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**National Network of Safeguarding Adults Board Chairs: Annual Report on 2019 to 2020**

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**How the report is set out**

This report has four sections:

**Section 1: The National Network of Safeguarding Adults Board Chairs**

**Section 2: A model of self-led peer support and the implications for our annual activity**

**Section 3: Our priorities for 2019 to 2020**

**Section 4: Looking to 2020 and 2021 – Covid and Safeguarding; next steps with our priorities**

## **Section 1: The National Network of Safeguarding Adults Board Chairs**

### **1.1 The Care Act (2014)**

This established Safeguarding Adults Boards (SAB) in law. The Care and Support Statutory Guidance that accompanied the Act, set out expectations of those who chair Safeguarding Adults Boards. Where possible the chair should be independent, but this is not a requirement, and the network opened up membership to all SAB chairs in 2016, having been set up as a peer support group for independent chairs in 2009. The network model is not one of subscription or affiliation that brings in money from members or SABs. The funding section sets out the headlines about our finances.

### **1.2 What the Care and Support Statutory Guidance (2020)<sup>1</sup> says**

Chapter 14, section 150 states: 'Although it is not a requirement, the local authority should consider appointing an independent chair to the SAB who is not an employee or a member of an agency that is a member of the SAB. The chair has a critical role to lead collaboratively, give advice, support and encouragement but also to offer constructive challenge and hold main partner agencies to account and ensure that interfaces with other strategic functions are effective whilst also acting as a spokesperson for the SAB. An independent chair can provide additional reassurance that the Board has some independence from the local authority and other partners. The chair will be accountable to the chief executive of the local authority as the lead body responsible for establishing the SAB but should be appointed by the local authority in the name of the SAB having consulted all its statutory partners. There is a clear expectation that chairs will keep up to date with, and promote, good practice, developments in case law and research and any other relevant material.'

### **1.3 Why Safeguarding Adults' Boards are important, and why supporting chairs is crucial**

The year began with a Panorama programme exposing abuse at Whorlton Hall assessment and treatment centre for adults with learning disabilities and very complex issues. This was almost 10 years after a previous Panorama had exposed equally shocking abuse at Winterbourne View, and a national programme of change and 'never again' commitments from national government and relevant local organisations. The year ended with adult safeguarding at the forefront of the national consciousness as England and Wales went into lockdown in the final week of March, due to the spread of the new coronavirus. Care homes and adults with care and support needs who were not visible, or unable to receive their usual support, were of huge concern as the year ended. 2019 to

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<sup>1</sup> See <https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance>

2020 underlined just how important adult safeguarding is, more than any year since the Care Act came into force.

#### **1.4 The Network's Terms of Reference**

The Network's terms of reference mirror the Care and Support Statutory Guidance (2020). Our remit is to:

- Share best practice and good examples with regards to the implementation of the Care Act 2014;
- Support the implementation of SABs becoming statutory bodies under the Care Act 2014 in a coherent and consistent way;
- Share and disseminate knowledge and learning between Boards;
- To work with partners in respect of information sharing agreements, budgets and performance;
- Improve consistency of approaches to safeguarding and contribute to the raising of overall standards of adult safeguarding;
- Continue to develop a national voice and resource for consultations and advice on safeguarding matters; and
- Provide peer support and networking opportunities.

#### **1.5 Geographical reach and numbers in our network**

The network covers England and Wales, Northern Ireland, the Channel Islands and the Isle of Man. The year has seen the evolution of chairing arrangements with some combined arrangements for areas that span more than one local authority area – for example Merseyside, which has one independent chair. Some places have mirrored changes to their children's arrangements with a Statutory Partner chairing, the SAB, for example Manchester. Others have a scrutineer or adviser in addition to the Statutory Partners – again they are welcomed into and contribute to our network. Bath & North East Somerset local authority area, the City of Bristol and Shropshire local authority area moved during the year to combined arrangements for one independent person to chair the former three statutory partnerships – childrens' safeguarding, adult safeguarding and community safety. Existing network members were appointed to both roles. In Milton Keynes a wide strategic partnership has since 2018 included the health and wellbeing statutory functions, Childrens' Services Partnership statutory functions and the Community Safety Partnership statutory functions, and a network member is employed as scrutineer in this instance. The vast majority of local authority footprints have one SAB and one chair but the level of steady change during 2019 to 2020 suggests

this may alter. A number of network colleagues chair children's safeguarding partnerships but this has slightly diminished, due to a required alteration to children's safeguarding partnership boards in updated statutory guidance Working Together to Safeguard Children 2018.

### **1.6 Levels of involvement – individuals and regions**

In March 2020 there were 132 safeguarding adults partnerships, including the variations outlined above. Some chairs work across areas as part of their contract, others choose to work in more than one area. Not all chairs respond to communications from the network but continue to be sent them in the hope they are useful. On average one chair per month has joined or left the network.

The network met four times in the year. Our self-organising unfunded arrangement means we need free meeting space. I secured a consistent venue in central London thanks to Social Care Institute for Excellence and used the opportunity of their remote meeting capability to encourage and build up virtual attendance. This has left us well placed to continue meeting as a virtual network as necessitated by the coronavirus pandemic. Average attendance was 25 people in person and five joining online.

### **1.7 Regional Activity**

The regions for our network are

North West England and Greater Manchester

North East England

South East England

London

South West England

Eastern England

Yorkshire and the Humber

East Midlands

West Midlands

London is unique in having a Safeguarding Adults Board with an established chairs' network that existed for some years before the London SAB. London chairs benefit from a venue to meet in at London Councils, plus some dedicated administrative support. Some other regions have a history of meeting and organising, but others do not – all of this activity relies on volunteering and goodwill.

## **Section 2: A model of self-led peer support and the implications for our annual activity**

### **2.1 Self-help and our links to the Care and Health Improvement Programme**

The network relies on the willingness of SAB chairs to contribute to it and to support each other.

There is a wide range of skills, experience, interests and contacts in the group. As a group we explicitly set out to address what the Care and Support Statutory Guidance (2020) states – *‘There is a clear expectation that chairs will keep up to date with, and promote, good practice, developments in case law and research and any other relevant material’ (para 14.150).*

One vital source of support that the network draws upon is the Safeguarding Adviser in the Care and Health Improvement Programme at the Local Government Association. Jane Lawson carried out this role for three years and was a regular contributor to the network, leaving her role at the end of this year. Whilst in role, Jane achieved many things and will be missed. These included leading a substantial piece of work based on regional workshops and consultations, begun in 2018 to 2019, which resulted in publication in the first half of the year of framework documents on undertaking safeguarding enquiries. SAB Chairs contributed to the development of work on prevention and the Merseyside SAB chair was due to support this by running a workshop funded using the model set out earlier in the report. This was paused due to Covid but remains an ambition. The next section picks up on another major strand of work by the Safeguarding Adviser.

### **2.2 Service users, carers, community engagement and Making Safeguarding Personal:**

The network draws on examples from different boards in order to drive up safeguarding practice and collaboration / co-production with adults who have care and support needs. It recognises the role of their families, and others who are important to them. The range of work is broad, spanning community engagement to Care Act (2014) requirements about capturing, reporting on, and responding to individual experiences of safeguarding processes (Making Safeguarding Personal). From its start the network has consistently come back to this work and constantly share local examples and crucially, seeking assurance at our boards. The Making Safeguarding Personal Programme began in 2010, initiated by the Local Government Association and it went on to become an integral and required part of adult safeguarding practice. In February 2020 we were invited to contribute to the Local Government Associations update during this year of its nationally used and recognised Making Safeguarding Personal Outcomes Framework. The original set of documents were short guides and checklists not just for SABs but for commissioners and providers of services with a role in adult safeguarding.

### **2.3 Funding**

The coordinator's role was funded through the Care and Health Improvement programme of the Local Government Association for up to ten days of coordinator time per year. The only other funding – from the same source – paid for a SAB chair to run and write up a workshop (which developed into 'The Rough Guide for SAB Chairs'), and this year there was potential to pay for three of these. The network bid at the end of 2018/2019 for funding from the NHS Safeguarding Adults National Network with a proposal to draw on the best emerging models of safeguarding across health and social care, and we were awarded £5000 to run and write up workshops, in line with our developed model. Unfortunately, due to Covid 19, this work did not take place but there is the opportunity to bid for further monies in the 2020/2021.

### **2.4 The Coordinator – Fran Pearson**

One of the few paid roles in the network is that of national coordinator. This combines administration with networking and influencing as well as being a conduit to all members. The coordinator has always been a SAB chair. In the section on our response to Covid 19, I set out the additional work that I have done during the pandemic. The coordinator's role is advertised every two years and a recruitment process takes place. I would like to thank Robert Templeton who was my predecessor and laid strong groundwork that I have benefitted from. Robert was greatly valued by the network and we wish him well in a new role. I started on 1<sup>st</sup> April 2019 so this report covers my first year. During the year I was SAB independent chair for Luton (Eastern Region), Newham (London) and was appointed to Leicester City and Leicestershire and Rutland (East Midlands) part way through the year. This meant I was fortunate to know a proportion of colleagues in the network through those regions and they actively welcomed me to communicate with them and gave me valuable feedback.

### **2.5 The Executive Group and their role**

The Executive group of SAB independent chairs who have volunteered their help, has been a huge support to me as coordinator of the Network. I would like to thank them all. Some represent regions, others bring particular expertise or connections to relevant national groupings (for example the Directors of Adult Social Services or the National College of Policing), or work streams (for example prison safeguarding). For 2019 to 2020, colleagues who gave their time and advice were:

Fiona Bateman

Tim Bishop

Adi Cooper

Mark Godfrey

Paul Kingston	Ged McManus
Ivan Powell	Michael Preston-Shoot
Deborah Stuart-Angus	Simon Turpitt
Sian Walker	Shirley Williams

The group has advised me as coordinator, liaised with regions, volunteered to work on our 'Rough Guide' and numerous other drafting and commenting tasks, and acted as a contact with relevant bodies and workstreams. Their range of professional and SAB chairing experience is extensive, and what they bring collectively is a broad spread of knowledge and approaches. This in turn means we can contribute to national debates, scrutinise and provide constructive challenge, and credibly call out shortcomings which leave adults with care and support needs at risk. This breadth and credibility is replicated throughout our network.

### **Section 3: Our priorities for 2019 to 2020**

#### **3.1 How priorities were agreed**

Two successive meetings of the network, at the end of last year and the beginning of this year, sought views and confirmed four priorities. All members had the opportunity to be involved via email conversations seeking views.

#### **3.2 An influential, outward-facing network**

The network wants to be outward facing; influence national legislative change, strategy and policy development; and establish or build on national alliances. The experience and expertise within our network enables us to do this but needs to be kept up to date in line with the Care and Support Statutory Guidance. Our priorities for the year reflect these intentions.

#### **3.3 Our priorities**

##### Priority 1

**Prevention** - sharing and promoting the most impactful local initiatives with the aim of innovating, improving wellbeing; and reducing the need for safeguarding 'further upstream'. Includes service user/community engagement.

##### Priority 2

**To contribute and add value to strategic legislative and policy development** by working with government and other relevant national bodies

Priority 3

**Explore the opportunities to improve outcomes** for adults at risk arising from new arrangements for children's safeguarding – particularly around transitions and Liberty Protection Safeguards

Priority 4

**To lead and influence the development of accountability and assurance frameworks** that all SABs can draw upon, informed by the most current work on

quality standards

governance

risk

Safeguarding Adults Reviews and their impact on safeguarding systems

## **Progress on Priorities**

### **Prevention**

3.4 At our September 2019 network meeting, using a proposal by the Safeguarding Adviser from the Local Government Association's Care and Health Improvement Programme, chairs honed down what the purpose of two workshops led and run by our own membership would look like. The independent chair of the SABs that cover Merseyside offered to host one of these. It has been delayed due to the Covid 19 pandemic, but we now have a framework to help us define, name and share good practice for the whole network. This also contributes to our fourth priority around assurance and fits with our peer support model for improvement.

### **To contribute and add value to strategic legislative and policy development**

This priority was taken forward during the year in a number of ways they are described below.

**3.5 An increasing contribution** During the year nationally and regionally, chairs on behalf of the network, increased our contribution to these developments. Through the network coordinator we are represented at the Association of Directors of Adult Social Services (ADASS) Safeguarding Policy Network – this year saw further work to align our priorities so we were using common language and collaborating on common goals. The NHS Safeguarding Adults National Network (SANN) is another hugely important partner group, again the network is represented by the coordinator. Further,



during this year, a SAB independent chair, Paul Kingston, also was employed to chair the SANN. Working with the NHS network leaders on our bid for funding to develop a best practice guide to integrated safeguarding models created an opportunity that can hopefully be picked up later in the 2020/2021 year. The next annual report will cover our influence and involvement during the Covid 19 pandemic at more length, but these relationships meant that as soon as national forums were set up, we were invited to join them.

**3.6 The Department for Health and Social Care (DHSC)** The DHSC Safeguarding and Deprivation of Liberty Safeguards Team had colleagues leave and start during the year, and the General Election also limited their ability to talk about policy in November and December 2019. However, all three members of the team attended our December network meeting, and this formed the basis for us and them being able to rapidly get together at the start of the Covid-19 pandemic, which was essential due to the centrality of adult safeguarding to so much that unfolded. They facilitated our representation at a number of Covid-19 and safeguarding national forums as a result.

**3.7 Connecting with the regulator** Another relationship that developed over the year, and again was crucial when the pandemic created huge issues in care homes and the home care sector, was that with the Care Quality Commission. The support and availability of their relevant inspector and safeguarding lead has benefited the network in a number of ways.

**3.8 Policing and the prosecution of crimes** Nationally, representatives of the network supported policing initiatives and developments. Most notably we followed up on a significant publication in July 2019 called 'The Poor Relation: **The police and Crown Prosecution Service's response to crimes against older people**<sup>2</sup>, where regulators were critical of police forces and the Crown Prosecution Service for the way they handled and brought prosecutions for crimes against older people. We continue to be linked to this work and next year's report will set out how we have sought assurance on the substantial issues it raised. In March 2020 the network via the coordinator was invited to contribute to a working group developing a 'Missing Adults' protocol. This resulted from the 2019 All Party Parliamentary Group that focused on adults with mental health issues who go missing. Paused due to the Covid-19 pandemic, the work restarted in June 2020 and our role and influence will be covered in next year's annual report. This links strongly back to policing relationships nationally.

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<sup>2</sup> <https://www.justiceinspectorates.gov.uk/hmicfrs/publications/crimes-against-older-people/>

**3.9 Other significant partnerships that we have worked on** The Office of the Public Guardian and the Department of Work and Pensions are other significant partners. Work with them has been led by individual chairs on behalf of the network and the outputs and outcomes are now more apparent so will be included in the 2020/2021 annual report.

**Explore the opportunities to improve outcomes** for adults at risk arising from new arrangements for children's safeguarding

3.10 As section 1.5 sets out, this is an area that individual chairs have locally been influential in developing. In turn colleagues have brought their experience back to the network. Evaluation by the Department for Education of the changes to children's safeguarding is only now under way at time of writing so this priority is one that can be progressed during 2020/2021 and hopefully we can secure further funding to work with the Safeguarding Adults National Network of the NHS on our proposal to identify and share best practice. Deprivation of Liberty Safeguards were due to be revised, a large programme of work that SABs were central to has as a result been put back to 2022. However, an area of joint work regionally and locally has been on Deprivation of Liberty for 16 and 17 year olds, and this provides an opportunity for collaboration across children's and adults partnerships. The same is true of work on transition from children's to adults services and in the area of exploitation. Work at board level has been a consistent priority to which SAB chairs are committed, and maybe because of local focus, has been less of a topic for the network.

**To lead and influence the development of accountability and assurance frameworks**

**3.11 The Rough Guide for SAB Chairs** - A workshop developed and led by independent chair Sian Walker responded to the need expressed by members to *support each other in responding to a range of issues and capture learning since the implementation of the Care Act 2014* (wording from LGA website on the publication of The Rough Guide). The focus that network members wanted at the workshop was on Safeguarding Adults Reviews and how we work with families, innovate, and respond to the requirements of the Care Act (2014). Sessions were led by a local authority lawyer and a systems learning / review programme manager from Social Care Institute for Excellence. Demand for places exceeded capacity at the venue and the drawing together of what became known as The Rough Guide, responded to what network members needed. Other network members contributed substantial time and effort to compile, edit and critique various drafts of the Guide.

3.12 The Rough Guide was published in June 2019 after further rounds of comment and contribution from the network. As the introduction on the webpage says: It is not formal advice or guidance and should be used to have local conversations about the issues so that local solutions can be found. It is also suggested that The Rough Guide could be useful for new SAB Chairs as part of their induction materials. It includes: status of SABs; accountabilities and responsibilities for responding to complaints and disputes; access for SABs to appropriate legal support; support and resources for community engagement, including press communication; commissioning work and decision making; involvement of interested parties in Safeguarding Adults Reviews (SARs); instructing independent authors/reviewers; embedding learning following a SAR; and holding and processing data. The National SAB Chairs Network intend to keep this under review as there is ongoing learning in these areas of practice.

Access 'The Rough Guide' on the Local Government Association website:

<https://www.local.gov.uk/rough-guide-safeguarding-adult-board-chairs>

3.13 Because of the expertise in our network, our assurance processes have benefited from national projects and publications led by our members. One such example was the developmental work and final report on Adult Safeguarding and Multi Exclusion Homelessness by Michael Preston-Shoot published in January 2020., following workshops organised through the Care and Health Improvement Programme, safeguarding work stream. SAB chairs connected their local experts with the workshops and the final report references many examples of good practice from boards and adult safeguarding partners. Most importantly for this priority it lists assurance areas that SABs can use for local scrutiny.

<http://londonadass.org.uk/wp-content/uploads/2020/02/01.-Adult-Safeguarding-and-Multiple-Exclusion-Homelessness.pdf>

**3.14 Transforming Care** In regions, we shared assurance methods that we had developed around those most vulnerable adults with complex combinations of mental health diagnoses, learning disabilities and behaviours that can challenge, represented by those in Whorlton Hall. Nationally, we debated the recommendations of the Safeguarding Adults Review into Atlas Homes<sup>3</sup>. The year saw a range of parliamentary reports published work by the Care Quality Commission on the challenges of secure settings where patterns of abuse seem to reoccur despite the undoubted commitment of adult safeguarding partnerships and many others. The focus of this work has been in our regional

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<sup>3</sup> <https://www.devonsafeguardingadultspartnership.org.uk/about/safeguarding-adult-reviews/>

groups, but it is a priority for 2021 to work with all relevant bodies on being more nationally influential.

**3.15 Analysis of Safeguarding Adults Reviews, a national first** - In February 2020, the Care and Health Improvement Programme (CHIP) funded by the Department of Health and Social Care, commissioned the first national analysis of Safeguarding Adults Reviews completed in 2017/18 and 2018/19. The analysis is being carried out by Suzy Braye and Michael Preston-Shoot (who is a network member). Chairs have helped assemble the substantial volume of material – 230+ reviews - for the analysis. A report will be published in autumn 2020 and next year's network report will comment on the implications for SABs.

#### **Section 4: Looking to 2020 and 2021**

##### **Influencing and assurance**

#### **4.1 Safeguarding Adults Reviews – limits to learning resulting from the lack of equivalent resources to children's safeguarding reviews**

All board chairs spend a large proportion of their time on different aspects of Safeguarding Adults Reviews as set out in s44 of the Care Act (2014), and also in scrutinising and implementing the findings of a much broader set of learning activity. The lack of support with our statutory duties under the Care Act (2014) that has caused some frustration this year. In 2018 to 2019, the Department for Health and Social Care funded developmental work on Quality Markers for Safeguarding Adults Reviews and the establishment of a national library where completed and published Safeguarding Adults Reviews can be accessed and searched for particular data. The funding ended and the work has largely ceased except for, typically of our network and partners, voluntary peer support which continues through a network of Safeguarding Adults Review 'Champions'. In the year ahead, we are keen to see resourcing and recognition of our repeatedly stated desire to commission the highest quality reports and subsequent improvements for adults with care and support needs and their families. We welcomed the commissioning of the national analysis of Safeguarding Adults Reviews. We hope that the analysis when published is a vehicle for next steps.

#### **4.2 Supporting improvement and championing service users and families in relation to secluded and secure settings**

The focus of this work has been in our regions, but it is a priority for 2021 to work with all relevant bodies on being more nationally influential. Published reports and ongoing work by the Care Quality Commission are a useful basis for discussion because of their reflective nature. We will be constructive but not hesitate to challenge why the Transforming Care Programme has not delivered the improvements that government promised when abuse was uncovered at Winterbourne View almost a decade ago.

#### **4.3 Learning from best practice in local and regional engagement work in a way that enables all SABs to respond to BlackLivesMatter.**

BlackLivesMatter was founded in 2013 in response to the acquittal of Trayvon Martin's murderer and has developed into a global movement with a mission to eradicate white supremacy and build local power to intervene in violence inflicted on Black communities by the state and vigilantes. The growth, pace, and urgency of the movement has coincided with the Covid pandemic and forms another relevant context for SABs to work within – building on engagement work that is already established.

#### **4.4 Integrated Care Networks and adult and childrens safeguarding**

Children's Safeguarding partnerships had to implement far reaching changes beginning in 2018. After a pause due to Covid-19, the Department for Education is at time of writing, about to resume evaluation of these changes – which will be of interest to our network and help us achieve our third priority. We will also try and pick up our work with the NHS Safeguarding Adults National Network on the bid we did have funding for and which we are hopeful of securing new funding for. The title of proposed work was "Making the best outcomes-based model the consistent model" for integrated safeguarding footprints.

#### **Covid-19 and Safeguarding adults; next steps with our priorities**

**4.5 Influence\_** The rapid response to the adult safeguarding aspects of the Covid pandemic – care of adults at risk, concerns about the motivation of a tiny fraction of the huge numbers of volunteers at the outset, the implications for hidden adults arising from shielding, the response to homeless adults and rough sleepers with care and support needs, and trying to establish the risks and lived experience of those adults with care and support needs at increased risk of exploitation and domestic abused, reached national consciousness. The network had a place at many of the national strategic safeguarding forums and we can evaluate and reflect on this next year.

#### **4.6 Strengthening regional networks to a consistent level / new ways of assurance**

Boards adapted and focused the way they did assurance and the network immediately developed principles to support this, mindful that Local Resilience Forums were coordinating and driving pandemic responses. Additionally, regional networks in some parts of the country that had not previously existed, came together – all as usual led by the initiative of network members. Ann Baxter began to represent the North East of England on our executive, strengthening communications with that region, and Deborah Stuart Angus set up virtual meetings for East of England. As coordinator, advised by the executive, I sent out regular targeted and relevant information to the network. We can reflect on the impact of this work for our next report, and as a network we tried to intervene constructively but to name shortcomings as well. However, I would like to end this one by offering our condolences to all those who lost loved ones in social care settings, secure institutions, hospitals, or in their own homes during the pandemic. I would also like to acknowledge the role of all professionals who delivered services to adults with care and support needs, often at considerable personal cost, a proportion of which was overlooked or rarely referenced in the media.