officers Forum

Essex Chief Executives each lead their own individual organisations and come together as a wider forum to build strong working partnerships across the whole county which ensures collaboration and dissemination of best practice. Their collective support of the Essex Safeguarding Adults Board means that all upper and lower tier authorities are engaged in its work and their interest isn't limited by geography.

3. Essex Care Association

Essex Care Association (ECA) represents around 300 independent social care providers across Southend, Essex and Thurrock. In the past year we invited our members to an online session to share any issues they had about safeguarding. We collated this and followed it up with a meeting between the ECA Committee and the Director of ASC Safeguarding and Quality Assurance, ECC, to discuss issues raised and how we can jointly improve practice. We will follow this up with further meetings and look for opportunities to include a similar discussion in the ECC Locality Forums which we co-chair.

We have also worked with Essex Police and the Gangmasters and Labour Abuse Authority to obtain and disseminate information about Modern Slavery, which has risen up the agenda due to increased International Recruitment in Social Care. We did this to ensure that ECA members are aware of the pitfalls around IR and can ensure they have followed guidance on what can be a very complex issue.

4. Essex Fire and Rescue Service

ESAB partners were kept abreast of the National Fire Chiefs Council (NFCC) work in regard to the business case requesting amendment to the Rehabilitation of Offenders Act 1974 (exceptions) to incorporate fire & rescue authority employees throughout 2022 - 2023.

Following debate in June within both House of Commons and House of Lords, legislative change was achieved and the statutory instrument is due to come into force as of 6th July 2023. All fire and rescue authority employees/volunteers are now eligible for a minimum of Standard Disclosure and Barring Service (DBS) checks. This new eligibility augments existing access to Enhanced DBS checks with a check of the relevant adults' or children's barred list for those employees who undertake regulated activity.

Appropriate criminal records checks are crucial to allow our fire and rescue services to understand and mitigate risk, to protect colleagues and the public, and to support high standards of integrity.

The National Fire Chiefs Council (NFCC) have produced a variety of guidance to support the sector with an efficient and effective response to the legislative change. The guidance, provides information regarding:

- DBS Eligibility. Supported by DBS this guidance assists in determining the level of DBS check that may be appropriate to conduct on individuals undertaking various roles;
- Guidance and framework for conducting risk assessment of an individual with information found on their DBS certificate; and
- Managing allegations guidance in relation to concerns of harm relating to fire and rescue authority employees.

The DBS Eligibility guidance recommends, for all roles, that a minimum of a Standard DBS Check is undertaken. From this guidance, and other key documents such as the Safeguarding Fire Standard, NFCC Safeguarding Guidance and Self-Assessment and the National Framework, the expectation on fire and rescue services is clear. All fire and rescue services must have appropriate arrangements in place to comply with these expectations. Further additional implementation support is being provided by NFCC and DBS via a series of workshops throughout the next few months.

5. Safer Essex

Over 2022/23, Safer Essex have discussed a number of issues impacting on Community Safety in Greater Essex. These include: Project Minerva (VAWG), 2022/23 Violence & Vulnerability Plan, ECFRS Safe & Well visits, Domestic Homicide Reviews, Rural Crime Strategy, Review of Community Safety Partnerships, Support for Vulnerable Victims, Water Safety, Suicide Prevention Strategy, Serious Violence Strategic Needs Assessment and Community Safety Hubs. Safer Essex also agrees an annual Community Safety Plan that outlines its priorities for the year.

6. HMP Chelmsford

Over the 2022 – 2023 year, the following initiatives have been put in place to support the prisoners in our care, with very positive feedback:

Unlock my life-mental health ambassadors.

The aim of trained mental health ambassadors is to engage men via peer groups/ one on one meeting to achieve reduction in violence and self-harm. The mental health ambassadors work with prisoners identified by the mental health team, safer custody team and relevant staff that require positive intervention where no intervention was possible before. The targeted group are those who require and request help who do not fall under mental health services within HMP Chelmsford i.e. who are not diagnosed with any disorder or who do not take anti-psychotic medications. This intervention fills a "void" that prisoners within our establishment have stated there is i.e.- "if you're not on an ACCT or CSIP you don't get any help" as our safety survey suggested.

Mental health ambassadors encourage their peers to engage in purposeful activity, find coping strategies and act as a buddy to them to support and guide them through their custodial time at Chelmsford. Their peer groups will be held in the coffee shop to provide a relaxed safe environment, which provides a sense of privilege to partake in activity there. MHA will assist landing Officers to provide support to prisoners with complex needs and will be an option for wings to manage poor copers.

The MHA have all been provided with T-shirts, so they are clearly visible on the wings, they are currently working on redesigning a leaflet to advertise what they do, have asked if updates on their use/progress be added to the daily briefings, are looking at creating a basic paper slip that can be filled in by prisoners who require support and can then be dropped into an MHA box on the wing. The MHAs can then check the box daily and will know who to talk to. This will assist with reducing stigma and discrimination, by keeping the request as private as possible.

Chess Wingman: 5 Aside CHESS Mentors in Prisons

The Wing MAN programme is inspired by the real-life story of John Healy as told in his award-winning autobiography, Penguin Classic 'The Grass Arena' (also a film of the same name). Born in 1942 John was a violent alcoholic by the time he was 15. Homeless, he spent the next 15 years in and out of prison. His story is one of millions failed by society; a society that picked up the cost of his imprisonment and treatment. Treatment and support that never reached him because he simply didn't know how to trust. John was a hard-core addict who went through programme after programme. On his last trip into Pentonville a fellow prisoner, 'Harry the Fox', patiently taught John how to play the game, chess. John became a chess addict and champion, and to do this, he gave up drink. The point is that it took a trusted insider to get through to John before he could start his journey to unlocking his genius. Arguably John is one of the greatest graduates of the prison system and we believe his story can show the way for others. A 5asideCHESS Wingman will provide genuine peer support and mentoring to fellow prisoners using 5asideCHESS as a tool to play, teach, chat and signpost. A wingman is one of your own – someone you can trust and who, like 'Harry the Fox' for John, can potentially get through when others can't.

7. Essex Housing

The most significant developments in Social Housing over the 2022 - 2023 year which link to safeguarding:

- Damp and Mould: Following the coroner's November 2022 report into the death of Awaab Ishak in Rochdale, the Regulator of Social Housing (RSH) asked all larger registered providers of social housing to submit evidence about the extent of damp and mould in tenants' homes and their approach to tackling it. This covered local authorities and private providers such as housing associations who together own and manage over four million homes in England.

RSH next steps:

- We will expect all registered providers to make improvements to how they protect tenants from the potential harm that damp and mould can cause.
- We will continue to carry out for conduct further analysis of submissions and we will engage directly with individual providers who have given us poor quality information or reported high prevalence of damp and mould, to establish whether they are tackling the issue effectively.
- We will take appropriate regulatory action against providers if we find they are not compliant with our standards, in line with our usual practice.
- We will introduce more active consumer regulation of social housing from April 2024, including inspections of providers. The quality of homes – including damp and mould – and repairs services will be a key focus and the evidence we have received will help inform our work.
- We will take the necessary action where we find poor performance to make sure tenants receive the services they deserve. Reshaping consumer regulation: our implementation plan sets out more information about our work to deliver proactive consumer regulation.

- Qualifications required for Social Housing Mangers: Social housing managers must gain professional qualifications under new rules to protect residents and raise standards in the sector, Housing Secretary Michael Gove announced today (26 February 2023). The changes will be made through amendments to the Social Housing (Regulation) Bill which will drive up standards in the sector and hold landlords to account over the service they provide to their tenants. The Bill will also give the Regulator tough new powers – allowing them to enter properties with only 48 hours' notice and make emergency repairs with landlords footing the bill. It follows Awaab's Law, introduced earlier this year in the wake of the tragic death of two-year-old Awaab Ishak, which will force social landlords to fix damp and mould within strict time limits.

- Domestic Abuse: Local Authorities and social landlords continue to strengthen their approach to supporting survivors of Domestic Abuse following the introduction of the Domestic Abuse Act 2021. The act states a person has a priority need for assistance if they are homeless as a result of being a victim of domestic abuse.

Thank you.