Adult B Safeguarding Adults Review Action Plan for Overview Report

Recommendation and scope	Action(s)	Target Date	Lead	Progress/ next steps	Status (RAG) Rating
Recommendation 1: All agencies to reassure the SAB that their practice, when working directly with service users, enables their practitioners the opportunity for direct personal contact, separate from family members, regardless of where they are providing the service.	Safeguarding leads to report on internal policy, procedures and training in place that detail personal contact and give assurance to the SAB that staff are competent and confident in this area of practice. Ensure the importance of seeing service users is contained within safeguarding training including resolution / escalation processes if the opportunity to do this is being prevented	January 2020	OP Subgroup / TWD Subgroup		G
	To update and refresh the SAB MSP leaflet to ensure that clear information is provided regarding the expectation for staff to have direct personal contact with adults they are working with. For all SAB partners to ensure this documentation is distributed widely within their agencies.	September 2020	SCN Subgroup / OP Subgroup	Published on SAB website on 23/11/2020.	G
	A multi-agency task and finish group to develop MSP guidance, with positive case studies. This will include information on comprehensive risk assessments and appropriate resolution mechanisms to respond to situations in which an individual cannot be seen alone and there is a concern or suspicion that a third party is preventing	September 2020	OP Subgroup	Guidance published on SAB website 08/10/2020.	G

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	this or the adult is experiencing undue influence / coercion.				
	A multi-agency learning briefing to be produced for staff in all SAB agencies covering the key findings and learning from this SAR with particular reference to: • Professional curiosity. • MSP including the importance of direct personal contact. • Effective information sharing and partnership working. To share the learning briefing with neighbouring SABs by way of the South East Regional SAB network.	February 2020	PQA Subgroup SAB Development Manager	Action completed - Learning briefing has shared with all SAB members and neighbouring SABs.	G
	All agencies to complete a feedback template to evidence how the learning has been applied and shared within their organisations.	April 2020	All SAB agencies		G
Recommendation 2: The SAB to undertake a sample audit of general agency involvement in the safeguarding process including invitation and attendance at safeguarding meetings and receipt of minutes of such meetings.	All agencies to be reminded of good practice in relation to partnership working and effective communication via the learning briefing.	February 2020	PQA Subgroup		G

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This is to inform the development of robust mechanisms that ensure appropriate representation at safeguarding meetings, information sharing if attendance is not confirmed, and secure electronic communication.	Refresh and update the SAB Information Sharing Guide and Protocol to include direct reference to these good practice principles.	April 2020	PQA Subgroup / SAB Development Manager	East Sussex Information Sharing Guide and Protocol published on 24/03/2020. Pan-Sussex Information Sharing Guide and Protocol published on 24/08/2020.	G
	Conduct a sample audit of cases in relation to multi-agency involvement in the safeguarding process.	August 2020	PQA Subgroup	Joint multi-agency audit meeting between East Sussex and Brighton & Hove SABs held on 07/02/2020. Report agreed by PQA subgroup on 18/08/2020. Action plan in place.	G
	Review and strengthen multi-agency mechanisms that ensure appropriate invitation and representation at safeguarding meetings, including information sharing where attendance at meetings is not confirmed.	September 2020	OP Subgroup	ASCH have updated safeguarding meeting templates and developed chairing protocol to support the effective coordination and ensure full representation from partner agencies at safeguarding meetings / discussions.	G

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	Follow up audit of cases to be completed in 12 months' time to analyse progress and improvements in relation to the multi-agency mechanisms outlined above.	June 2021	SDT reporting to PQA Subgroup	Audit completed and presented to PQA in August. SDT will be taking forward recommendations from this audit for ASCH.	G
Recommendation 3: The SAB to develop multi-agency workforce development opportunities for practitioners working with complex cases, for example where there is coercion and control, to enable improved confidence in engaging directly with service users and developing greater professional curiosity and more effective safeguarding of vulnerable adults.	Continue to promote the 2-day Domestic Abuse training programme delivered on behalf of the SAB, ESSCP and Safer Communities Partnership. Deliver multi-agency coercion and control training, which SAB partner agencies will be encouraged to attend.	October 2019	TWD Subgroup	Three dates for coercion and control training were delivered in 2019 and were fully subscribed. Current training programme is being delivered virtually.	G
	The learning from this review, along with parallel learning from other reviews and multi-agency audits, will feed into a SAB Learning Event to be convened a year from the publication of the action plan. This will support a review of progress made and how learning in this area has been embedded into practice.	May 2021	SAB	Joint virtual conference with Brighton & Hove SAB took place on 26/05/2021 with a focus on multi-agency learning from recent SARs including Adult B.	G
	The content of the Sussex Safeguarding Adults Policy and Procedures to be reviewed to ensure there is sufficient guidance relating to issues of consent where there are concerns about the influence of	March 2021	Pan-Sussex Policy and Procedures Review Group	Updates to domestic abuse chapter added to online procedures on 28/05/2021.	G

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	coercion and control on decision making.				
Recommendation 4: The SAB should consider developing alternative arrangements for investigating unexpected adult deaths where abuse is suspected or known to be a factor in the death. These arrangements should be based on existing adult legal mandates and established agency roles, drawing on the learning in Children's Services about the strengths and weaknesses of the current Child Death Review processes.	A multi-agency working group to be convened to review current arrangements for investigating unexpected adult deaths, where abuse or neglect is known or suspected. This will involve consideration of relevant national and local learning / existing processes.	November 2020	OP Subgroup	Published 09/11/2020.	G

Updated 16.08.2021

Key to RAG ratings:		**Key to acronyms/abbreviations used:**	
Green:	Objective completed	**ASCH:**	Adult Social Care and Health
Amber:	Work in progress / further actions planned or required	**ESSCP:**	East Sussex Safeguarding Children Partnership
Red:	Objective not completed or action not meeting target	**MSP:**	Making Safeguarding Personal
		OP:	Operational Practice
		PQA:	Performance and Quality Assurance
		SAB:	Safeguarding Adults Board
		SAR:	Safeguarding Adults Review
		SCN:	Safeguarding Community Network
		SDT:	Safeguarding Development Team
		TWD:	Training and Workforce Development Subgroup