County Buildings, Stafford
DDI (01785) 276147
Please ask for Jonathan Lindop
Email: jonathan.lindop@staffordshire.gov.uk

**Safe and Strong Communities Select Committee**

Wednesday 6 January 2021
**14:00**
Meeting to be conducted using Microsoft Teams - Microsoft Teams

**NB**. Attendance by the public and press is via webcast only which can be viewed here - https://staffordshire.public-i.tv/core/portal/home

Members are requested to join the Teams meeting through the Outlook calendar booking (click "Join Microsoft Teams Meeting").

Also, please ensure your Laptops/Tablets are fully charged prior to the commencement of the meeting.

John Tradewell
Director of Corporate Services
24 December 2020

---

**A G E N D A**

**PART ONE**

1. **Apologies**

2. **Declarations of Interest**

3. **Minutes of meeting held on 5 November 2020** (Pages 1 - 8)

4. **Customer Feedback and Complaints Service** (Pages 9 - 46)

   (a) Children's Social Services Annual Report 2019-20

   Report of Cabinet Member for Children and Young People

   (b) Learning from Complaints

   Report of Cabinet Member for Children and Young People

5. **Elective Home Education** (Pages 47 - 52)

   Report of Cabinet Member for Education (and SEND)

6. **Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board Annual Report 2019/20** (Pages 53 - 100)

   Report of Cabinet Member for Health, Care and Wellbeing

7. **Work Programme** (Pages 101 - 108)

   Report of Scrutiny and Support Manager

8. **Date of Next Meeting - Monday 1 March 2021 at 10.00 am, Virtual/On-line**

9. **Exclusion of the Public**

The Chairman to move:-

"That the public be excluded from the meeting for the following items of business which involve the likely disclosure of exempt information as defined in the paragraphs of Part 1 of Schedule 12A (as amended) of the Local Government Act 1972 indicated below".

---

**PART TWO**
(All reports in this section are exempt)

Nil

**Membership**

| | |
|---|---|
| Ann Beech | Bryan Jones |
| Ron Clarke (Shadow Vice-Chairman) | Jason Jones |
| Ann Edgeller | Paul Snape |
| John Francis (Chairman) | Bob Spencer (Vice-Chairman) |
| Trevor Johnson | Mike Worthington |

**Scrutiny and Support Manager:** Nick Pountney Tel: (01785) 276153

**Minutes of the Safe and Strong Communities Select Committee Meeting held on 5 November 2020**

Present: John Francis (Chairman)

| Attendance | |
|---|---|
| Ann Beech | Jason Jones |
| Ron Clarke | Paul Snape |
| Ann Edgeller | Bob Spencer (Vice-Chairman) |
| Bryan Jones | Mike Worthington |

**Apologies:** Trevor Johnson

**PART ONE**

## 45. Quorum

The Chairman confirmed that the meeting was quorate.

## 46. Declarations of Interest

There were no Declarations of Interest made.

## 47. Minutes of meeting held on 13 October 2020

**RESOLVED** – That the minutes of the meeting held on 13 October 2020 be confirmed and signed by the Chairman.

## 48. Customer Feedback and Complaints Service - Adults Social Services Annual Report 2019-20

The Committee considered a report of the Cabinet Member for Health Care and Wellbeing informing them of the Customer Feedback and Complaints Service – Adults Social Services Annual Report 2019/20 (schedule 1 to the signed minutes).

The Annual report had been prepared in order to comply with the Authority's statutory duty to publish details of complaints made under the NHS and Community Care Act 1990 and Local Authority Act 1970. Complaints against the County Council and Midlands Partnership NHS Foundation Trust (MPFT) (who, delivered Adult Social Care and Older People's front line services on behalf of the Authority) during 2019/20 required:- (i) 187 Stage 1 – Local Investigations and; (ii) 35 Stage 2 - Local Government and Social Care Ombudsman investigations. In addition, there had been a further 114 complaints which had been handled and resolved informally. However, there had been no complaints requiring independent investigation.

Members noted that there had been a steady increase in the number of complaints received over the previous two year from 2018/19. The majority of complaints during 2019/20 were in respect of “Poor Communication” and “Care Management” by staff (32%) and the service area to have received most complaints was the Fairer Charging Service (38%).

During the discussion which ensued Members gave careful scrutiny to the Annual report, asked questions and held the Cabinet Member to account. In response to a point by a Member regarding the use of ‘plain’ English, the Cabinet Member informed them of a Task and Finish Group which had been established by the Authority with a view to improving the clarity of communication with service users. However, he acknowledged the challenges associated with an increased use of on-line/digital technology and referred the measures they were implementing to provide greater assistance in this area.

The Chairman expressed concern that 50% of complaints received by the Care Commissioning Service were in respect of services provided by a Care Provider. In response, the Cabinet Member highlighted that only 28 complaints had been escalated to the County Council for investigation during the year which represented 15% of the total. However, the Authority were currently working with MPFT to understand more about the issues raised and context surrounding those which had been escalated.

In response to a request from a Member, the Cabinet Member undertook to supply them with details of the complaints received during 2019/20 from service users in Staffordshire Moorlands District.

In conclusion, Members said that they were satisfied the Authority had taken appropriate steps to resolve individual complaints and improve service delivery, where necessary since 2019/20. Also, they were encouraged that the total number of complaints had been relatively small having regard to the extent of Adult Social Services provision although they recognised the likely impact of the current Covid-19 pandemic on the statistics for 2020/21 when they became available.

The Chairman then thanked the Cabinet Member for his attendance and opportunity to give constructive scrutiny to the above-mentioned matters for the benefit of residents of the County.

**RESOLVED** – That the report be received and noted.

**49. Customer Feedback and Complaints Service - Children's Social Services Annual Report 2019-20**

The Committee gave preliminary consideration to a report of the Cabinet Member for Children and Young People informing them of the Customer Feedback and Complaints Service – Children’s Social Services Annual Report 2019/20 (schedule 2 to the signed minutes).

The Annual report had been prepared in order to comply with the Authority's statutory duty under the Children Act 1989 Representation Procedure (England) Regulations 2006 to publish details of (i) the number of complaints recorded regarding children's services; (ii) the outcome of each complaint made and; (iii) whether relevant statutory timescales had been adhered to.

Members noted that during 2019/20 there had been a total of 137 complaints investigated through the various statutory complaints' procedures comprising:- (i) 124 dealt with under Statutory Stage 1 (local resolution) procedures; (ii) 12 dealt with under Statutory Stage 2 (independent investigation) procedures and; (iii) 1 dealt with under Statutory Stage 3 (Complaint Review Panel) procedures. In addition, a further 187 complaints had been dealt with under the County Council's own Corporate Complaints Procedures and 47 investigated by the Local Government and Social Care Ombudsman. However, there had also been 225 complements received by the Authority relating to Children's services.

The Cabinet Member undertook to provide further details of the matters contained in the report including lessons learned to their next meeting for full and detailed scrutiny could be provided.

**RESOLVED** – (a) That the report be received and noted.

(b) That the Customer Feedback and Complaints Service – Children's Social Services Annual Report 2019/20 be brought to their next meeting for further consideration.

## 50. Court Backlog: Impact on Children's Social Care

The Committee considered a report of the Cabinet Member for Children and Young People regarding a backlog in the Court/judicial system which had been exacerbated by the 2020 Covid-19 pandemic and its impact on the delivery of children's social care services in Staffordshire (schedule 3 to the signed minutes).

The President of the Family Division issued instructions on 19 March 2020 that all family hearings should take place remotely until further notice, unless fairness and justice required that a court-based hearing should be conducted. This coincided with in the introduction of national social distancing measures in an attempt to stem the spread of the virus. Since that time, substantial delays in proceedings were being experienced owing to (i) the requirements of remote hearings; (ii) a shortage of judges and; (iii) Magistrates having stopped sitting causing an increase in cases referred to District and Circuit Judges.

During the early stages of lockdown, in order to manage their case lists, judges had been forced to reduce the time allocated for hearings, vacate scheduled hearings and list only urgent cases. Most contested fact findings or final welfare hearings had been adjourned and the inability of Local Authorities to conduct specialist assessments in a timely way was a further contributory factor to court proceedings being delayed.

In Staffordshire, whilst new and urgent care proceedings had continued to be issued to safeguard children requiring immediate protection, the overall impact of the above-mentioned delays remained significant. In particularly there had been:- (i) an increase in the numbers of looked after children (owing to planned discharges, SGO's and Adoption Orders not being made); (ii) an increase in social workers' workloads arising from (i) above; (iii) issues in respect of care assessments becoming outdated; (iv) an increased risk of birth parents challenging Adoption Orders on the basis of a change in circumstances; (v) disruption in the bonding process between adoptive parents and children; (vi) a decrease in opportunities for older 'hard to place' children to achieve permanency. However, the County Council were actively working with partners and the judiciary to identify opportunities to reduce pressures in the court system and associated financial consequences on the Authority.

During his presentation of the report, the Cabinet Member highlighted that there were currently 60 proceedings in motion together with various other Adoption Orders which could not be completed at present owing to the backlog. However, he referred to regional meetings which had been held with Judge HHJ Sonia Harris regarding implementation of a Court Recovery Plan and informed them that additional time had been identified during December 2020 for her to consider Adoption Orders relating to Staffordshire Children. In addition, a further such session was to be arranged in January 2021. The Cabinet Member went on to re-assure them that representations made by the County Council were helping to highlight the backlog and associated problems with the Ministry of Justice, Department of Education, and HM Court and Tribunal Service etc so that appropriate solutions could be found, as a matter of urgency. He also referred to the on-going financial implications for the County Council arising from the continued delays.

During the discussion which ensued Members expressed serious concern over the impact of the court backlog on the welfare of children in the County. They acknowledged the importance of the Authority's safeguarding role and hoped that progress could be made in reducing the volume of outstanding cases, as soon as possible. However, they acknowledged that the County Council had worked in partnership with other agencies in an attempt to mitigate the effects of the current situation and recognised that efforts were being made by Government and judiciary to address the problem.

The Chairman then thanked the Cabinet Member for his attendance and opportunity to give constructive scrutiny to the above-mentioned matters for the benefit of residents of the County.

**RESOLVED** – (a) That the report be received and noted.

(b) That the Committee be kept informed of any further developments relating to Court Backlog: Impact on Children's Social Care so that further scrutiny could be given, as appropriate.

## 51. Impact of Covid-19 on Children appearing in Criminal Courts

The Committee considered a report of the Cabinet Member for Children and Young People regarding the impact of the 2020 Covid-19 pandemic on children appearing in Criminal Courts (schedule 4 to the signed minutes).

The Legal Aid, Sentencing and Punishment of Offenders (LASPO) Act 2012 introduced a new remand framework for 10 to 17-year olds and provided that every child or young person remanded to Youth Detention Accommodation (including either a Young Offender institute, Secure Training Centre (STC) or Local Authority Secure Children's Home (LASCH)) automatically had 'Child in Care' status. A new funding formula for children on remand accompanied the Act which removed the previous 75% subsidy received by Children's Directorates for those remanded to local authority secure accommodation.

Children aged 15 years and under were more likely to be remanded to LASCH or STCs (the most expensive types of remand establishments) owing to their vulnerability. Generally, children on remand to Crown Court were accused of very serious offences and/or had an adult co-accused. In these circumstances sentencing of offenders took place together and resulted in extended remand periods placing additional pressures on budgets.

The 2020 Covid-19 had significantly impacted on the ability of Courts to operate within their usual time limits. This particularly affected Crown Courts and children awaiting trials alongside adults. Whilst the maximum recommended time a child should spend on remand was six months, courts were applying discretion to custody time limits owing to the significant backlog caused by the pandemic. This meant that currently there were more children on remand for longer periods and therefore 'looked after' for longer than usual.

In Staffordshire, of the three children currently on remand two had reached their six-month custody time limit. Whilst they were found guilty at the beginning of September, sentencing (which would normally take place within three weeks of the verdict) had been delayed until mid-November 2020 placing an additional cost of approximately £19,000 on the remand budget.

Whilst the 2020/21 projected overspend in the remand budget (based on analysis of the first four months of the year) was £192,000 the Staffordshire YOS Management Board had identified underspends in other pooled budgets which would cover the costs of remands during the year. However, in the event the current situation continued beyond April 2021, the partnership had no identified funding available.

Concerns regarding the impact of the pandemic on the YOS both in terms of the effect on children's health and welfare and budgets had been raised with relevant stakeholders including:- (i) the Youth Justice Board; (ii) Youth Custody Service; (iii) House of Commons Justice Select Committee; (iv) Her Majesty's Courts and Tribunal Service; (v) Staffordshire Police and; (vii) Stoke-on-Trent and Staffordshire Safeguarding Board.

During his presentation of the report, the Cabinet Member highlighted that 132 children were currently awaiting sentencing in Staffordshire. Steps had already been taken by the Authority to increase capacity so that the consequences of those cases in the YOS could be dealt with once the court processes had concluded. In the meantime, requests had been made for Out of Court Discharges for minor offenses, where appropriate and support was being provided to those children and families (including the three on remand) concerned.

In the discussion which ensued Members expressed serious concern over the impact of the current situation on the health and wellbeing of young people. However, they acknowledged that the County Council were working in partnership with other agencies in an attempt to mitigate the social and financial effects of the pandemic and paid tribute to the Cabinet Member, his staff and wider YOS for their continuing efforts to safeguard vulnerable children in difficult circumstances. Whilst the number of young people currently on remand in the County was relatively small, they looked forward to a resolution of the issues which had been highlighted in the criminal justice system, as soon as possible.

The Chairman then thanked the Cabinet Member for his attendance and opportunity to give constructive scrutiny to the above-mentioned matters for the benefit of residents of the County.

**RESOLVED** – (a) That the report be received and noted.

(b) That the Committee be kept informed of any further developments relating to the impact of Covid-19 on children appearing in Criminal Courts so that further scrutiny could be given, as appropriate.

**52. Work Programme**

The Committee considered a rolling Work Programme for 2020/21 (schedule 5 to the signed minutes).

**RESOLVED** – (a) That the report be received and noted.

(b) That, with the addition of:-

- "Customer Feedback Complaints Service – Children's Social Services Annual Report 2019/20" and;

- "Safeguarding Adults on the Cusp of Care",

to the list of business for transaction at their meeting on 11 January 2021, the Work Programme be approved.

(c) That the updated Work Programme 2020/21 be brought to their next meeting for approval.

## 53. Exclusion of the Public

**RESOLVED** – That the public be excluded from the meeting for the following items of business which involve the likely disclosure of exempt information as defined in the paragraphs of Part 1 of Schedule 12A of the Local Government Act 1972 (as amended), indicated below:-

---

**PART TWO**

## 54. Exempt minutes of meeting held on 13 October 2020

(exemption paragraph 3)

**RESOLVED** – That the exempt minutes of the meeting held on 13 October 2020 be confirmed and signed by the Chairman.

**Chairman**

| Local Members Interest |
| --- |
| N/A |

# Safe and Strong Communities Select Committee - Wednesday 06 January 2021

# Customer Feedback and Complaints Service – Children's Social Services Annual Report 2019/20

### Recommendation

I recommend that the Committee:

a. Consider the Annual Report of the Customer Feedback and Complaints Service, Children's Social Services 2019/20, taking the opportunity for any comments on the content of the report.

**Report of Cllr Mark Sutton, Cabinet Member for Children and Young People**

## Summary

### What is the Select Committee being asked to do and why?

1. The Committee is being asked to consider the Annual Report of the Customer Feedback and Complaints Service, Children's Social Services 2019/20, taking the opportunity for any comments on the content of the report.

## Report

### Background

2. In line with The Children Act 1989 Representation Procedure (England) Regulations 2006, the Local Authority is required to produce an Annual Report. This report must include the number of complaints recorded under the Representation Procedure together with information on the outcome of each representation and whether statutory timescales were adhered to.

3. The Annual Report, Customer Feedback and Complaints Services, Children's Social Services 2019/2020 is being submitted for scrutiny and endorsement.

4. The report contains information about the nature of complaints received, together with responses provided and their handling by the Council.

5. It is important that the Local Authority uses the evidence available from Complaints and Representations to inform service improvements. The report provides information about how complaints investigations are used to identify specific themes, where service improvement can be addressed and highlights where the County Council is providing quality services to customers which may be identified

from compliments received. This is in line with the Council's Strategic Plan, to use Customer Insight to develop high quality services which meet customer needs.

## List of Background Documents/Appendices:

Appendix 1 – Customer Feedback and Complaints Service, Children's Social Services, Annual Report 2019/20

## Contact Details


| | |
|---|---|
| **Assistant Director:** | Tracy Thorley, Assistant Director for Corporate Operations |
| **Report Author:** | Kate Bullivant |
| **Job Title:** | Complaints, Access to Information and School Appeals Manager |
| **Telephone No.:** | 01785 277407 |
| **E-Mail Address:** | kate.bullivant@staffordshire.gov.uk |

Delivering the Difference Together

Putting the people of Staffordshire first

Staffordshire County Council

# CUSTOMER FEEDBACK AND COMPLAINTS TEAM STATUTORY ANNUAL REPORT 2019-2020 CHILDREN AND FAMILIES SERVICES

## Introduction

This report provides information for the Statutory Children's Complaints and Representations Service and the Corporate Feedback Procedure for Children and Families services, for the period 1 April 2019 to 31 March 2020. The report and service is provided in accordance with the Complaints and Representations Procedures established under the Children Act 1989 and the Local Authority Act 1970.

The Procedures were amended from 1 September 2006 by The Children Act 1989 Representations Procedure (England) Regulations 2006, and 'Getting the Best from Complaints', the accompanying guidance.

## The Statutory Complaints Procedure

The Statutory Procedure provides a Procedure for making representations about the discharge by a Local Authority of its functions under Part 3 and specified functions under Parts 4 and 5 of The Children Act 1989, certain functions under 2002 Act and functions regarding Special Guardianship support services.

There are three stages to the Statutory Complaints Procedure:

**Stage 1 – Local Resolution**
This stage is usually carried out by a Team Manager, who is required to carry out an investigation by discussing the complaint with the relevant practitioners and the complainant and taking into account any evidence which is held by the Local Authority, before making an informed finding on each specific complaint. There is a timescale of 20 working days to complete this stage.

**Stage 2 – Independent Investigation**
This stage involves the commissioning of an Independent Investigating Officer (IIO) and an Independent Person (IP) who will carry out an evidence-based investigation by meeting with various practitioners concerned and viewing evidence held on the Local Authority files. The IIO and IP will each prepare a report, including recommendations for the service to consider. The responsible Assistant Director will then consider the reports and recommendations and prepare a response to the complainant detailing whether they accept the findings and recommendations, before all reports and responses are sent to the complainant. There is a timescale of 65 working days to complete this stage.
The Complaints Team are required to accept all requests for a Stage 2 Investigation, however attempts are always made to try and resolve the issues locally, by the Complaints Team offering to meet the complainant along with the relevant Head of Service.

**Stage 3 – Complaint Review Panel**
This stage involves the commissioning of three independent Panel members, who will attend a Panel meeting alongside the IIO and IP, the complainant, a representative from the service, the Complaints Manager, a Clerk to the Panel and anyone else who is considered to be required. The Panel will consider the adequacy of the Stage 2 Investigation in light of any additional information provided by the complainant. Panel will reach a view as to whether any findings need to be overturned and whether any additional recommendations need to be implemented. The report provided by Panel will be shared with the Local Authority and the Director for Children's Services (DCS) will prepare a response to the complainant which will detail whether the recommendations are accepted. The Panel report and response from the DCS is then shared with the complainant.

**Local Government and Social Care Ombudsman (LGSCO)**
In the event that a complainant remains dissatisfied following exhaustion of all three stages of the complaints procedure they can take their complaint to the LGO. A complainant can access the LGSCO at any point but the LGSCO normally provides the Local Authority with the opportunity to process through all stages of the complaints procedure unless they decide otherwise. Complaints referred back to the Local Authority to process are classed as 'premature referral' complaints. If the Local Authority take the

decision to refuse to investigate a complaint or refuse to escalate the complaints to the next stage of the procedure, a complainant may then also approach the LGSCO.

## The Corporate Complaints Procedure

The Corporate Complaints Procedure can be utilised when the representation does not fit the criteria to be investigated via the Statutory Complaints Procedure and is regarding a non-statutory service or if the representation is being made in the complainants own right about a service which they have personally received, subject to the specific detail of the complaint.

There are two stages to the Corporate Complaints Procedure:

**Stage 1: Local Resolution**
This stage usually involves a Team Manager investigating the complaint by conducting discussions with staff members and liaising with the complainant. The Team Manager will then reach a conclusion in terms of the findings of the complaint. The timescale of this stage is 20 working days.

**Stage 2: Internal Review**
A complainant can submit a request for a Stage 2 Review; however, the Complaints Team have discretion in whether this is accepted. The complainant must provide sufficient evidence to warrant this. If accepted, a senior manager will review the stage 1 response alongside the evidence supplied by the complainant and will reach a finding on each aspect of the complaint. The timescale for completing this stage is 25 working days.

**Local Government and Social Care Ombudsman (LGSCO)**
The option to approach the LGSCO is available to the complainant for the Corporate Feedback Procedure, as it would be for the Statutory Procedure.

## Key Numbers and Initial Overview 2019/20

A total of **324** complaints investigated through the different stages of the Statutory and Corporate Complaints Procedures.

**225**
compliments received.

**52%**
of completed complaints responded to within prescribed timescales.

**18%** of completed stage 1 complaints found upheld, **39%** found not upheld, **43%** found partially upheld.

**212**
matters recorded under the Duty category.

**44**
recommendations made following Stage 2 Independent Investigations under the Statutory Complaints Procedure.

## Composition of Total Feedback Received

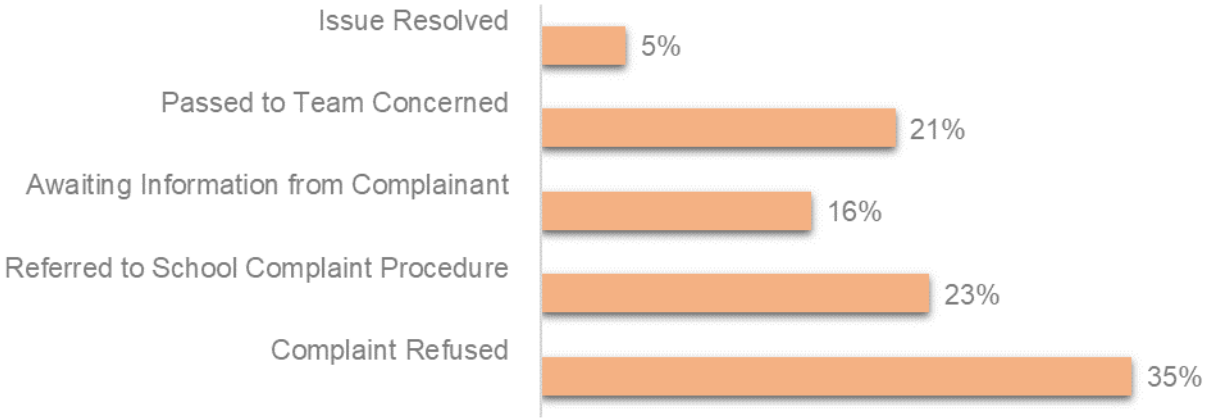
The chart below provides a general overview of the total amount of feedback which has been recorded by the Complaints Team. For the purpose of the below chart some feedback has been categorised together, such as duty and Local Government and Social Care Ombudsman (LGSCO) matters, these shall be further broken down as the report progresses.

| Category | 2018/19 | 2019/20 | Change |
|---|---|---|---|
| Duty | 186 | 212 | 14% ⇧ |
| Statutory Stage 1 Complaints | 103 | 124 | 20% ⇧ |
| Statutory Stage 2 Independent Investigations | 8 | 12 | 50% ⇧ |
| Statutory Stage 3 Panels | 1 | 1 | - |
| Corporate Stage 1 Complaints | 113 | 169 | 49% ⇧ |
| Corporate Stage 2 Reviews | 8 | 18 | 20% ⇧ |
| Local Government and Social Care Ombudsman Cases (LGSCO) | 29 | 47 | 62% ⇧ |
| Compliments | 242 | 225 | 6% ⇩ |
| MP Enquiries | 74 | 69 | 9% ⇩ |

.

## Duty Matters

A total of 212 matters have been recorded under the duty category. The following chart provides a breakdown of how these have been categorised.




## Duty Matters by Operational Leadership*

LAC and Disability Services: 34%
Partnership and Development: <1%
Education and Skills: 14%
Specialist Safeguarding, Targeted Services and Youth Offending Services: 51%

*matters referred to access School complaints procedures are not included within these figures.

Matters which are recorded under this category account for a significantly large amount of the total feedback received this reporting year. This is a theme which was also apparent in the last reporting year. All correspondence which is recorded under the duty system is time intensive; however, the 35% of complaints which were refused should be noted. In order to refuse a complaint, the Complaints Team need to be confident that the decision is underpinned by the statutory guidance and that the perception of the Complaints Team is correct. These complaints require close liaison with the Social Work Team to ensure that the information, which is being relied on, is accurate and has been interpreted correctly. Once a complaint has been refused, the complainant has the option of contacting the LGSCO who can scrutinise the decision and potentially recommend an investigation is commenced; it should be noted that all decisions to refuse investigation of complaints this reporting year have been accepted by the LGSCO and no fault has been found in that regard.

The Complaints Team wish to note that all feedback which is received requires a response in some form and as such the fact that feedback does not qualify for a formal investigation, should not cause staff to assume detailed enquiries and work will be undertaken in order to respond in some form. The Complaints Team remain committed to carefully screening each aspect of feedback received to consider whether it is capable of further investigation and meets the strict criteria within the legislation. It would not be possible to complete this work without the support of the Social Work Teams who assist this process by ensuring the most up to date documents are recorded on the system and who are always on hand to provide their views if required.

## Statutory Stage 1 Complaints: Key Themes

### Numbers

An overall 14% increase is reported for Stage 1 Statutory Complaints across the services. Upon comparison to 2018/19 this equates to a 40% increase for Specialist Safeguarding and a 12% increase for LAC and Disability.

### Nature of Complaint

Case management remains the consistent theme for nature of complaints, allowing for 86% of the Statutory Stage 1 Complaints. Staff conduct and standard of service each account for 4%.

### Timescales

Whilst there has been a 14% increase in Statutory Stage 1 Complaints, responding to these within timescale has reduced from 61% in 2018/19 to 52%.

### Resolved

Various complaints have been resolved to complainant's satisfaction via meetings facilitated with the Complaints Team and Heads of Service. This has been following a request for a Stage 2 Independent Investigation and has therefore reduced the cost to the public purse.

### Findings

Only 2% of Stage 1 Statutory Complaints have been found to be wholly upheld.

### Relationship

75% of Statutory Stage 1 Complaints were received from parents of service users. Only 7% were received from a young person directly or an Advocate on behalf of a young person.

The Complaints Team processed a total of 118 complaints through the Statutory Complaints Procedure at Stage 1. The chart below provides a breakdown with a comparison for the previous reporting years:

| Reporting Period | TOTAL |
|---|---|
| 2017/18 | 54 |
| 2018/19 | 103 |
| 2019/20 | 118 |

The data above reports a 14% increase in complaints being facilitated through Stage 1 of the Statutory Complaints Procedure. It is always difficult to provide future forecasts of complaints, as complaints are subjective and down to how an individual perceives a situation. The Complaints Team regularly emphasise the point that the volume of complaints taken solely, is not an indicative measure of the quality of service provided by the respective teams. The outcome of an investigation and whether the complainant takes steps to instigate further investigation, provide a more useful and evidence-based measure of performance and more importantly provide learning for the services to shape their future intervention and practice.

## Breakdown

The following tables provide a further breakdown into operational leadership and individual teams, of the 118 complaints investigated at Stage 1 of the Statutory Complaints Procedure, with a comparison of the preceding year.

| Specialist Safeguarding, Targeted Services and Youth Offending Service | TOTAL 2018/19 | TOTAL 2019/20 |
|---|---|---|
| Specialist Safeguarding Units | 49 | 73 |
| First Response Team | 1 | 3 |
| Emergency Duty Team | 1 | - |
| LADO Service | 2 | 1 |
| **TOTAL** | **55** | **77** |
| **Looked after Children and Disability Services** | **TOTAL 2018/19** | **TOTAL 2019/20** |
| Care Planning/Court Teams | 13 | 12 |
| Disability Services | 10 | 10 |
| Throughcare Teams | 10 | 16 |
| Adoption Service | 5 | 3 |
| Fostering Service | 5 | 6 |
| **TOTAL** | **42** | **47** |

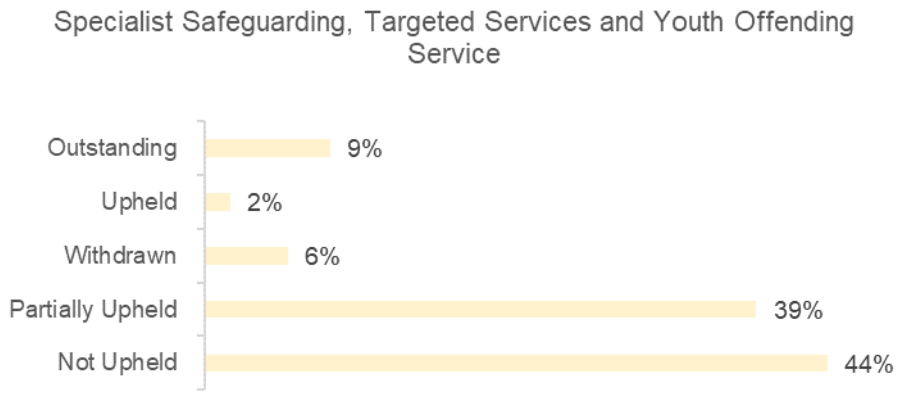
## Outcomes of Stage 1 Statutory Complaints*

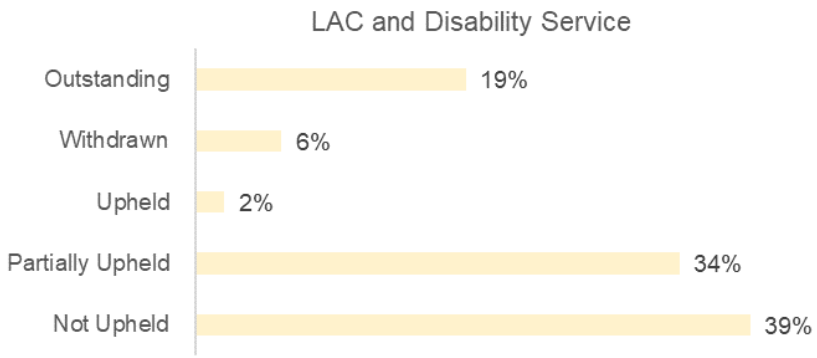
| Reporting Period | Upheld | Partially Upheld | Not Upheld | Complaint Withdrawn |
|---|---|---|---|---|
| 2017/18 | 22% | 39% | 37% | - |
| 2018/19 | 6% | 56% | 34% | 5% |
| 2019/20 | 2% | 39% | 39% | 7% |

*at the time of reporting 13% of complaints remained open/outstanding.

The figures above report that despite there being a 14% increase in Stage 1 Statutory Complaints in comparison to previous reporting years; there is a decrease in complaints being found to be wholly upheld for the second reporting year. There is a decrease to be noted in complaints found to be partially upheld; this still supports the fact that local level managers who are investigating complaints at Stage 1 are able to be open and transparent and identify faults within their services yet also balance this against any evidence which indicates the team has acted appropriately.

## Outcomes by Operational Leadership



## Timescales for Responding to Stage 1 Statutory Complaints

The following chart shows a comparison of the response timescales for Stage 1 Statutory Complaints for 2019/20 against previous reporting years.

| Reporting Period | Within Timescale | Over Timescale | Complaint Withdrawn |
|---|---|---|---|
| 2017/18 | 45% | 53% | - |
| 2018/19 | 53% | 42% | 5% |
| 2019/20 | 54% | 40% | 6% |

The above figures show that there has been no increase in complaints being responded to over the prescribed timescale. There have however still been a significant number of complaints which have been responded to out of timescale. The Complaints Team fully accept that services are under increasing pressure and competing demands and that investigating a responding to complaints at Stage 1 can be time consuming. The advice provided to all staff investigating complaints is that if a complaint is likely to fall outside of timescales, communication with the complainant is paramount to ensure that they are aware of any potential delay and that their expectations are appropriately managed.

## Stage 2 Statutory Independent Investigations

The below table shows the number of Stage 2 Investigations commissioned this reporting year yet also proves some comparative data of the preceding year and the percentage of stage 1 complaints progressing to the next stage.

| Reporting Period | Number of Stage 1 Statutory Complaints | Number of Stage 2 Independent Investigations | Percentage of Stage 1 Complaints Progressing to Stage 2 Investigation |
|---|---|---|---|
| 2015/16 | 70 | 11 | 16% |
| 2016/17 | 91 | 9 | 10% |
| 2017/18 | 54 | 5 | 9% |
| 2018/19 | 103 | 8 | 8% |
| 2019/20 | 118 | 12 | 10% |

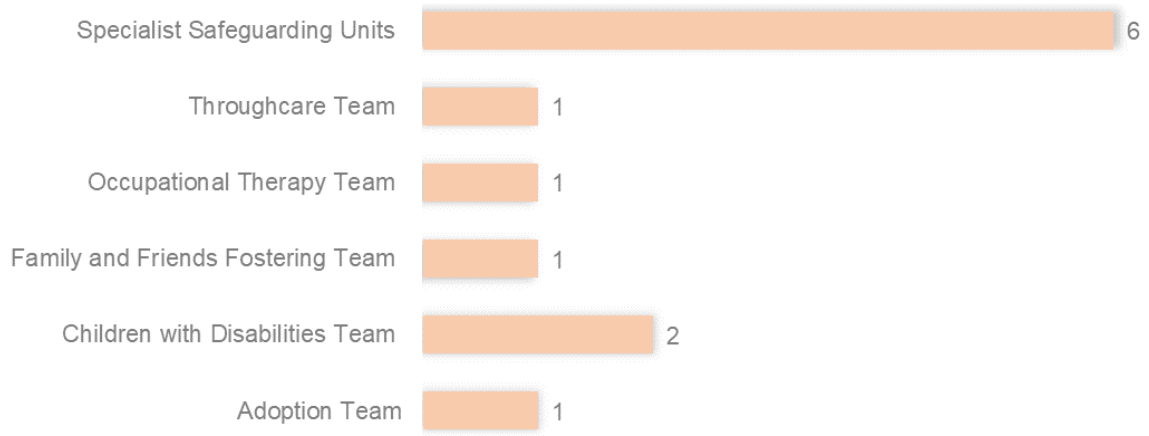
This data shows a slight increase in the percentage of complaints which have progressed to the next stage of the Statutory Complaints Procedure. It should be noted that each complainant has differing reasons regarding why they wish to escalate their complaint, and it should not be assumed this is due to a poor investigation at Stage 1. It is routinely communicated to all staff that a thorough response at Stage 1 and evidence that attempts have been made to contact and discuss the issues with the complainant, will support the stance of the service should the matter escalate through the Statutory Complaints Procedure.

The table below shows the Stage 2 Investigations that took place in respect of the services within Families First.

| Service | Number of Stage 2 Independent Investigations |
|---|---|
| Looked after Children and Disability Services* | 6 |
| Specialist Safeguarding, Targeted Services and Youth Offending Services* | 6 |

*a total of 5 Stage 2 Investigations remain in the process of being investigated.

The chart below provides a further breakdown into individual teams:




## Findings and Recommendations from Stage 2 Statutory Investigations

The tables below offer a small selection of some of the complaints that escalated to Stage 2 and the actions which the services have taken to complete the recommendations made by the Investigating Officer, from the 6 completed investigations there was a total of 97 individual complaints investigated.

The table provides an overview of the findings from the combined 97 complaints:

| Finding | Percentage |
|---|---|
| Upheld | 21% |
| Not Upheld | 60% |
| Partially Upheld | 19% |

The following table provides a small selection of some of the recommendations which have been implemented as a result of Stage 2 Statutory Investigations. These recommendations are disseminated to practitioners through a variety of methods such as staff memos, discussed in individual supervisions and team meetings and shared at higher level management meetings.

| Service: Looked after Children and Disability Services |
|---|
| A selection of recommendations accepted by the service: |
| • That the Council should take steps to ensure that important information for service users, their carers and representatives is provided in a form and format which serves the requirement for clarity, unambiguousness and accountability. |
| • That contingency arrangements are put in place for situations where it becomes likely that statutory visiting requirements cannot be met, and that any subsequent difficulties are referred to senior management. |
| • In cases when a referral is made to Children's Services by the parent with whom the child resides and there is shared parental responsibility the other parent should be consulted and informed as soon as possible. |

| Service: Specialist Safeguarding, Targeted Services and Youth Offending Services |
|---|
| A selection of recommendations accepted by the service: |
| • The Independent Investigating Officer recommends that Children's Social Care ensure staff are careful not to discuss confidential information (issues around complaints or issues relating to another family) in front of third parties, time should be taken to discuss such issues separately. |
| • Communications – letters, emails, phone calls – should be responded to promptly whether or not an immediate answer can be provided |
| • Social Workers should be reminded that written follow ups to meetings where actions have been agreed are helpful. This is particularly true if the parent has said that s/he has a poor memory. |
| • Children's Services should explain the need for three social workers for the children whilst acknowledging that this can be confusing and lead to a lack of clarity. |

## Stage 3 Complaint Review Panels

The below table provides an overview of any Stage 3 Complaints Review Panels which were held in 2019/20 and the respective services involved:

| Service | Number of Stage 3 Complaints Review Panels |
|---|---|
| Specialist Safeguarding, Targeted Services and Youth Offending Services | 1 |

Through the Stage 3 Complaints Review Panel process, the Panel will consider information presented by the complainant before inviting officers in attendance to make comment on these. They will then deliberate before submitting a report including recommendations to the Local Authority and the complainant. The Local Authority will then provide a response to those recommendations and inform the complainant of how these shall be implemented.

The below table provides an example of some recommendations implemented following the Stage 3 Complaints Review Panel.

| **Service: Specialist Safeguarding, Targeted Services and Youth Offending Services** |
|---|
| A selection of recommendations accepted by the service: |
| • That the Local Authority considers making contact with Children's Services in the area that the child was last known to be living, to ensure that they are aware of all of the Safeguarding concerns raised. |

## Corporate Stage 1 Complaints Key Themes:

### Numbers

There has been a significant increase in Stage 1 Corporate Complaints of 49% in comparison to the previous reporting year. This equates to a 95% increase for Education Strategy and Skills and a 25% increase for LAC and Disability.

### Nature

Following the trend for Statutory Complaints, case management is the main theme of Corporate Stage 1 Complaints, accounting for 68%. This is followed by communication which accounts for 12%.

### Timescales

The percentage of Stage 1 Corporate Complaints responded to within timescale has fallen to 50%, compared to 66% in the last reporting year.

### Remedies

An explanation and an apology accounts for 66% of remedies for Stage 1 Corporate Complaints.

### Trends

The overall increase in Stage 1 Corporate Complaints is attributable to the SEND Service. Complaints relating to this service have increased by 114% compared to the previous reporting year.

### Relationships

The majority of feedback within the Corporate Complaints Procedure is from parents of young people. Very minimal contact is received from young people themselves.

The Complaints Team processed a total of 169 complaints through the Corporate Complaints Procedure at Stage 1. The chart below provides a breakdown by quarter together with a comparison for the previous reporting year.

| Reporting Period | TOTAL |
|---|---|
| 2017/18 | 130 |
| 2018/19 | 113 |
| 2019/20 | 169 |

The above data represents a 49% increase in Corporate Stage 1 Complaints this reporting year. As with the data for Statutory Complaints, it is not possible to forecast figures for complaints as it is not predictable to know what may constitute a complaint to someone.

## Breakdown

The following tables provide a further breakdown of the 169 complaints investigated at Stage 1 of the Corporate Complaints Procedure:

| Education Strategy and Improvement | TOTAL 2018/19 | TOTAL 2019/20 |
|---|---|---|
| SEND Teams | 49 | 105 |
| School Admission and Transport | 1 | 1 |
| Home Education Team | 5 | 2 |
| Education Psychology | 3 | 3 |
| Education Welfare | - | 1 |
| Performance Licence Team | 2 | - |
| School Penalty Charge Notices | - | 5 |
| TOTAL | 60 | 117 |
| **Looked after Children and Disability Services** | **TOTAL 2018/19** | **TOTAL 2019/20** |
| Care Planning and Court Team | 9 | 11 |
| Fostering Teams | 3 | 4 |
| Occupational Therapy Team | 1 | - |
| Disability Team | 1 | - |
| Throughcare Team | 1 | 3 |
| Adoption Team | 1 | 1 |
| Intensive Prevention Service | - | 1 |
| TOTAL | 16 | 20 |
| **Specialist Safeguarding, Targeted Services and Youth Offending Services** | **TOTAL 2018/19** | **TOTAL 2019/20** |
| Youth Offending Team | - | 1 |
| Specialist Safeguarding Units | 28 | 18 |
| First Response Team | 2 | 3 |
| Early Help Teams | 6 | 10 |
| TOTAL | 36 | 32 |

When looking at the above data, the biggest increase by far relates to the SEND Service where complaints have increased by 114% compared to the previous reporting year. The main theme for complaints relating to this service is the failure to adhere to prescribed timescales and thee delay in securing an Educational Psychologist to complete an assessment.

## Outcomes of Stage 1 Corporate Complaints

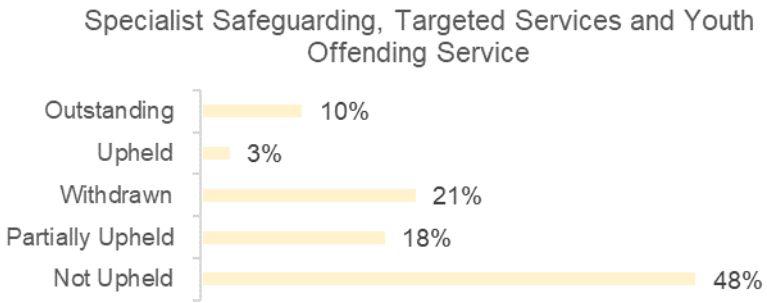
The table below illustrates the outcome of complaints dealt with under Stage 1 of the Corporate Feedback Procedure during this reporting year with a comparison for the preceding year*:

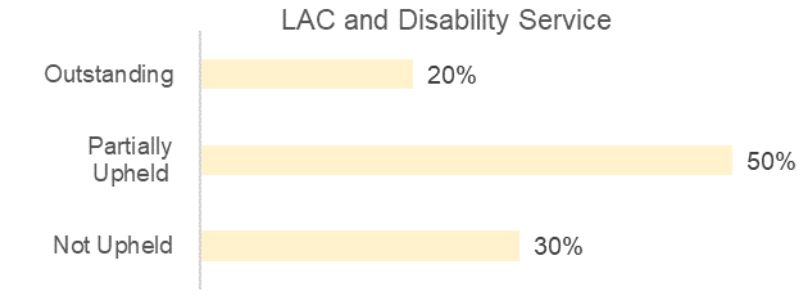
| Reporting Period | Upheld | Partially Upheld | Not Upheld | Unable to make a Finding | Complaint Withdrawn |
|---|---|---|---|---|---|
| 2017/18 | 8% | 34% | 51% | - | 1% |
| 2018/19 | 19% | 44% | 35% | 1% | 5% |
| 2019/20 | 22% | 30% | 24% | - | 6% |

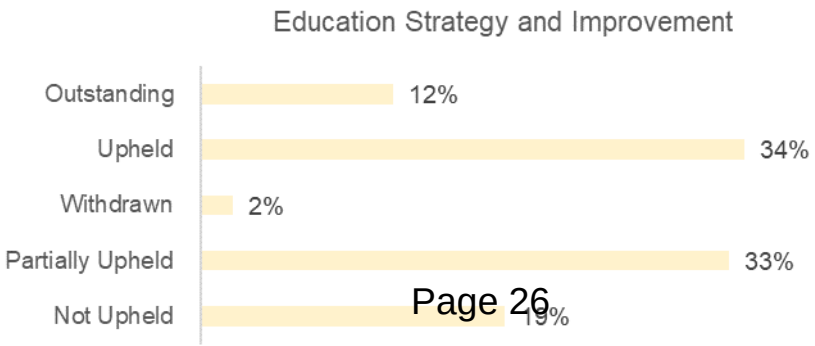
The data above shows an increase in the complaints which are found to be upheld and a decrease in those found not upheld.

*at the time of producing this report, 21 complaints remained outstanding and as such the data above may alter in the future.

## Outcomes by Operational Leadership:



## Timescales for Responding to Stage 1 Corporate Complaints

The table below illustrates the timescales for responding to Stage 1 Complaints via the Corporate Complaints Procedure, with comparative data for the preceding year:

| Reporting Period | Within Timescale | Over Timescale |
|---|---|---|
| 2017/18 | 53% | 40% |
| 2018/19 | 66% | 34% |
| 2019/20 | 50% | 32% |

These figures show that 56% of the completed complaints have been responded to within the prescribed timescale set out within the Corporate Feedback Procedure. This is a decrease of 16% from the previous reporting year, however it should be noted that there has been a 49% increase in Stage 1 Corporate Complaints. Maintaining communication with complainants is key when timescales will not be met and the Complaints Team will continue to support managers in ensuring this takes place.

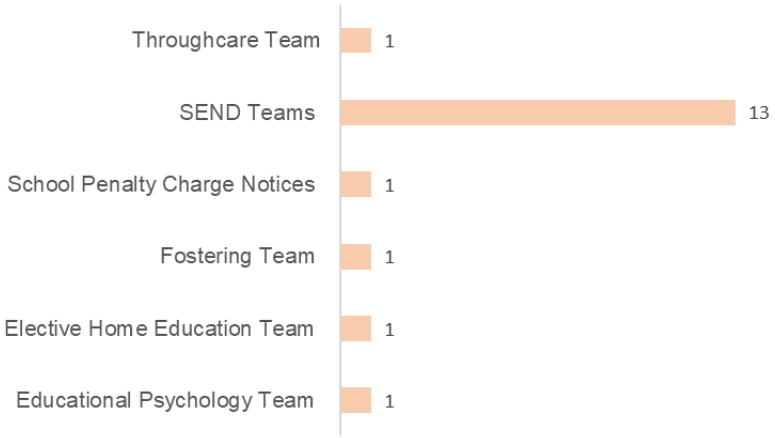
## Stage 2 Corporate Complaints – Internal Review

During this reporting year, 16 complaints were accepted for an internal review at Stage 2 of the Corporate Complaints Procedure. The Complaints Team has discretion with requests of this nature and each request is assessed on its own merit. If it is felt that there would be no benefit to the complaint progressing to a Stage 2 Review, then the request is refused, and the complaint directed to the LGSCO.

The table below shows the Stage 2 Reviews that have taken place in respect of the services:

| Service | Number of Stage 2 Reviews |
|---|---|
| Education Strategy and Improvement | 16 |
| Looked after Children and Disability Services | 2 |

The chart below provides a further breakdown into teams:



## Recommendations and Learning from Corporate Stage 2 Reviews

The below table provides a small selection of recommendations and learning which has been identified from Stage 2 of the Corporate Complaints Procedure.

| **Service: Looked after Children and Disability Services** |
|---|
| Action taken by the service following recommendations: |
| • Team Manager to ensure appropriate management overview within Social Worker Supervisions, in particular around partnership working with parents. |

| **Service: Education Strategy and Improvement** |
|---|
| Action taken by the service following recommendations: |
| • The service is working closely with HR in order to recruit educational psychologists directly and have recently recruited additional SEND Keyworkers to address the increased demand on the service. |
| • Whilst usual process is to inform schools and the service expect that in turn schools will inform parents, the service are currently reviewing these procedures and have invested in an on-line portal which will further enhance communication directly with parents. |
| • In conjunction with parents and other agencies, the service has developed a new set of quality standards which will form the basis for training. The Keyworker staffing levels within the SEND Service have also been increased to help manage the additional caseloads as well as the statutory annual reviews. |

## Local Government and Social Care Ombudsman (LGSCO)

The LGSCO has processed 47 individual matters for the services during this reporting period. The LGSCO will make a judgement on whether they chose to investigate the complaint themselves or make enquiries with the Local Authority before making a decision.

The below table provides further detail; the LGSCO finding reported below how it is stated from the LGSCO:

| Service | Status | Findings | Recommendations |
|---|---|---|---|
| Care Planning and Court Team | Refusal to Investigate | Refusal to Investigate | No recommendations |
| Care Planning and Court Team | Enquiry | Investigation Discontinued | No recommendations |
| Children with Disabilities Team | Investigation | Maladministration and Injustice | I recommended that the Council: • Issues a further formal apology acknowledging the failings identified and their impact; • Pays £1,500 to Mrs B on behalf of her daughter C; • Pays £500 to Mrs B on behalf of C's eldest sibling; and • Pays £1000 to Mrs B on behalf of the whole family. In the same time period I also recommended that for the avoidance of doubt the Council provide Mrs B with clear and unequivocal information about the way in which funds held in the DP account may be used and confirmation that they do not need to be repaid to the Council. Further, I recommended that within three months of the date of the decision on this complaint the Council: • Completes the revisions to the assessment of C's needs; • Offers and completes carer and young carer assessments (unless these are refused, in which case the refusal should be documented); • Puts any services deemed necessary to meet needs identified by the above assessments in place, and takes any other actions deemed necessary in respect of CiN planning, within four weeks of completion of those assessments; and • Reviews lessons learned from the complaint, resulting in a plan to address all identified shortcomings, with timescales. This should include the areas of record keeping, communications with and support for service users or potential service users, complaint handling, and commissioning arrangements where services are required to meet needs. It should also include ensuing that relevant staff are reminded of the statutory guidance on care and support for deaf-blind children and adults and of the need to ensure appropriate MSI assessment is promptly arranged where appropriate. I recommended that a senior member of staff undertake regular monthly oversight of progress of all the above matters to guard against further drift and ensure accountability. |
| Children with Disabilities Team | Enquiry | Investigation Commenced | LGO investigation began. |

| | | | |
|---|---|---|---|
| Children with Disabilities Team | Investigation | Maladministration and Injustice | I recommend the Council make a symbolic payment of £2,000 to Ms M and H to acknowledge the impact of its failure to provide the additional support the Council decided Ms M needed from early 2017 until H started at a residential special college in 2018. The Council should make the payment within 4 weeks of my final decision. I recommend the Council revisit Ms M's request for specialist equipment to monitor H at night when he visits. The Council explained that it cannot provide specialist medical equipment. If the Council identifies H needs night-time support, either with specialist equipment or from a carer, it should ensure the need is met, and provide assistance to Ms M to secure support if the Council decides not to provide it itself. The Council should ensure this is done within 4 weeks of my final decision. I recommend the Council review its processes to ensure it makes timely decisions when assessments identify unmet needs, and care plans are updated following decisions by the 'resources panel' to show how needs identified in an assessment will be met. The Council should complete the review within 12 weeks of my final decision. I recommend the Council review the sufficiency of its residential respite service for disabled children. The Council should complete the review within 12 weeks of my final decision. |
| Educational Psychology Team | Refusal | Refusal to Investigate | No recommendations |
| Friends and Family Fostering Team | Refusal | Refusal to Investigate | No recommendations |
| Home Tuition Team | LGO - Prem Ref | Premature Referral | Instigated the Complaints Procedure. |
| Home Tuition Team | LGO - Prem Ref | Premature Referral | Instigated the Complaints Procedure. |
| Early Help Teams | Investigation | - | Awaiting decision. |
| Penalty Notice School Admissions Team | Refusal | Refusal to Investigate | No recommendations |

| | | | |
|---|---|---|---|
| School Transport Policy Team* | Investigation | Maladministration and Injustice | Apologise to Mrs X for the faults I have identified; b) Consider Mrs X's appeal about the safety of the walking route and transport issues at stage two of its appeal process. Mrs X should be invited to present her case to the panel; c) Write to all parents who appealed to the Council about the safety of the walking route and transport issues and inform them of their right to escalate their appeal to stage two; d) Complete all stage two appeals; e) Ensure that the independent panel members are independent of the original decision-making process and suitably experienced. This should ensure a balance is achieved between meeting the needs of the parents and the local authority, compliance with road and safety requirements and that no child is placed unnecessarily at risk. If the appeal upholds any of the cases, or the Council wishes to agree a remedy without presenting its case to a fresh appeal panel, the Council should: f) agree a financial payment for alternative transport the parent(s) have provided since September 2018. g) review its home to school transport provision in line with statutory requirements |
| School Transport Policy Team* | Investigation | Maladministration and Injustice | as above. |
| School Transport Policy Team* | Investigation | Maladministration and Injustice | as above. |
| School Transport Policy Team* | Investigation | Maladministration and Injustice | as above. |
| School Transport Policy Team* | Investigation | Maladministration and Injustice | as above. |
| School Transport Policy Team* | Investigation | Maladministration and Injustice | as above. |
| School Transport Policy Team* | Investigation | Maladministration and Injustice | as above. |
| School Transport Policy Team* | Investigation | - | Awaiting decision. |
| School Transport Policy Team | Enquiry | Investigation Commenced | LGO investigation began. |
| SEND Team | Enquiry | Maladministration and Injustice | The Ombudsman finds there was some fault in the way the Council considered Miss X's application for post-16 transport for her son. This caused Miss X uncertainty as to what the outcome may have been. I have recommended the Council reconsider the appeal. |

| | | | |
|---|---|---|---|
| SEND Team | Investigation | Maladministration and Injustice | The Council has agreed to give Ms X an opportunity to provide further evidence to support her appeal and refer the matter back to the panel to reconsider. If a revised decision is to award transport, the Council should reimburse Ms X for any reasonable expenses she has incurred providing transport for Y. This action should be taken within one month from the date of this decision. |
| SEND Team | Investigation | No Fault | No recommendations |
| SEND Team | Enquiry | Investigation Commenced | LGO investigation began. |
| SEND Team | Enquiry | Premature Referral | Instigated the Complaints Procedure. |
| SEND Team | Enquiry | Refusal to Investigate | No recommendations |
| SEND Team | Refusal to Investigate | Refusal to Investigate | No recommendations |
| SEND Team | Investigation | No Fault | No recommendations |
| SEND Team | Enquiry | Investigation Discontinued | No recommendations |
| SEND Team | Refusal | Refusal to Investigate | No recommendations |
| SEND Team | Investigation | Maladministration and Injustice | I considered C and the family were caused an injustice between January 2019 and 29 September 2019 when Mr B included the issue in his appeal. I calculated this was approximately six months of term time, with the first three months providing one night a week and the latter three with no provision at all. I considered a suitable remedy would be £1600 calculated as follows: • Three months of reduced provision @ £150 per month: £450 • Three months of no provision @ £300 per month: £900 • Time and trouble for Mr B and the family: £250. Mr B considers this is insufficient. He says C missed out on 35 nights of provision and at current costs would amount to between £7,000 and £10,000. He says it is not even enough to pay for a week's holiday at a disabled activity centre for the whole family and will not act as a deterrent for the Council. I do not consider this level of remedy is appropriate: We aim to remedy personal injustice wherever our investigations reveal there has been fault. Sometimes we will recommend a financial payment to the person who brought their complaint to us. This might be to reimburse a person who has suffered a quantifiable financial loss, or it might be more of a symbolic payment which serves as an acknowledgement of the distress or difficulties they have been put through. But our remedies are not intended to be punitive and we do not award compensation in the way that a court might. Nor do we calculate a financial remedy based on what the cost of the service would have been to the provider. I consider £1600 is a reasonable remedy in these circumstances. It is in accordance with our guidance and recognises the injustice caused to C and Mr B. |
| SEND Team | Enquiry | Investigation Commenced | LGO investigation began. |
| SEND Team | Enquiry | No Fault | No recommendations |

| | | | |
|---|---|---|---|
| Specialist Safeguarding Unit (SSU) | Enquiry | Refusal to Investigate | No recommendations |
| Specialist Safeguarding Unit (SSU) | Refusal to Investigate | Refusal to Investigate | No recommendations |
| Specialist Safeguarding Unit (SSU) | Refusal to Investigate | Refusal to Investigate | No recommendations |
| Specialist Safeguarding Unit (SSU) | Enquiry | Refusal to Investigate | No recommendations |
| Specialist Safeguarding Unit (SSU) | Enquiry | Refusal to Investigate | No recommendations |
| Specialist Safeguarding Unit (SSU) | Enquiry | Investigation Commenced | LGO investigation began. |
| Specialist Safeguarding Unit (SSU) | Investigation | Maladministration and Injustice | The only fault I have found for the complaints investigated is in relation to the failure to invite Mrs B to a child in need meeting in June 2017 and failure to provide her with the minutes of that meeting. I am satisfied the Council has apologised to Mrs B and sent a memo to those dealing with child protection and child in need cases to remind them of the policy on involving parents in meetings and providing minutes of meetings. I am satisfied with the action the Council has taken and make no further recommendation |
| Specialist Safeguarding Unit (SSU) | Refusal to Investigate | Refusal to Investigate | No recommendations |
| Specialist Safeguarding Unit (SSU) | Refusal to Investigate | Refusal to Investigate | No recommendations |
| Specialist Safeguarding Unit (SSU) | Refusal to Investigate | Refusal to Investigate | No recommendations |
| Specialist Safeguarding Unit (SSU) | Investigation | - | Awaiting decision. |
| Specialist Safeguarding Unit (SSU) | Refusal to Investigate | Refusal to Investigate | No recommendations |
| Specialist Safeguarding Unit (SSU) | Enquiry | No Fault | No recommendations |
| Specialist Safeguarding Unit (SSU) | Enquiry | Refusal to Investigate | No recommendations |
| **TOTAL** | | | **47** |

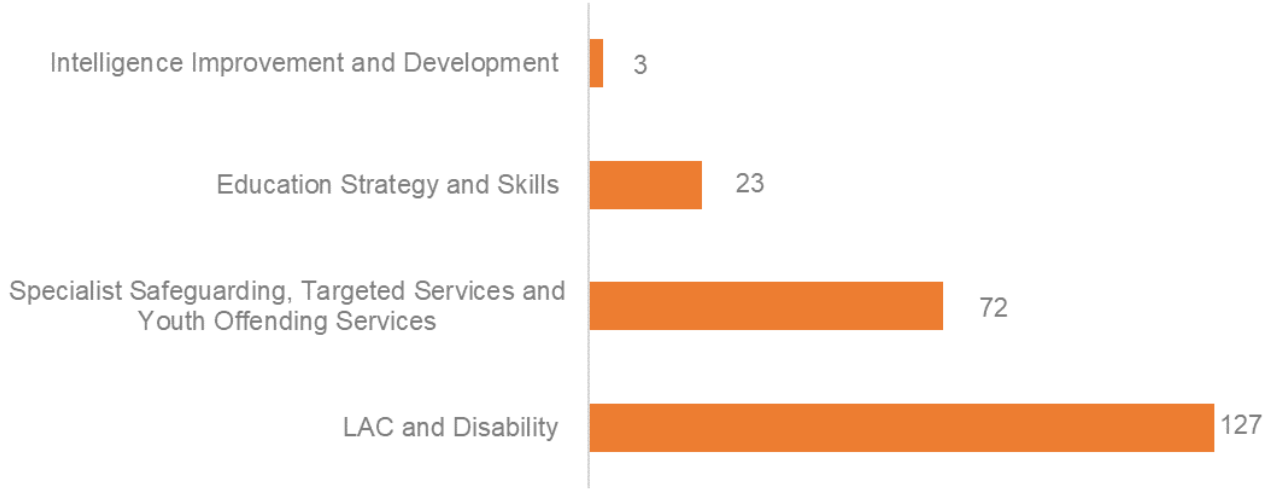
*There are multiple investigations recorded for the School Transport Policy Team; however, these all relate to the same complaint which surrounds a decision regarding home to school travel assistance. A number of parents approached the LGSCO, who were represented by one parent. The LGSCO logged each case individually, although the finding is the same for each.

From the 47 complaints which the LGSCO have considered, 34% have reached a finding of fault. The complaints which have identified fault, shape learning for the Local Authority in the same way that learning identified from all complaints is taken forward. The LGSCO will monitor any recommendations and their case shall remain open until they are satisfied that a proposed remedy has been implemented.

## Compliments

A total of 225 compliments have been recorded for this reporting period.

The below chart provides a breakdown of these compliments between the services:




## Examples of Compliments

## Specialist Safeguarding, Targeted Services and Youth Offending Services

- 'Hiya only me… I just really want to say a massive thank you for everything you've done over the last year to support us. I really appreciate it. I obviously know you've got to close things I wish so would Z wish you could be around forever… It's sad to know you'll be leaving us… you've helped us both loads you are an amazing support worker and we will miss you loads xxx thank you again for everything xxx'
- "Thank you and thank you for all you have done for her. She is a very lucky girl. I just hope she learns to appreciate people and learns from her mistakes."
- X's care commitment and dedication to our families goes above and beyond and her assessments are exemplary. We don't celebrate or praise our colleague's achievements enough these days, so on behalf of the children, and me, a big "thank-you".
- She recognises that she has been traumatised by the events she has survived and welcomes the help and support that is being offered to her. Which without X working this case in the way she did would not have been possible. This has brought a family to safety and enabled them to come together to heal. Please pass my thanks onto X for her through and commendable work.
- Just to tell you how much we appreciated to have someone like X who made a big difference to my kid's life. She is hardworking and very supportive all the way through. She visited me and my children and listened to us our concern carefully, finding out the root of the problem. She informed us about the progress and gave us the reassurance. Her professionalism for her job has impressed me very much. As a result, me and my kids are having a much happier life now but

without someone like her, this result would not have been achieved. I would like to say a huge thank you to your team and especially X who will be continually making the difference to the unfortunate families.

- In addition to the good practice alert, mother said she felt that if she had a different social worker, she wouldn't have made the changes she did. She said that I was a people's person and never looked down on her.
- I just wanted to make you aware how fantastic X is. I have never seen anyone who is more dedicated to putting the child at the heart of the process. She really is an exceptional practitioner and I want to say a big thank you from everyone.
- Currently ongoing before me is an intractable and acrimonious private law dispute. In fact, it is one of the most difficult private law cases I have seen. X is the author of the report. The report is an extremely thorough and very competent piece of work. It helpfully sets out a detailed chronology of all relevant information and identifies the real issues in the case. Further, X goes on to grapple in a very fair handed manner the difficulties presented by both parents. Finally, the report thoroughly analyses the impact upon the child and arrives at a fully reasoned conclusion. In a difficult case such as this it is not an exaggeration to say that the report is a 'godsend' in assisting the court in trying to make the right decisions for this child who is caught in the midst of a very acrimonious adult conflict.
- 'Ms X spoke positively about her relationship with Mr Z, Social Worker, and explained that he would "sit down" with her during home visits and appeared to treat them respectfully and to offer them help in their relationship with Y. Ms X noted that Mr Z had provided assistance in accessing support for Y, for example, in respect of a gym and college.'
- I have just taken this time to wish you plenty of joy over the festive season and every day of the coming year. You have been an epitome of excellence, leadership and wisdom. I regard your leadership as transformational, as you enable people to do the greatest things. I say this because I have seen how you have looked me since my first day at work and up to now you still guide me. I really appreciated your leadership. The saying that goes like "The greatest leader is not necessarily the one who does the greatest things, but she is the one that gets the people to do the greatest things" applies to you. You genuinely care for and show love to the people in your team and for that I am grateful.

## Looked after Children and Disability Services

- X shared how pleased she was with my attempts to work with Z, which was often under pressure as Z could be verbally abusive to me and threatening.
- He was highly complementary of the excellent work completed by X as part of the rehabilitation plan before and after. The work with the father and children was deemed excellent, sensitive, and insightful. The Guardian has specifically asked that this is passed on to her manager.
- X was very pleased that he is having you as his PA, as he is aware of you from some of friends as they have given him lots of positive feedback about you.
- Our solicitor has sent through the court order today and has also passed on their thanks to placements as below: *'enormously assisted in those efforts by colleagues in the office, including the duty social worker and the placements team members.'*
- Thanks for the update and all that you are doing for him. Your approach is very efficient and caring and much appreciated
- I will see you tomorrow, but I just wanted to also take this opportunity to thank you for your input. X has really bonded with you and with your help, support and understanding I feel that we have come a long way. I still think we have a bit more work to do but I feel quietly confident about the future and more in control than I did when I made that SOS call. You really are a star.
- She thanked me for being a good social worker who is honest, fair and didn't judge her. I was quite taken back.

- We are so grateful for all that you have done for us over the years. You've always fought our corner and supported us without judgement and ensured that with the support you've helped put in place, we have stayed and coped as a family. It will break my heart the day X leaves home but deep down I know it'll be the best for him. Thanks to you we have been able to keep him at home. I'm sure you will now have a new case/child to work with. They will be the next lucky family to have you working for them. Go work your magic. You're a star in our eyes. Thank you.
- I just want to say that I really appreciate the work that Social Worker X is doing with a young person we both work with. He has gone over and beyond with support for him and our work together has proved beneficial for that young person. He is a credit to your team. I hope you can pass on this praise and to thank him for his efforts.
- Hi, just to say thanks for your support with this case and with sorting the issue which arose with the cot yesterday. The OT Team is a brilliant team, really supportive and well led, I know you have a lot on at the moment and are really busy, so I wanted to let you know that it is appreciated! Hope you have a nice weekend
- Your approach in discussing review conferences with me prior to the meeting and providing regular updates is invaluable, at all times, but particularly at this time given the capacity issues within my service at this time. Your knowledge of your cases is always excellent, and you are always child focused. Your approach to being direct and honest with parents about your concerns is very skilfully done, this is often no easy task as parents can become defensive or hostile. You always manage to achieve a balance so that parents hear your concerns but do not disengage. It is a pleasure to work with you.
- I hear lots of adoption support (or lack of) horror stories from friends in other areas - & feel so pleased that we adopted in Staffordshire and are able to work with the best post-adoption senior family support worker ever!
- X described her as being her most favourite social worker ever. She was described as being lovely and listened to her and also said that she was able to talk to her. She also spoke positively about Z and said that she was one of the most efficient social workers that she has worked with and as well as listening actually sorts out the things that need to be done. We don't always receive positive feedback, so I hope that you enjoy this one, it is well earned.
- Last night I had a phone call from X's mum. She was over the moon (to say the least) and wanted us both to know that Z has now got a job and is a changed young man at home and drug wise. He will be working full time. She wanted me to let you know even though we worked with him a while ago and said without our support this would never have happened. She also wanted me to tell management of IPS and T3. She was over the moon and emotional and said the family is in a very different place thanks to IPS and T3.
- X has made herself available to us day and night and even at times when she is not 'on duty', she is punctual, reliable and has always backed us up and fought our children's corner at difficult meetings and appointments with health professionals and educational settings. All the while coaching us on how best to handle this situation for ourselves too. She is a great listener who offers sound advice and first class practical and emotional support.
- She stood in on an unplanned situation and worked brilliantly. Her relationship with the children is amazing and was proven to be the case when X himself told her he had not seen her in 10 months and yet all of the children gave her hugs and wanted to catch up with her. She was really supportive to him at an absolutely awful time. I also feel she really supported me as it was the first time, I had done a placement move and her experience shone through. So, thank you.
- With the support of them, he was able to attend the parents BBQ and parents' event, this again was successful, and staff supported him to listen to the feedback from staff on his progress. The school's Prom event was a huge success, he was supported by two staff members who dressed the car up with balloons and banners - making his last Prom at school a memorable event.

## Education Strategy and Improvement

- I'm sure you mainly get negative messages, but I wanted to thank you and Staffordshire County Council for all the help that has been given to help X achieve one of her goals in life, university. Without the support from the EHCP, X wouldn't have even got any GCSE let alone a place in college and now uni. So THANK YOU.
- A message to every individual who has worked with me...
  You all are incredible people and you should all be extremely proud of yourselves for helping students like me to achieve something great in life! I will miss you all, in fact, I have got tears in my eyes writing this message, but I will keep you all informed regarding my future plans by sending emails to the office! There is so much more I want to tell you all but no words will ever express how grateful I am and how I appreciate each and every one of you! I love you all and once again, thank you! I hope you enjoy these photos of me being a little kid in the park but hey, I wanted to make you all smile because you all did tell me that my sense of humour was great and I remember you also told me to never stop being me so I will always carry that and more wherever I go!!
- I have finally found time to sit and email you regarding my mum and X who assists her. I am so thankful for all that X has helped my mum with over the last few years. My mum used to be very shy and embarrassed about her disability and didn't like being out in public, let alone sign in public. My mum is a completely different person now, she is no longer embarrassed and is happy to sign in public. She has a routine with X now and looks forward to her visits. On occasions when I have needed to speak to X or arrange appointments, X has always been on hand and very accommodating. If X were to stop her visits, I truly believe my mum would revert back to her former self. My mum cannot sing X's praises enough.
- The meeting was brilliant. The commissioning and quality managers they sent were really lovely and listened to what we said. There was only about 7 of us parents but that worked out quite well as anymore and I think people would have struggled to be heard. Just to let you know – The overwhelming feeling from all the parents was that AOT are everything to the parents and we all feel like you keep us in the loop for all things ASC and we all feel very well supported by your department.
- I would like to compliment (Education Welfare Officer). X recently helped our family with a very difficult situation concerning our 12-year-old daughter. X went above and beyond her role and helped/advised us when nobody else would. The way she dealt with our daughter and the way she researched and offered advice was superb and I cannot express how much she helped us through a very difficult time. She was consistently professional, courteous, showed empathy and above all she cared. She is a CREDIT to Staffs Council and should be recognised for the work she does as she made ALL the difference to our situation. Thank you from the bottom of our hearts!!!!!!
- Just to let you know I was on the phone to a parent and before ending the conversation she told me how grateful she has been for the support she has received from X and Y. Given the fact we mostly tend to hear about things that do not go well, I thought we need to celebrate a compliment and to remind ourselves that we do a lot of good work. Her foster son has had a very unsettled time, but he is now somewhere where he really likes, and parents feel very positive about. X and Y worked really well together covering for each other when absent during the summer holidays and moving the case forward. I also spoke to another parent who was very grateful for the conversation and appreciated the significant pressure we are under as a service.
- X has been approachable, responsive, open, supportive, reliable, kind, proactive and an advocate for our fostering. This support is very much appreciated. She is truly a great asset to this important front-line team.

- Thank you so much for finding the time to respond to my e-mails, and I did note and appreciate that it was sometimes out of your working hours, and always quickly. Also, thank you for passing X EHCP agreed amendments on to process quickly due to the possible merging of processes - his review, the 'secondary school transfer review' and my 'preferred school' deadline. I've had the pleasure of working with her before during X's Statement/EHCP transfer, so I completely knew I was in safe hands! as we work easily and quickly together, providing we have coffee and chocolates. She's a credit to your team, and I hope you clone her soon!
- I want to thank you for your steadfast work, commitment and care. It's been refreshing to work with you. The support workers have nothing but praise for the service you have offered, and I would concur it has been exceptional. Please accept and record our comments as a compliment.
- I just wanted to pass on X's thanks and appreciation for the work that you and your team are doing with schools' admissions. He reflected positively on our admissions process. I hadn't appreciated that you keep the schools and academies informed on the levels of applications to their schools as the process develops, which allows them to target their social media advertising campaigns away from the over-subscribed schools and into those which are less popular. The result is that there is a higher level of first choice pupils than there might otherwise be, which is good for us, but more especially for the staff in the schools who have more focussed pupils in their classes.

## Intelligence Improvement and Development

- Very professional and appropriate management of a difficult and complex situation.
- Thanks to the chairperson. This is the first time we have had a more positive experience.
- Excellent diffusion of conflict, good negation skills. Well done.

## Annual Report Commentary from the Complaints Team

The data contained within this Annual Report shows that all feedback received has increased over this reporting year, aside from compliments and MP enquires which have only slightly reduced. The most significant increase is seen within the Stage 1 Corporate Complaints and the correspondence received from the LGSCO.

An increase in all categories of feedback has evidently resulted in an increased workload for the staff responding to the complaints and equally for the Complaints Team in processing and screening the feedback received. Whilst the timescales of responding to complaints has reduced compared to the previous reporting year, the Complaints Team will continue to support staff and strengthening the point that good communication needs to take place when complaints fall outside of timescale. A complaint is far more likely to escalate to the next stage if they feel they have not been listened to and as such allowing a complainant the opportunity to verbalise their concerns will benefit the investigation as it adds context to a written complaint and will undoubtedly result in the complainant being more understanding if an extension is to be given on the timescale.

Whilst this reporting year has still brought an increase in Stage 2 Independent Investigations; it has also seen various meetings take place between the complainant, a Senior Manager and the Complaints Team. These meetings are significantly important and have seen numerous Stage 2 Independent Investigations prevented. Whilst this clearly provides a valuable saving to the Local Authority financially, it also demonstrates the commitment of the service to working in partnership with complainants to resolve matters as soon as possible at a local level.

Learning from all complainants continues to be shared by senior management, demonstrating their dedication to disseminate this in the widest possible sense and ensuring that local level practitioners remain informed and aware of any significant matters. Staff are thanked for their commitment in accepting these recommendations and carrying these out as part of their day to day roles. The Complaints Team also remain committed to assisting in the learning from complaints by creating and

sharing reports, assisting with learning events and being approachable to discuss any queries with staff regarding the complaints processes.

The increase in correspondence from the LGSCO has resulted in additional work for all services involved and they are thanked for their assistance in meeting the strict timescales set by the LGSCO. It should be noted that there are numerous financial payments which the LGSCO have recommended this reporting year. The Complaints Team remain committed to working with the LGSCO to gain a better understanding of their decision-making process regarding financial remedies and this reporting year saw the first formal meeting take place between the Complaints Team and the LGSCO External Relationship Co-ordinator. It is hoped this meeting can be built upon and ultimately result in us having more knowledge surrounding the processes the LGSCO follow and how we can potentially raise any future queries.

There is noticeably a significant increase in Corporate Stage 1 Complaints and specifically for the SEND Service, where there is a 114% increase in comparison to their figures from the previous year. It is appreciated that the service is under intense pressure in terms of timescales and the low availability of Educational Psychologists. The Complaints Team wish to thank the staff within the service who have provided detailed responses to complaints and LGSCO investigations during this period. The Complaints Team are committed to supporting the service wherever possible and will continue to develop this working relationship during the following months.

Compliments for the Local Authority have only slightly decreased upon the previous year, however positive feedback should not be measured in this way as each individual compliment should be held in the highest possible regard. It is known just how valuable and appreciated each compliment is to staff members, who are working in areas which can be demanding and challenging. It should also be noted that senior managers are equally as thankful for each positive piece of feedback received and will celebrate the practitioner's achievements and congratulate them personally. During a time where staff have had to significantly adapt and alter their working patterns, positive feedback is appreciated more than ever and as such the Complaints Team would encourage all services to share this with us as it is felt that there may be feedback which has not been captured.

The Complaints Team continue to receive exceptional support from managers at all levels within the department and despite the ongoing pressures faced by all staff within the services, their cooperation and willingness to investigate and respond to complaints is routinely noted.

**Report Author:**
Elaine Hemming - Customer Feedback and Complaints Officer Children's Services
elaine.hemming@staffordshire.gov.uk

| Local Members Interest |
| --- |
| N/A |

# Safe and Strong Communities Select Committee - Wednesday 06 January 2021

# Customer Feedback and Complaints Service – Children and Families - Learning from Complaints

### Recommendation

I recommend that:

a. The Committee considers the additional document which is to be read in conjunction with the 2019/20 Complaints Annual Report for Children and Families Services, taking the opportunity for any comments on the content of the document.

**Report of Cllr Mark Sutton, Cabinet Member for Children and Young People**

## Summary

### What is the Select Committee being asked to do and why?

1. The Committee is being asked to consider the document which details how the service implements change as a result of complaints, taking the opportunity for any comments on the content.

## Report

### Background

2. The document has been created at the request of members of the Safe and Strong Communities Select Committee. The document provides specific detail into how change is implemented into the service as a result of complaints.

## List of Background Documents/Appendices:

Appendix 1 – Learning from Complaints – Children and Families Services

## Contact Details


**Assistant Director:** Tracy Thorley, Assistant Director for Corporate Operations

**Report Author:** Elaine Hemming
**Job Title:** Complaints Officer – Children and Families Services
**Telephone No.:** 01785 278601
**E-Mail Address:** elaine.hemming@staffordshire.gov.uk

# Addition to the Children and Families Services 19/20 Complaints Annual Report

## Introduction:

This report has been produced at the request of the members of the Safe and Strong Select Committee. Members have requested further specific detail is provided in terms of how the services implement change as a result of complaints investigations.

This document should be read in conjunction with the 2019/20 Complaints Annual Report, which provides detailed information surrounding the different complaints procedures and data which is pertinent to each service.

## The Basis of Learning from Complaints and How the Council Learn from Complaints:

The Complaints Process is a means through which to interrogate and improve how the Council deliver services, complaints should be used as an opportunity to assist with the development of shaping future services and should be instrumental in recognising the views of the individuals who are receiving services from the County Council. Complaints should not always be considered in a negative manner, as there can be valuable opportunities to utilise these and create more of a learning culture from them.

The Complaints Team firmly believe that services should maintain their focus on the outcomes of complaints rather than the volume of such. It is naturally the complaints which are upheld which provide the Council with the deeper understanding of how things can be adapted, to minimise the chance of future complaints being made.

Whilst the majority of learning comes from those complaints which are found to be upheld, there can of course be learning to be gained from any complaint regardless of the finding. A complaint represents an individual's perception and view of a situation, by investigating that view in greater depth the service can undoubtedly gain a richer understanding of the individual and use that knowledge in the work moving forwards.

Learning is taken from complaints where fault has been found, to try and reduce the risk of the situation occurring again. To implement any recommendations or learning from complaints the Council may make changes to policies, processes or training programmes, amend templates used or convene learning events where feedback can be provided.

## Specific Examples:

The following are examples of what the services have implemented as a result of complaints being investigated.

## Looked after Children and Disability Services:

- As a result of a complaint which surrounded the Family and Friends Fostering Team, the service is in the process of reviewing the information and training available for Special Guardians to ensure that it meets their specific need. This is already being progressed via the creation of the Special Guardian Pod, which aims to provide beneficial support to this group of people. The work which the Pod carries out will help to inform future planning for the service.

- As part of a complaint surrounding the Children's Disability Service, the Council agreed to review the support available to parent-carers of children and young people in transition, in collaboration with the appropriate local representative body. This was completed as part of the work surrounding the Preparing for Adult process and the service continues to review this to ensure it meets the outlined recommendation.

- The service agreed to explore the closer integration of children's and adult Direct Payment systems, as part of the strategic move towards a more integrated process of transition. This work has been completed with children moving onto the P Card System.

- Contingency arrangements were put in place for situations where it becomes likely that statutory visiting requirements cannot be met, and that any subsequent difficulties are referred to senior management. This was relayed to staff via email in the form of a memo.

- As part of a complaint surrounding the Throughcare service, the service agreed to ensure that any accommodation which it arranges for vulnerable users of its services is suitable, when this has not been refused by the individual, within the meaning of the relevant regulations.

- The service agreed to take time to explain to a young person how and for what purpose the Setting Up Home Grant is paid, in the interest of eliminating unrealistic expectations.

## Specialist Safeguarding and Early Help:

- Officers have been briefed with regards to the Council's policy concerning the use of recording devices in meetings – this was achieved via an amendment being made to a policy and being shared with staff. Whilst the specific complaint related to the Safeguarding Teams, the learning can be applied to the whole service.

- Staff were reminded via a memo sent through email, that in cases when a referral is made to Children's Services by the parent with whom the child resides and there is shared parental responsibility the other parent should be consulted and informed as soon as possible.

- As part of a complaint which related to the Independent Reviewing Officer (IRO) Service; the service agreed to clarify its position on the attendance of multiple representatives from a single agency at Child Protection Conferences. This was developed by the IRO service who have developed a process where the IRO will seek clarity regarding multiple professionals attending from the same service and will then make an informed decision as to whether this is needed.

- The local authority agreed to looking into into disability awareness training for all staff in the Safeguarding Team. Specifically building a knowledge of ASD and ADHD which may have enabled the social worker to engage with and support this child in a more effective way. This was implemented by disability training being written into the training programme for all newly appointed SWs and mandatory training for newly qualified social workers as part of the ASYE.

- The service was advised to review the inclusion of tick boxes in templates for social work reports, on the basis that they can require a misleadingly binary approach, rather than critical narratives which convey richer information. This recommendation was partially agreed on the basis that the tick boxes are required to collect data for the councils statutory return; however a memo was sent to remind staff that written assessments must evidence the reason for the inclusion of any ticked boxes ensuring that appropriate and factual information is included in the wider recording.

- The service accepted that thought should be given to additional training of workers in the Child Protection arena of the sensitivity and importance of initial visits in establishing a cooperative relationship with parents for the benefit of the children concerned and the family. Whilst it was noted that training in this regard should already be taking place, the service has agreed to ensure this was implemented into training for newly qualified Social Workers as part of their ASYE.

## Developing Learning from Complaints in the Future:

We have recently been reflecting on and exploring how we can share the key messages, themes and learning from complaints through other avenues and forums to ensure these are reaching as many practitioners as possible. Through recently attending the Practitioners Briefings and the Practice Forum and sharing the detail of learning from complaints, it has become apparent that we need to be sharing this detail in a more routine and accessible way to ensure it has the widest possible reach. The feedback received from these sessions was positive and practitioners are keen to understand the outcomes of complaints and what has changed as a result of these. It has become apparent that when information regarding changes is communicated via email, there may be some practitioners who miss this due to their demanding workload.

Whilst practitioners may be aware of certain policy changes as a result of a complaint being made, it has been noted that it may be beneficial for them to be aware of the reasoning behind those changes being made and for some context to be given. In line with the above development we are considering how best to inform and update practitioners on a regular basis and how we can ensure messages and key learning is shared. This may be through collating information for all services and sharing it on a quarterly or bi-annually basis with key practitioners and managers who can disseminate this or use it as part of their routine team meetings.

One of the key positive themes which came from these meetings was that learning needs to be shared across the whole service , just because a complaint related to one service does not mean that the learning cannot apply to other services. This is something which we can move forward with and ensure any learning is shared in a wider sense and not restricted to the individual service.

As part of the ongoing work noted above, we have also stressed that it is important to share the positive feedback, which is received, and this can equally inform and shape service provision. We are considering how to share they key themes from positive feedback; to enable practitioners to share their ways of working with each other and discuss their experience of working with the individual who submitted a compliment.

.

**Report Author:**

Elaine Hemming - Customer Feedback and Complaints Officer Children's Services
elaine.hemming@staffordshire.gov.uk

# Safe and Strong Communities Select Committee

# Wednesday 6th January 2021

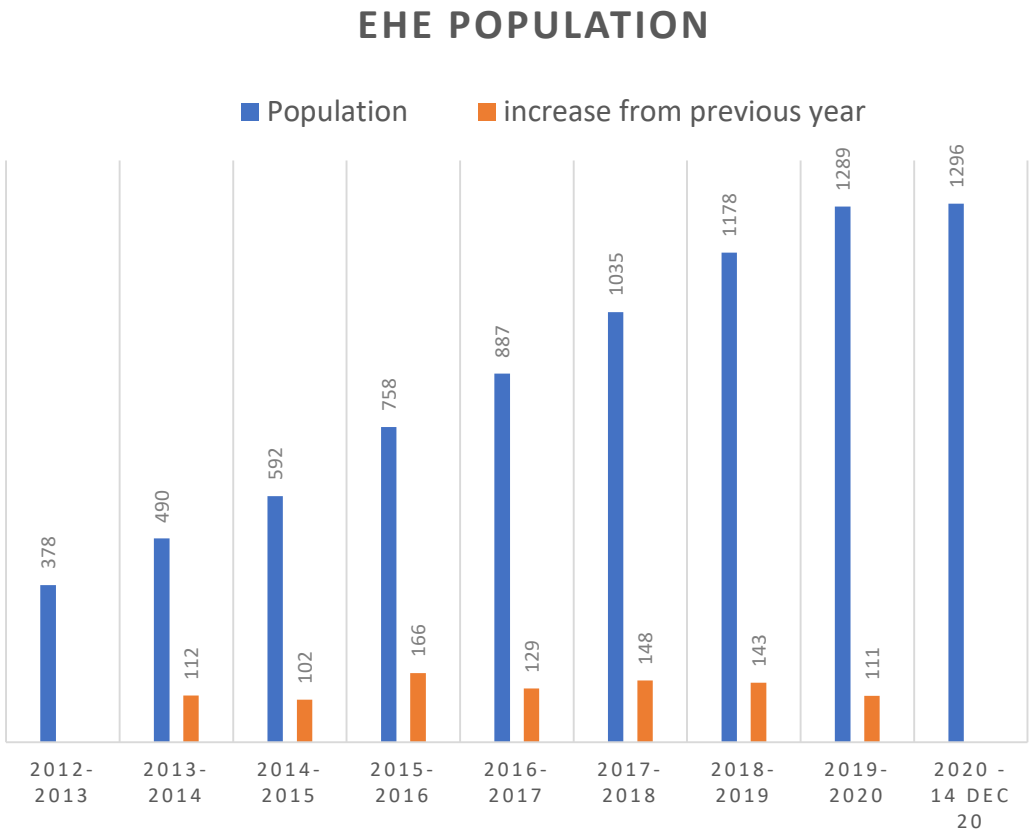
# Elective Home Education (EHE)

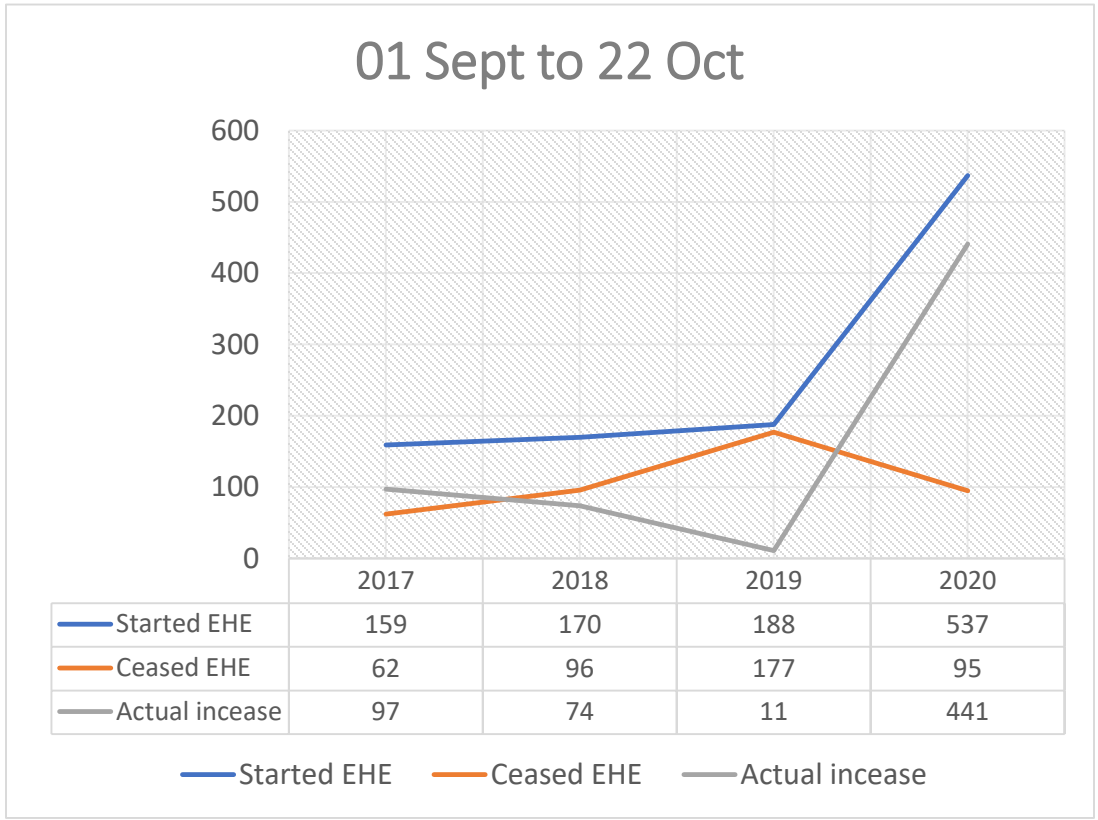




Author: Karl Hobson – Head of Targeted Education Services

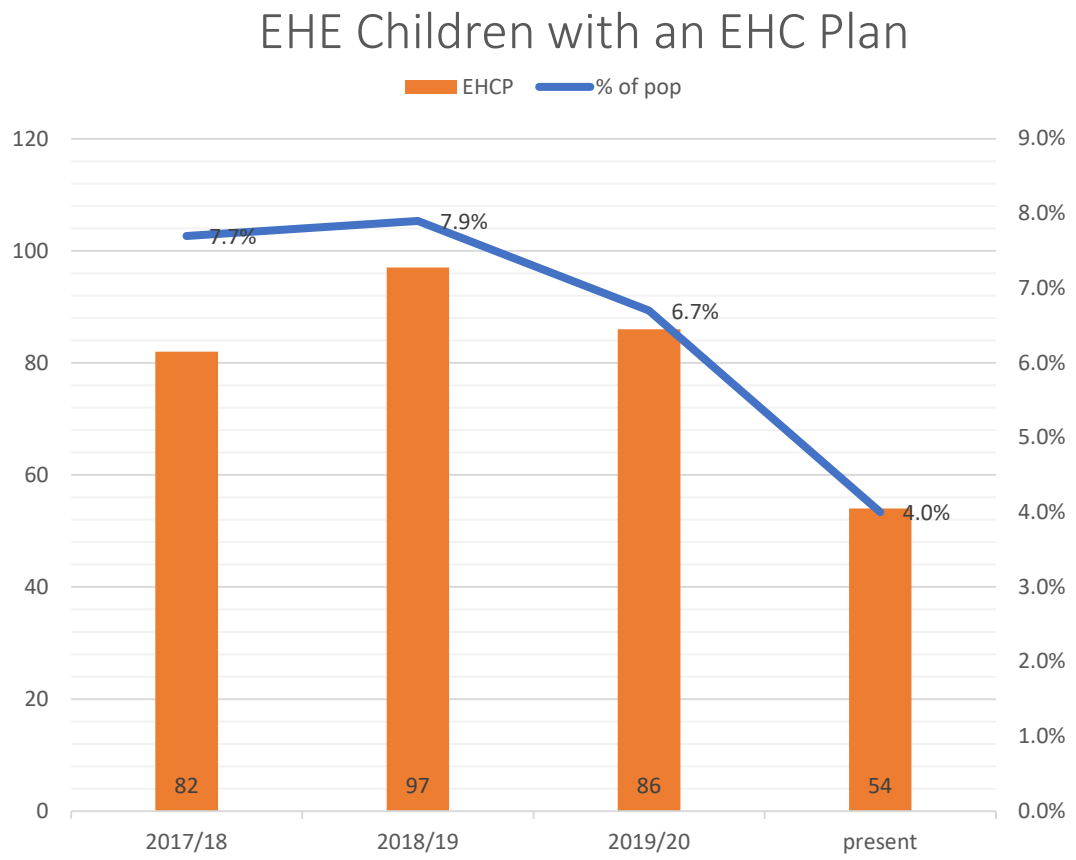
The total number of children and young people in Elective Home Education (EHE) has increased to 1296 in the current year. This is an increase to date of  537 new EHE students, in the same period last year this figure was 188.

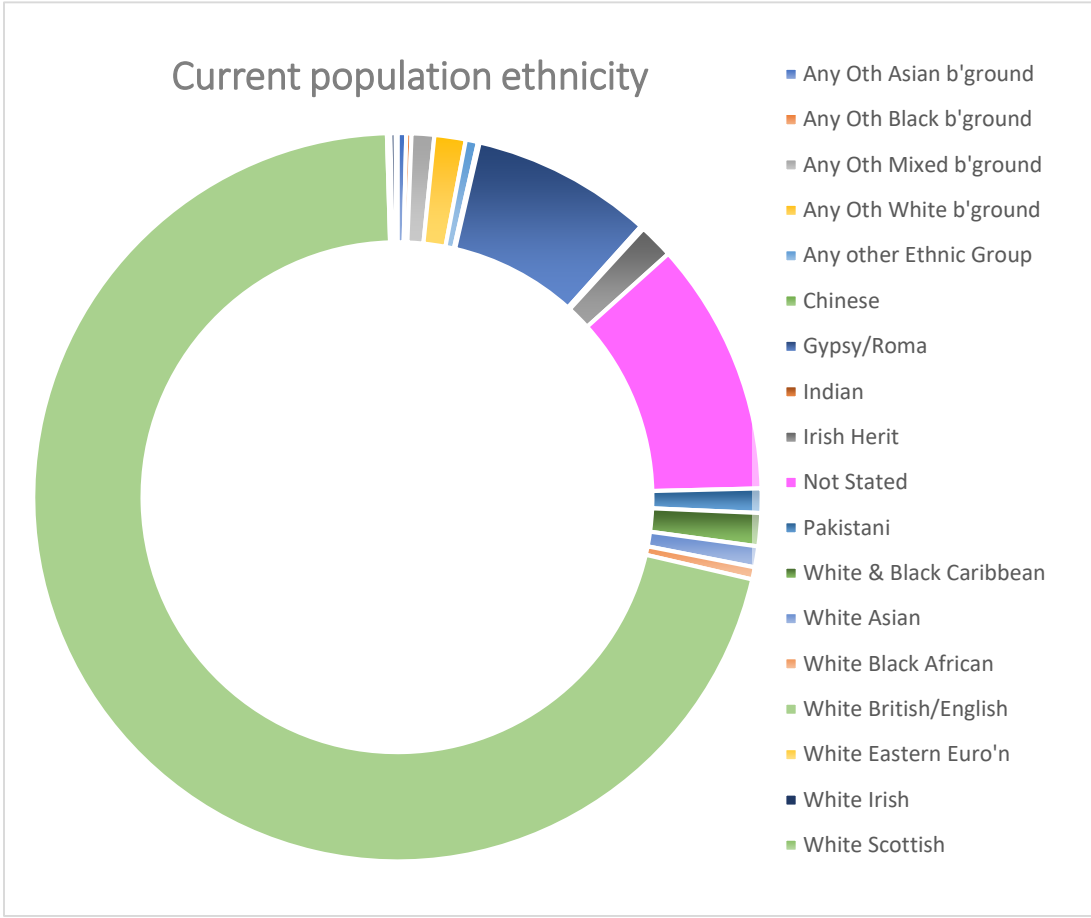


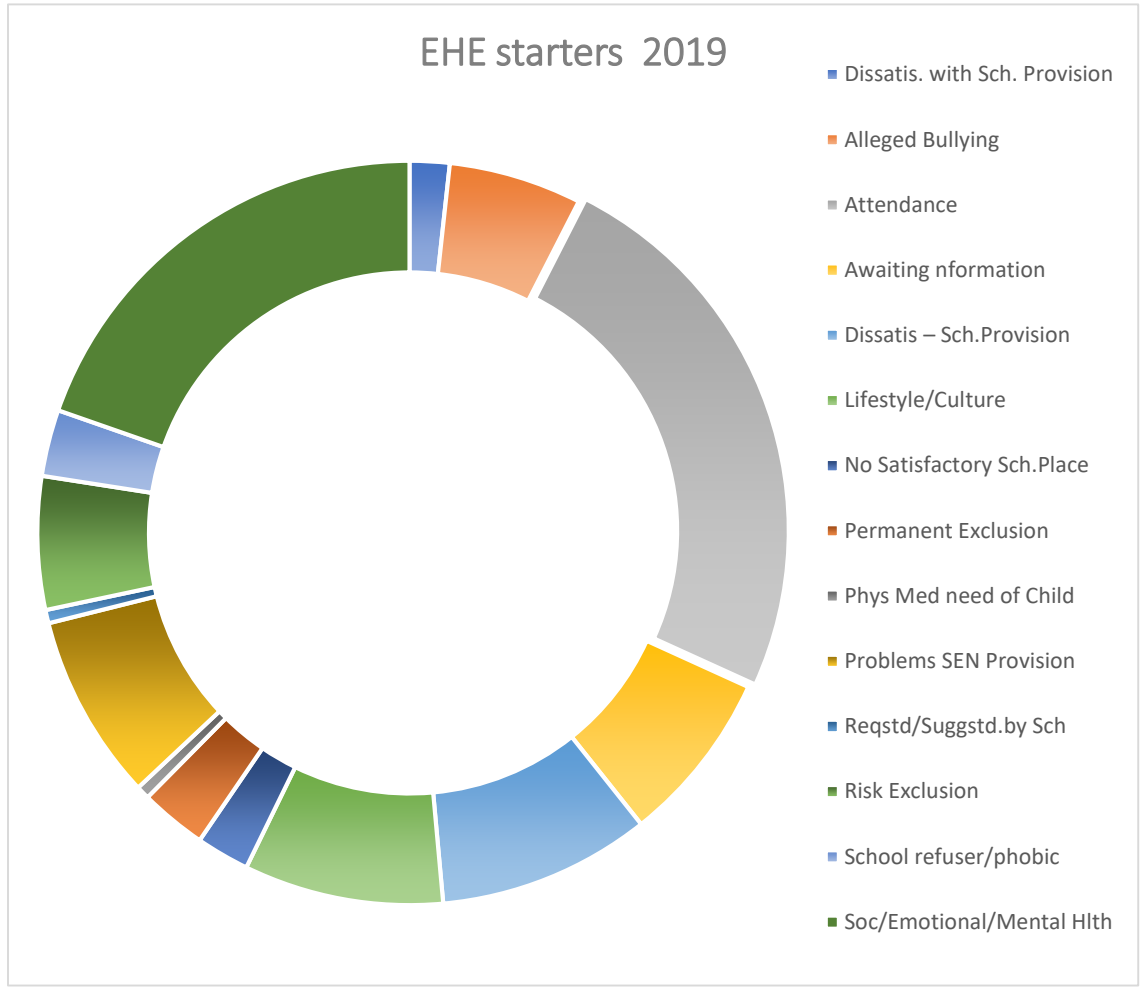
The proportion of children with an EHCP who are EHE experienced a slight decrease last year, currently  this year we have 54 children with an EHCP.

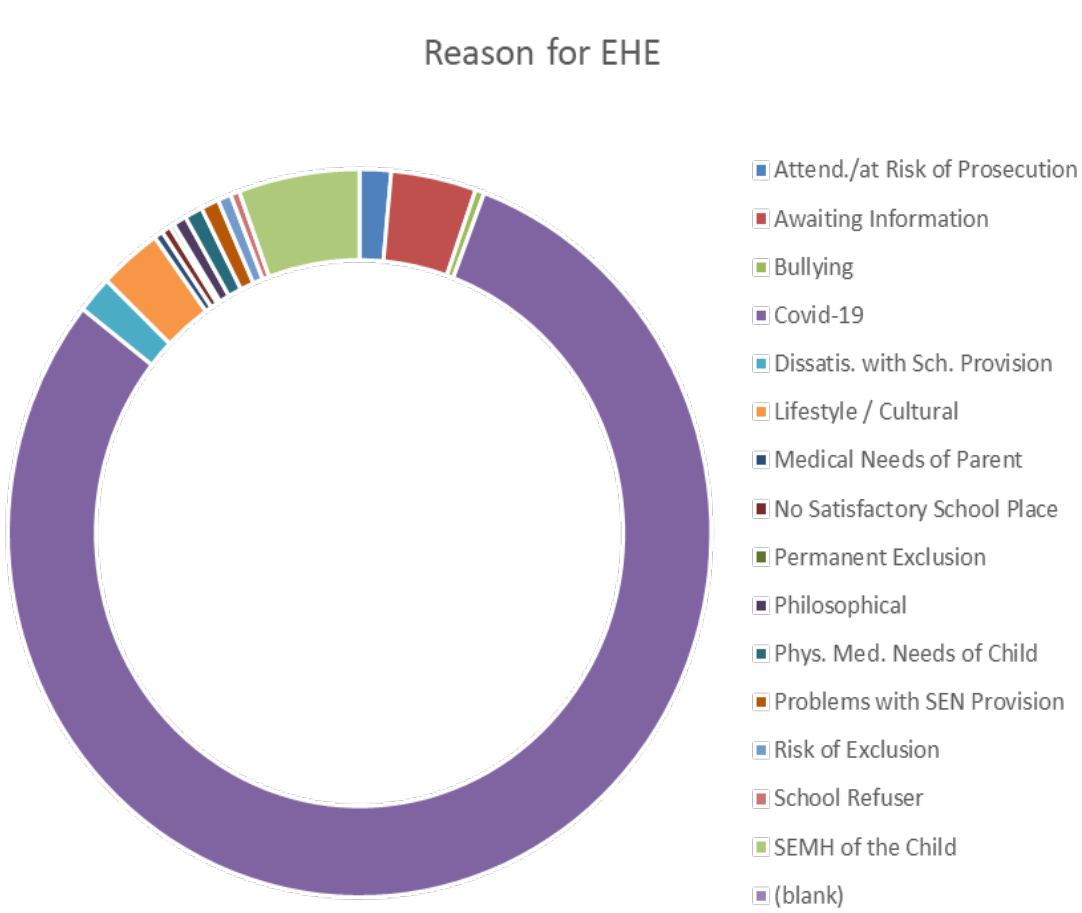
The majority of EHE children (71%) identify themselves as white British/English, with 11% choosing not to express a definition and 8 % identified at Gypsy Roma Traveller heritage.



In 2020 of the parents starting EHE 80% are saying they have chosen to do so due to the Covid 19 pandemic. In comparison during the same period in 2019 the highest reasons given for choosing EHE were attendance issues, followed by Social, emotional, mental health issues.



# EHE population vulnerability indicators

**Current whole population**

- 0 currently looked after by LA
- 8 Previously looked after by LA
- 6 on child protection plan
- 24 Currently Child in need (CIN)
- 18 previously known to Youth Offending Service
- 54 with an EHCP

- 315 cases categorised as a concern (education or welfare)

**01/09/20 – 22/10/20 starters**

- 0 currently Looked after by LA
- 3 previously Looked after by LA
- 4 on child protection plan
- 7 Currently Child in Need (CIN)
- 0 previously known to Youth Offending Service
- 31 receiving Early Help Support
- 8 with an EHCP
- 29 cases categorised as a concern (education or welfare) .

# Local and National Picture

- 3 new staff within EHE service
- Additional resources to cope with Covid increase
- Draft EHE policy to be shared with EHE parents.
- Use of school attendance orders has increased, but only used when parents have not demonstrated satisfactory education provision or progress.

- National increase in parents choosing to EHE due to Covid 19
- Survey completed for Commons Education Select Committee about EHE on 06.11.2020 and oral evidence sessions took place during November
- The DfE “Out of school consultation” report is due out in January 2021
- April 2019 saw the New DFE guidance for LA’s and parents
- DfE are stating they remain committed to registration system

| Local Members Interest |
| --- |
| N/A |

# Safe and Strong Select Committee - Wednesday 06 January 2021

# Staffordshire and Stoke on Trent Adult Safeguarding Partnership Board Annual Report 2019/20

### Recommendations

The Safe and Strong Select Committee is asked to:

a. Receive the SSASPB Annual Report in accordance with the requirements of the Care Act 2014 Statutory Guidance

b. Provide feedback and challenge to the work of the SSASPB

**Report of Cllr Johnny McMahon, Cabinet Member for Health, Care and Wellbeing**

## Summary

### What is the Select Committee being asked to do and why?

1. What: To scrutinise the work of the Staffordshire and Stoke on Trent Adult Safeguarding Partnership Board (SSASPB), and to consider or comment on the progress that the Board has made since the last report.

2. Why: In order to comply with the requirements of the Care Act 2014 Statutory Guidance (Chapter 14, Paragraph 160) which states that the SSASPB must send its Annual Report to a number of bodies including the relevant overview and scrutiny committee meeting of the Local Authority.

## Report

### Background

3. Safeguarding Adult Boards (SABs) became statutory under the Care Act 2014 which states that the main objective of a SAB is to assure itself that local safeguarding arrangements and partners act to help and protect adults in its area who:

    a. Have needs for care and support
    b. Are experiencing or at risk of abuse and neglect; and
    c. As a result of those care and support needs are unable to protect themselves from either the risk of, or the experience of abuse and neglect.

4. The SAB has a strategic role to oversee and lead adult safeguarding and is interested in a range of matters that contribute to the prevention of abuse and

neglect. These include the safety of patients in local health services, quality of local care and support services, effectiveness of prisons and approved premises in safeguarding offenders and awareness and responsiveness of further education services. SAB partners also have a role in challenging each other and other organisations where there is cause for concern that actions or inactions are increasing the risk of abuse or neglect.

5. The SAB has 3 core duties:

    a. To publish a strategic plan
    b. To publish an Annual Report
    c. To undertake Safeguarding Adult Reviews in accordance with criteria

6. This Annual Report of the Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board (SSASPB) covers the period 1st April 2019 to March 31st, 2020. Mr John Wood was the Independent Chair of the Board throughout the period. The report provides an overview of the work of the Board and its sub-groups and illustrated with case studies as to how the focus on Making Safeguarding Personal is making a positive difference to ensuring that adults with care and support needs are supported to make choices in how they will live their lives in a place where they feel safe, secure and free from abuse.

7. Adult Safeguarding Data: Staffordshire headlines for the reporting period 1st April 2019 to 31st March 2020:

8. The safeguarding partners have established and widely publicised the procedures for reporting concerns that an adult with care and support needs may be experiencing or is at risk of abuse or neglect and unable to protect themselves. Reported concerns can progress to a formal enquiry under Section 42 of the Care Act 2014, if the duty of enquiry requirements are met.

    a. **Concerns reported:** There have been 4150 occasions where concerns have been reported that adults with care and support needs may be at risk of abuse and neglect. The numbers have increased by 439 (11%) occasions compared to 2018/19. This increase is reflective of the national figure of 8.7%. Following initial assessment it was determined that the duty of enquiry requirement was met in 93% of concerns. This conversion rate varies considerably throughout the Country and is dependant upon how Local Authorities record and report safeguarding concerns and Section 42 enquiries. The national data shows that the number of Section 42 enquiries that concluded during the year increased by 8.7%.
    b. **Age:** Of the people subject of a Section 42 enquiry, those aged 75-84 and 85-94 (both 27%) represent the largest cohort, followed by 65-74 (12.5%). When comparing the breakdown of the general population of Staffordshire it is seen that adults over 65 are disproportionately over-represented in Section 42 enquiries.
    c. **Gender:** Females represent the majority of adults subject of a Section 42 enquiry, with 62% of the total. This has been a consistent proportion in Staffordshire in recent years.

d. **Ethnicity:** The majority of adults involved in a Section 42 enquiry are White (88.6%). Other categories of ethnicity (other than white) are below 1%, however 7.6 % of records do not have the ethnic background of the adult recorded.
e. **Primary Support Reason:** Physical support continues to be the most common primary support reason (49%) a decrease on the 61% reported in 2018/19. The second most prevalent was Learning Disability at 12% followed by Mental Ill-Health at 12%.
f. **Type of Abuse:** Neglect and Acts of Omission (35%), Physical Harm (22%) and Financial Abuse (18%) continue to be the three most prevalent types of harm and abuse. Nationally, the most common type of risk in Section 42 enquiries that concluded in the year was also Neglect or Acts of Omission, which accounted for 31.4%.
g. **Location of Abuse:** 49% of recorded concerns were at the adults' home, this is slightly higher than the national average which is 44.8%. Caution must be taken in this interpretation as those recording the location may interpret care/nursing homes as an adult's own home. 21% were recorded as in a residential home and 16% in a nursing home.
h. **Expressed Outcomes met:** The proportion of people subject of a Section 42 enquiry whose outcome was fully met reached 88%, an increase on 80% in 2018/19. A further 10% stated that their outcome was partially met. These figures are the same as the national average and is the best indicator from which to identify that Local Authorities are completing safeguarding enquiries in line with national policies and Making Safeguarding Personal.

9. It is of note that the report year ended with adult safeguarding in the spotlight as the United Kingdom went into lockdown in the final week of March 2020 due to the spread of the new coronavirus, COVID-19. Care homes and adults with care and support needs who were not visible, or unable to receive their usual support, were of huge concern.

10. The response to the safeguarding aspects including care of adults at risk, 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 abuse reached national consciousness. The impacts of these lived experiences will be reported in 2020/21.

**Link to Strategic Plan**

11. The assurance role of the Board supports the following Staffordshire County Council strategic priorities:

    a. Be healthier and more independent
    b. Feel safer, happier and more supported in and by their community

**Link to Other Overview and Scrutiny Activity**

12. The Deprivation of Liberty Safeguards (DoLS)

**Community Impact**

13. There is no anticipated community impact.

## List of Background Documents/Appendices:

Appendix 1: Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board (SSASPB) Annual Report 2019/20

## Contact Details


**Assistant Director:** Jo Cowcher, Assistant Director for Adult Social Work and Safeguarding

**Report Author:** Mr John Wood
**Job Title:** Independent Chair SSASPB
**Telephone No.:** Via 07971063465
**E-Mail Address:** john.wood1@staffordshire.gov.uk

Staffordshire and Stoke-on-Trent
Adult Safeguarding Partnership Board

**Abuse must stop**

# SSASPB Annual report 2019-2020

NHS

City of Stoke-on-Trent

Staffordshire County Council

Staffordshire Police

## 1. CONTENTS



**'If you suspect that an adult with care and support needs is being abused or neglected, don't wait for someone else to do something about it'.**

**Adult living in Stoke-on-Trent – Telephone: 0800 561 0015**

**Adult living in Staffordshire – Telephone: 0345 604 2719**

**Further information about the Safeguarding Adult Board and its partners can be found at:**
**www.ssaspb.org.uk**

Front cover includes photographs of Staffordshire and Stoke-on-Trent, from largest to smallest: Hanley Park in Stoke-on-Trent, Bridge over the river Trent in Burton-on-Trent, Cannock Chase Stepping Stones.

## 2. INDEPENDENT CHAIR FOREWORD

It is my privilege as Independent Chair to write the foreword to this Annual Report of the Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board.

As the Independent Chair, my role is to lead collaboratively, give advice, support and encouragement but also to offer constructive challenge and hold main partner agencies to account. I also ensure that interfaces with other strategic functions are effective. As an Independent Chair, I can provide additional assurance that the Board has some independence from the local authorities and connected partners.

This report provides a look back at the work by the partners of the Board and its sub-groups over the year 2019/20. The range of work includes broad and targeted community engagement to raise awareness of the importance of safeguarding as well as requirements to record, report on and respond to individual safeguarding experiences and importantly to identify the learning and required action when things go wrong.

This work is illustrated with case studies (pages 16-21) as to how the focus on Making Safeguarding Personal is making a positive difference to ensuring that adults with care and support needs are supported to make choices in how they will live their lives in a place where they feel safe, secure and free from abuse and neglect which is a fundamental right of every person.

The year ended with adult safeguarding in the spotlight as the United Kingdom went into lockdown in the final week of March 2020 due to the spread of the new coronavirus, COVID-19. Care homes and adults with care and support needs who were not visible, or unable to receive their usual support, were of huge concern.

The response to the safeguarding aspects including care of adults at risk, 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 abuse reached national consciousness. The impacts of these lived experiences will be reported in 2020/21.

As the Board has matured, the openness and willingness to both challenge and be challenged to provide assurances as to the effectiveness or services or where improvements are required has continued to develop. That culture is vital if we are to remain effective in continuing to meet our statutory responsibilities and the Board collectively recognises that it is vitally important that our safeguarding services are as good as they can be to meet the needs of some very vulnerable adults needing support to help keep them safe from harm.

At the time of writing this foreword, the Board has adapted its approaches to seeking assurances and acted as an important conduit for communicating relevant targeted information recognising that Local Resilience Forums are co-ordinating and driving pandemic responses. The declared pandemic has underlined just how important adult safeguarding is - more than at any time since the Care Act was enacted.

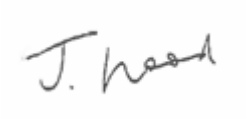
I would again like to take this opportunity to acknowledge the commitment and enthusiasm of all of our partners and supporters including the statutory, independent and voluntary community sector who have a clear focus on doing their best for those adults whom we are here to protect in these most challenging of times and consistently demonstrate a strong commitment to do that. I also add thanks to the inspectors

from the Care Quality Commission with whom safeguarding partners have developed constructive working relationships through established channels of communication and early intervention.

I am immensely grateful to all who chair the Board Sub-Groups as well as the Board Manager Helen Jones and the Board Administrator Rosie Simpson who work so hard behind the scenes to ensure that our business programme works efficiently.

I conclude this foreword by offering, on behalf of the Board partners, our condolences to all those who lost loved ones in social care settings, hospitals, secure institutions, 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.

John Wood QPM



## 3. ABOUT THE STAFFORDSHIRE AND STOKE-ON-TRENT ADULT SAFEGUARDING PARTNERSHIP BOARD (SSASPB)

The Care Act 2014[1] provides the statutory requirements for adult safeguarding. It places a duty on each Local Authority to establish a Safeguarding Adult Board (SAB) and specifies the responsibilities of the Local Authority and connected partners with whom they work, to protect adults at risk of abuse or neglect.

The main objective of a Safeguarding Adult Board, in this case the Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board (SSASPB) is to help and protect adults in its area by co-ordinating and ensuring the effectiveness of what each of its members does. The Board's role is to assure itself that safeguarding partners act to help and protect adults who:

- have needs for care and support
- are experiencing or at risk of abuse or neglect; and
- as a result of those care and support needs are unable to protect themselves from either the risk of, or the experience of abuse or neglect.

A Safeguarding Adult Board has three primary functions:

- It must publish a Strategic Plan that sets out its objectives and how these will be achieved
- It must publish an Annual Report detailing what the Board has done during the year to achieve its objectives and what each member has done to implement the strategy as well as detailing the findings of any Safeguarding Adult Reviews or any on-going reviews
- It must conduct a Safeguarding Adult Review where the threshold criteria have been met.

**Composition of the Board**

The Board has a broad membership[2] of partners in Staffordshire and Stoke-on-Trent and is chaired by an Independent Chair appointed by Staffordshire County Council and Stoke-on-Trent City Council in conjunction with Board members.

The Board membership is shown at Appendix 1, page 38.

The Board is dependent on the performance of agencies with a safeguarding remit for meeting its objectives. The strategic partnerships with which the Board is required to agree responsibilities and reporting relationships to ensure collaborative action are shown in the Governance Structure at Appendix 2, page 29.

**Safeguarding Adults – A Description of What It Is**

The statutory guidance[3] for the Care Act 2014 describes adult safeguarding as:

*"Protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time, making sure that the adult's wellbeing is promoted including where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action. This must recognise that adults sometimes have*

[1] Care Act 2014: http://www.legislation.gov.uk/ukpga/2014/23/contents
[2] SSASPB Board membership list: https://www.ssaspb.org.uk/About-us/Board-Agency-Membership.aspx
[3] Care and support statutory guidance: https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

*complex interpersonal relationships and may be ambivalent, unclear or unrealistic about their personal circumstances".*

Abuse and neglect can take many forms. The various categories as described in the Care Act are shown at Appendix 3, page 40. The Board has taken account of the statutory guidance in determining the following vision.

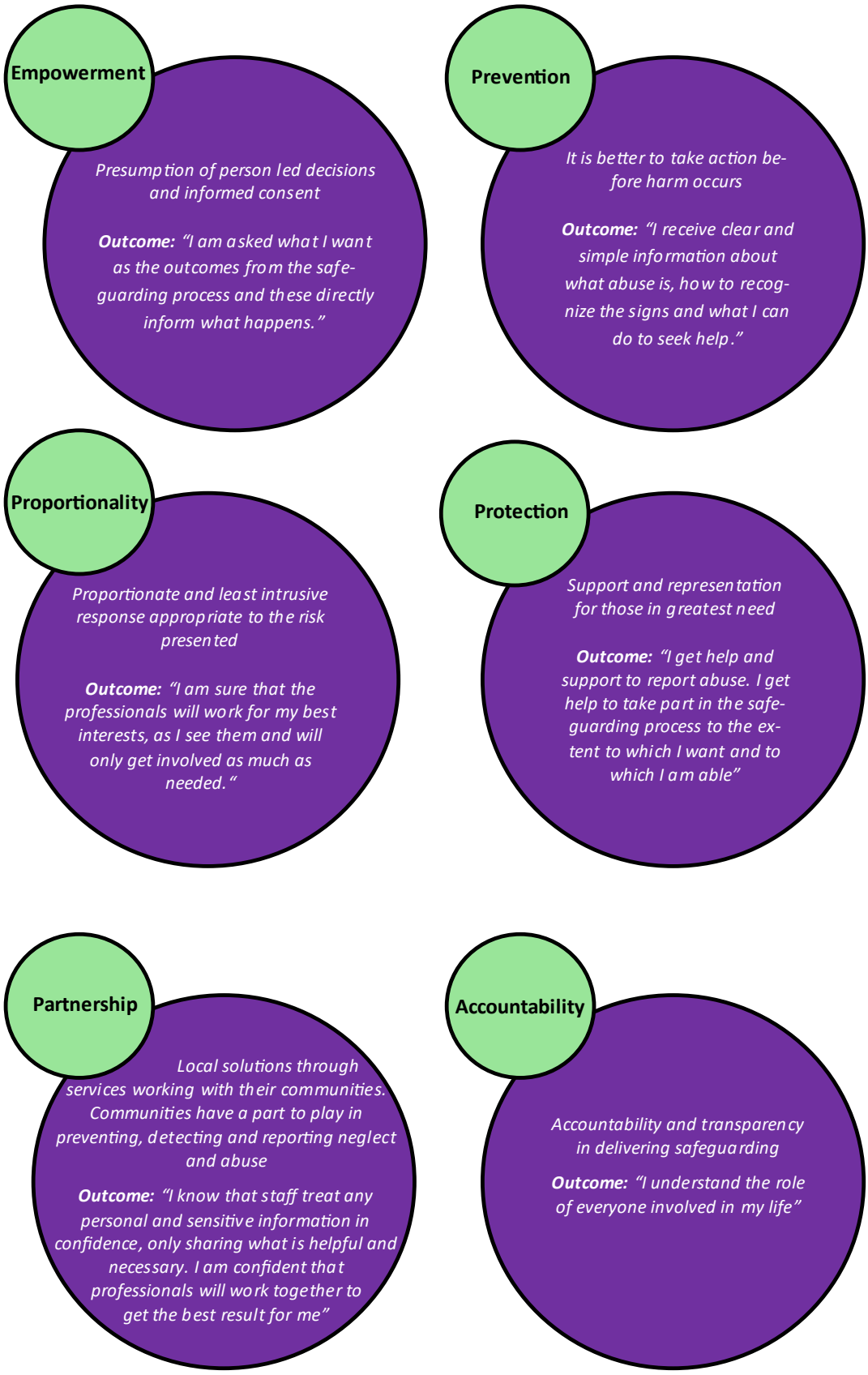
**Vision for Safeguarding in Staffordshire and Stoke-on-Trent**

'Adults with care and support needs are supported to make choices in how they will live their lives in a place where they feel safe, secure and free from abuse and neglect.'

Our vision recognises that safeguarding adults is about the development of a culture that promotes good practice and continuous improvement within services, raises public awareness that safeguarding is everyone's responsibility, responds effectively and swiftly when abuse or neglect has been alleged or occurs, seeks to learn when things have gone wrong, is sensitive to the issues of cultural diversity and puts the person at the centre of planning to meet support needs to ensure they are safe in their homes and communities.

## 4. SAFEGUARDING PRINCIPLES

The Department of Health (DoH) set out the Government's statement of principles for developing and assessing the effectiveness of their local adult safeguarding arrangements and in broad terms, the desired outcomes for adult safeguarding for both individuals and agencies. These principles are used by the Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board and partner agencies with safeguarding responsibilities to benchmark their adult safeguarding arrangements.



## 5. WHAT WE HAVE DONE

This section outlines the work done in partnership during the year to help and protect adults at risk of abuse and neglect in our area. It also highlights some of the key challenges that have been encountered and consequent actions.

**Executive sub-group**

**Chair: Kim Gunn, Designated Nurse for Adult Safeguarding North Staffordshire and Stoke-on-Trent Clinical Commissioning Groups**

**Vice Chair: Lisa Bates, Designated Nurse for Adult Safeguarding, South Staffordshire Clinical Commissioning Groups**

The Executive sub- group has responsibility for monitoring the progress of all sub-groups as well as its own work-streams. The core work of the Executive sub-group includes receiving and considering regular updates of activity and progress from sub-groups against their Business Plans; it ensures that the core functions of the Board's Constitution are undertaken and that the Strategic Priorities of the Board are delivered. The Executive membership is made up of the Chairs of the six sub-groups, Officers to the Board, the Board Manager and the Board Independent Chair.

**During 2019/20 the sub-group has:**

- Monitored the progress against the three Strategic Priorities (Leadership in the Independent Care Sector, Financial and Material Abuse and Engagement)
- Monitored the activity towards mitigation of risk using the SSASPB Risk Register
- Reviewed the membership of the Board and managed the Board membership process
- Reviewed the sub-group chairs in accordance with the SSASPB Constitution
- Managed and monitored the SSASPB budget
- Planned, organised and facilitated the Board Development Day held in June 2019 and the follow-on actions
- Reviewed the Strategic Plan
- Received updates from both Local Authorities regarding Large Scale Enquiries (LSEs) and Deprivation of Liberty Safeguards (DoLS) authorisation backlogs
- Approved final drafts of SSASPB documents
- Reviewed the SSASPB Constitution
- Overseen the arrangements for the SSASPB Safeguarding Conference held on 4th November 2019. The conference speakers and content were designed to enhance the skills of practitioners
- Determined how the Board links with other strategic fora e.g. Prevent, Domestic Abuse
- Agreed partner funding contributions for the period April 2020 to March 2023
- Arising from review of SSASPB budget enabled surplus financial contributions received in 2019/20 to be returned to funding partners to be used to support operational Adult Safeguarding responsibilities
- Sought and received assurance that Private hospitals in Stoke-on-Trent and Staffordshire are engaged with their partner organisations and CQC

- Reviewed the activity and achievements of Dr Lorna McColl for the Designated Adult Safeguarding GP initiative.
- Sought assurance on the response from Staffordshire Police to the Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) publication 'The Poor Relation'
- Monitored the progress of all Safeguarding Adult Review referrals received in 2019/20

**Safeguarding Adult Reviews sub-group**

**Chair: Simon Brownsword, Detective Superintendent Staffordshire Police**

**Vice Chair: Lisa Bates, Designated Nurse Adult Safeguarding South Staffordshire Clinical Commissioning Groups**

The Safeguarding Adult Reviews (SAR) sub-group has responsibility for ensuring that the SAR protocol is revised at least annually and that any SAR referrals comply with the process. The sub-group also has responsibility for identifying and cascading the lessons learnt from any reviews.

During 2019/20 there were 5 referrals considered for a Safeguarding Adult Review.

**'James'**

In March 2019 a referral was received outlining the circumstances around the death of 'James' a 28 years old man from Stoke-on-Trent who had been rough sleeping in the City centre. James was involved with numerous agencies including Probation, Police, Children Services, HM Prison services, Voluntary Sector services, a Mental Health Trust, Housing, Community drug and alcohol services and an acute Hospital.

Relevant organisations were asked to complete a detailed chronology of their involvement with James in the 10 months prior to his death. The information was considered at a SAR scoping meeting held in June 2019. A total of twelve agencies submitted chronologies and information; an indication of James's complex circumstances.

After careful consideration of the information shared it was unanimously agreed that the criteria for a SAR was not met. However, the process highlighted the need for a better understanding of the gateway for confidential information sharing between two of the organisations. It also identified a learning point that there is a need for documentation to clearly support the rationale for decisions made.

**'Andrew'**

A referral was received on 9th September 2019 in relation to the death of a 37 years old man from the Stoke-on-Trent area. He had complex needs and sadly died at home alone lying undiscovered for several days. A scoping meeting was held on 17th December 2019 which resulted in a recommendation to the SSASPB Independent Chair that the Section 44(1) Care Act 2014 criteria had been met. The recommendation was approved. The findings of the review will be provided in the Annual Report 2020/2021.

**'Paul'**

On 24th September 2019 a referral was received outlining the death of Paul a 52 years old man from Staffordshire who had lived with an acquired brain injury for some years. He had also become dependent upon alcohol. There were concerns about the length of time taken between the request for a care package,

predominantly to address his alcohol consumption, and for it to be put in place. Sadly, Paul died before the package had been arranged. The matters at issue were between two organisations and a Serious Incident Clinical Review (SI) had been conducted. The action plan had been shared with the SAR sub-group. It was agreed that the criteria for a SAR would not be met and that the learning had been achieved through the SI process.

**'Brenda'**

On 26th September 2019 a referral was received outlining the circumstances of the death of Brenda an 87 years old woman from Staffordshire who died at her home address following a period of ill health. The Independent Chair agreed with the recommendation made by the scoping panel held on 2nd December 2019 that the criteria for a SAR under Section 44(1) Care Act had been met. A Safeguarding Adult Review has started but has been pended during the Coronavirus/COVID-19 pandemic. At the time of writing, it is planned that the review will recommence in June 2020. The findings will be reported in the next annual report.

**'Joan'**

A referral was sent to the SSASPB on 8th November 2019. At the time of writing the referral has not yet been scoped as there is an ongoing criminal investigation and dependent upon the outcome the question of a Domestic Homicide Review. Whilst these parallel investigations take place information sharing outside the Police led investigation will not take place. A decision by the Crown Prosecution Service is awaited and an update will be given in the Annual Report 2020/21.

**Other SAR sub-group activity -** In addition to the management of SAR processes the sub-group has:

- Engaged with the Safeguarding Adult Board Managers National and Regional Networks to share good practice developed by other SABs
- Reviewed the SAR protocol to ensure continuous improvement and consistency with Regional SAR procedures
- Maintained links and reporting relationships with Community Safety Partnerships that are managing Domestic Homicide Reviews (where they involve adults with care and support needs)
- Attended specific Safeguarding Adult Review training delivered by Social Care Institute of Excellence in September 2019
- Clarified the relationship between Section 76 Homelessness Act 2018 and SAR processes. The circumstances of each homeless person will be considered against the Care Act 2014 criteria
- Reviewed the process to select Independent SAR reviewers

**Audit and Assurance sub-group**

**Chair: Sharon Conlon, Head of Strategic Safeguarding, Midlands Partnership Foundation Trust**

**Vice Chair: Claire Histead, Deputy Head of Safeguarding / PREVENT Lead, Midlands Partnership Foundation Trust to 28.08.19 followed by Amy Davidson Head of Safeguarding, North Staffordshire Combined Healthcare Trust to present.**

**The SSASPB 4-tiered audit framework:**

Below is an illustration of the audit framework which is referred to in the sub-group activity below


- Revised the terms of reference to incorporate elements transferred from the Learning and Development sub-group.
- Refreshed the SSASPB Performance and Quality Assurance Framework.
- Provided the detailed narrative from relevant partners to explain the performance data contained in the Annual Report
- Conducted the Tier 1 audit (Compliance with the SSASPB Constitution)
- Reviewed the list of partners from whom the Board seeks assurance about the compliance rate and quality of training provided using the Tier 2 audit
- Conducted the Tier 2 audit (Individual Agency Assurance self-audit) and received an excellent response with 27 returns
- Preparations were made for the Tier 2 peer review to take place in March 2020. This has been postponed to November 2020 and will be conducted in a revised format due to the COVID-19 pandemic
- The standards chosen for closer scrutiny through the audit were Standard 1(11): 'The organisation can demonstrate that it has a quality auditing system that checks policy compliance and the learning informs practice, performance and policies', and the whole of section 4: 'Training and Workforce Development'. The full list of Tier 2 standards is shown in appendix 4. The findings will be reported in the 2020/21 Annual Report
- Agreed the themes for and held three Tier 3 Multi-agency Case File Audits. These were on the themes of: Repeat referrals for the same category of abuse within 12 months, Neglect and Acts of Omission and Financial Abuse
- Agreed to support the West Midlands Regional data set collection. This will be progressed during 2020

## Prevention and Engagement

**Chair: Jo Sutherland, Statutory Service Lead and Principal Social Worker Staffordshire County Council**

**Vice Chair: Sarah Totten, Strategic Manager – Early Intervention, Contact and Hospital Adult Social Care, Health Integration and Well Being, Stoke-on-Trent City Council**

This sub-group was formed after a review of the structure of the SSASPB at its Development Day held in May 2018. One of its key functions is to drive the work in support of the Engagement Strategic Priority. It had been agreed that the sub-group initially concentrates on the Engagement element with a commitment to develop a Prevention focussed workstream in the autumn of 2020.

More information can be found on Page 14 in the Strategic Priority section.

## Policies and Procedures sub-group - Virtual

**Chair: Ruth Martin, Adult Safeguarding Team Leader, Staffordshire County Council**

**Vice Chair: Jackie Bloxham, Adult Safeguarding Team Manager, Stoke-on-Trent City Council**

In response to the recommendations from the Development Day held on 18th May 2018, the sub-group now works virtually. A contact list is held of partner agency staff who are well placed to assist with the production and review of policies, procedures, promotional material and guidance. The work is ongoing throughout the year and a record is kept of the documents which need to be reviewed together with the date this took place.

Although this group works virtually most of the time there is no less importance to its status within the structure of the SSASPB and it plays a vital role in ensuring that the Board documents are up to date and support interagency working.

The Policies and procedures sub-group have reviewed the below documents;

- Information sharing Guidance for practitioners document
- Considered the self-neglect guidance and what should be added to the SSASPB website
- The Escalation Policy
- Staffordshire Fire and Rescue Service's Safeguarding flowchart was considered for inclusion on the SSASPB website
- Safeguarding Enquiry Procedures initially reviewed virtually and met on the 19th January 2020 in person
- Considered and advised on the selection of photos for new SSASPB banners
- The Adult Sexual Exploitation content for the SSASPB website

## 6. BOARD DEVELOPMENT AND IMPROVEMENT ACTIVITY

The SSASPB Development Day was held on 7th June 2019 and attended by 24 Board members. The purpose of the day was for members to reflect on the responsibilities of the Board and what it is seeking to achieve with a constructive challenge as to its effectiveness.

The agenda included:

**Update on actions from the previous Development Day in May 2018**

- Review of Board member induction arrangements
- Shared understanding of the difference between safeguarding and quality of care concerns
- Member awareness of the role and relevance of the Board and associated accountabilities
- Review and refresh of the Strategic Plan
- Review of the membership and structure of the Board

**Roles and responsibilities of Board members**

- Examining what the Board is seeking to achieve; its aspirations and how it demonstrates effectiveness

**Safeguarding in practice**

- Considered the questions - are safeguarding partners sufficiently challenging of each other? Is the Board given early warning of systemic safeguarding concerns?

**Outcome focus**

- How does the Board demonstrate that it is collectively adding value and making a positive difference?

**Strategic plan**

- Conducted the annual review considering the question as to how it could be enhanced and the appropriateness of its priorities

**Consideration of chairing arrangements post 31st March 2020**

- Discussion of the arrangements after the tenure of the current Chair.

The matters arising and associated actions from the discussions have been examined by the Board Executive sub-group. The key outcomes include:

- Revised the strategic priorities by concluding as complete the priority relating to Leadership in the Independent Care Sector. Agreed a new priority Financial and Material Abuse. The next annual review will be conducted in 2021.
- Reviewed membership to ensure that the most appropriate organisations are engaged to support the Board's vision
- Confirmed that the Board constitution covering responsibilities remains fit for purpose
- Initiated and hosted a conference for front line practitioners and managers on the theme 'Let's Talk About Risk'
- Summarising specific actions in a tracker that is regularly reviewed and updated by the Executive sub-group.

## 7. PERFORMANCE AGAINST 2019/22 STRATEGIC PRIORITIES

In the reporting period (1st April 2019 to 31st March 2020) the two Strategic Priorities were:

- Engagement
- Financial and Material Abuse

Progress reporting towards Strategic Priorities is a standing agenda item at Executive sub-group meetings. A summary of progress is outlined below.

**Strategic Priority: Engagement**

**Lead:** Helen Jones, Board Manager

The activity around this priority is managed and co-ordinated by the Prevention and Engagement sub-group. The sub-group is chaired by the Statutory Service Lead and Principal Social Worker for Staffordshire County Council with the Strategic Manager for Early Intervention, Contact and Hospital Adult Social Care for Stoke-on-Trent City Council as vice chair.

Engagement is a broad term and for the purposes of the work of the Board this means engagement with several key groups of people including:

- Adults with care and support needs
- Carers and advocates
- Professionals and Volunteers
- Members of the public
- Board partners

**What we have done to engage with the key groups:**

Board partners have developed a range of methods to engage and communicate. In recognition of the advances in technology the SSASPB website is kept up to date and opportunities are taken to signpost visitors. The website serves as a useful repository for adult safeguarding information illustrated by the 58,774 visits between April 1st 2019 and March 31st 2020. The most visited sections are those relating to Safeguarding Adult Reviews and What is abuse? For those reading this report electronically the website can be accessed here.

The SSASPB has a focus on ensuring that the learning gained from a variety of reviews and audits is cascaded for practice to be improved. The following sections provide an illustration of some of that activity.

**District and Borough Council adult safeguarding awareness programme.**

During 2019/20 the SSASPB Business Manager and the Safeguarding Team Leader, SCC attended 4 events attended by District and Borough Council representatives who often come into contact with adults with care and support needs. The content was very much led by the audience and started with a brief introduction to the work of the Board and adult safeguarding awareness, followed by a question and answer session. The overall feedback from the evaluation sheets was 'very good' with a practical application to their day to day work.

**Self-neglect learning events.**

Following a review into safeguarding partner involvement with a male aged in his 50s where self-neglect was a contributory factor to his death the SSASPB organised learning events. The aim of the event was to improve the understanding of the lived experience of self-neglect. A total of 7 events were attended by 214 people, mostly professionals who work directly with adults with care and support needs.

One of the presenters, Lee, spoke candidly about his life experiences including periods of self-neglect and substance misuse. He is now a mentor with VOICES, Stoke-on-Trent after time as a volunteer sharing his experiences. He had a huge impact on those in attendance who were often visibly moved by his presentation. Many people acknowledged the benefits of speaking directly with someone who could give 'lived experience' of self-neglect and many recognised the value of his input through the evaluation of the event.

These events included presentations on themes of 'Adult Safeguarding and Self-neglect' presented by Ruth Martin Safeguarding Team Leader, SCC and Jackie Bloxham Adult Safeguarding Team Manager Stoke-on-Trent City Council and 'Self-neglect and Hoarding' presented by Mick Warrilow and Rio Case from Staffordshire Fire and Rescue Service.

The events received excellent feedback on the evaluation forms completed by practitioners. The successful format will be revised for future learning events having regard to the need to be COVID-19 compliant.

**SSASPB Conference – Let's Talk About Risk**

This event was held on 4th November 2019. It was attended by 167 people, most of whom were frontline practitioners including the voluntary sector, Council members and Strategic Managers. The purpose of the conference was to encourage front line practitioners to work with risk and remain within the various legal frameworks pertaining to adult safeguarding.

The conference programme started with a production from Afta Thought a professional training company who delivered a range of thought provoking practical illustrations of Making Safeguarding Personal and positive risk taking. This production set the scene for the presentations and discussions that followed on themes including:

- Legal literacy: working positively with risk
- Duties and responsibilities in safeguarding
- Positive risk management case studies on Financial Abuse; Hoarding and Self-neglect; Mental Health and Midwifery

The feedback from the evaluation forms was extremely positive with the vast majority of delegates indicating that the event was 'excellent' or 'very good' and would positively impact on their working practice.

Arising from the event a number of opportunities have been pursued to forge stronger links on adult safeguarding matters with a voluntary sector organisation which supports a wide network of carers of adults and with the School of Law at Keele University.

**Other engagement:**

In June 2019 the Board Manager visited a service-user group meeting hosted by the Midland Partnership Foundation Trust. The meeting was chaired by a service user and another who was present was very actively engaged in multi-agency work. The service-user group agreed to assist the Board with consultation on

publicity material aimed at service users and their carers' and families. The group was pleased to see that the Board had produced easy to read material (Section 42 enquiry questionnaire) and encouraged more use to be made of this method of communication.

On Monday 19th June 2019 the Board Manager met Healthwatch Board members Dave Rushton (Stoke-on-Trent) and Karen Jones (Staffordshire) to discuss how they could support the engagement Strategic Priority. Arising from the discussions the Board Manager produced two briefing notes: one to provide a 10-minute overview of the work of the Board and Adult Safeguarding and a second with additional information to include data and lessons learnt from reviews. The briefing notes have been posted on the SSASPB website and can be used by any partners to raise awareness of adult safeguarding and the work of the SSASPB.

Several Board partners participated in the inaugural National Adult Safeguarding week (18th to 25th November 2019) which was initiated through the Ann Craft Trust charity. The activities through the initiative were well received locally. This will become an annual programme that the SSASPB will support.

The SSASPB Practitioners forum commenced this year. It is a quarterly event where front-line staff are encouraged to discuss multi-agency working on specific themes. These fora have been introduced to identify any areas where there are challenges to safeguarding policy compliance within organisations so that there can be a better mutual understanding of partner roles, changes in procedures and enable practice improvement. Topics this year included, Safeguarding and Decision Making and use of the SSASPB Escalation Policy.

NHS England provided the Board with funding to bring GP practice managers together to raise awareness in a number of areas including Adult Safeguarding, Domestic Abuse and the requirements of the NHS Inter-Collegiate learning and development document. A total of 48 practice managers and other staff from GP surgeries came to the 3 events held in Stoke-on-Trent, Chasewater and Uttoxeter.

The following case studies exemplify Making Safeguarding Personal and cross-partner collaboration.

**Case Study: Midlands Partnership Foundation Trust**

'Michael' was subjected to Domestic Abuse for many years. Despite several agencies offering support, he had always declined as he felt that it wouldn't change things because it had gone on for so long. Over time Michael developed confidence in the network of support offered to him. He agreed that he may benefit from spending some time, for short periods at a day service, away from the home address. However, Michael's step-daughter (who lived with him and his wife) was against this saying that he couldn't afford the service.

When safeguarding enquiries were made it became evident that Michael was being financially abused. He was encouraged to attend the day service and was visited there by a safeguarding worker every week. Michael developed confidence in the discussions with the safeguarding worker and over a period of time expressed a wish to leave the house and the abusive situation to live on his own and take control of his life.

Other agencies became involved, including the Police, and with this multi-agency support he left his wife, stepdaughter and former home. It appears that Michael had been financially abused to the amount of tens of thousands of pounds over the years. He now lives happily on his own, with frequent visits to friends through the day service. He has become far more outgoing, enjoying his independence and lives his life without abuse.

**Case study: University Hospitals of North Midlands**

A 79 year old female, 'Margaret' attended a routine outpatient appointment at the University Hospitals of North Midlands accompanied by her son. She appeared very distressed and anxious at the appointment and staff had concerns for her welfare based upon the indicators seen. Time and space was created to allow for a discussion with her in private and she was asked if she had any concerns.

Margaret disclosed that she was living with a violent and aggressive son who often "flies off the handle", often without reason. She said that her son had a formal diagnosis of a mental health disorder with addiction problems and that he also had suicidal thoughts, as did she on occasions. She explained that on the day prior to her hospital appointment, when in the car with her son, he was aggressive and shouted at her. The behaviour was noted by a police officer who happened to be adjacent in a traffic queue and was prompted to ask if everything was okay.

Margaret explained to the clinic staff that she was too frightened to accept support. Recognising the sensitivities staff sought advice from the UHNM safeguarding team as to what could be done to help. Margaret gained the trust of the staff and consented to the making of a safeguarding referral. She was also willing to accept support from domestic abuse services New Era. Staff also engaged with the Mental Health Liaison Team to determine if the patient's son was known to their service and if he required on-going support. The information was also relayed to the patient's GP.

This case illustrates the diligence of the staff to recognise the signs of abuse and creating a safe environment for the disclosures to be made with the patient's consent which were immediately followed by prompt actions to assess and mitigate risks. This is an excellent example of effective multidisciplinary team working and proportionate information sharing between UHNM, community teams and services and the patient's GP.

**Case Study: North Staffordshire Combined Healthcare Trust**

Paula is a 46-year-old woman with a long history of contact with mental health services. She lives with psychosis, low mood and anxiety. She has been the victim of domestic abuse in many relationships throughout her adult life.

During 2019 she restarted a relationship with a man who had previously frightened and controlled her. Paula has a care co-ordinator (Sam) who she had worked with to create a safety plan that she could follow without her partner's knowledge.

When Paula began missing appointments, her family raised concerns that her partner had moved into her flat and that he was preventing them from visiting. The care co-ordinator Sam visited Paula at her home address to conduct a safe and well check but experienced challenge from her partner. Paula's partner said that she was very unwell with migraine and had been in bed for the past few days. Paula suffers frequently with migraine and was awaiting an appointment with Neurology.

Sam was able to persuade the partner to let him see Paula so help could be arranged. Paula was lying in bed with the duvet pulled up underneath her chin. With the partner's agreement Sam arranged an appointment with Paula's GP at the surgery. Sam shared their concerns around domestic abuse with Paula's GP and booked a double appointment so that Paula could have the opportunity to talk about her needs. Sam completed a referral to the Multi-agency Risk Assessment Conference (MARAC) and made an adult safeguarding referral.

Paula attended the surgery and her partner was asked to wait in reception which he reluctantly accepted. During the appointment Paula disclosed that her partner was very controlling and was not allowing her to have access to anything in her flat or have contact with her family. She was spending most of her time in bed at his request and she couldn't look at her mobile phone without him being abusive, so she had stopped using it. She had no way of keeping herself safe.

All of Paula's appointments take place at the surgery which was seen as a safe place. Paula was terrified of becoming pregnant therefore GP prescribed the contraceptive injection as a one off. This method is not usually used with women of Paula's age, but assessed as safe and the most discreet way of her receiving contraception. Paula now has an Independent Domestic Violence Advocate (IDVA) who attends her appointments. A safety plan has been devised so that Paula may discreetly report that she is at risk, this is then reported to the Police who will immediately respond as information has been shared with them that they can quickly retrieve.

**Case Study: Staffordshire Police**

After the death of his wife George moved from the family home into a local authority bungalow. He became friends with the woman who lived next door who had an adult granddaughter. The neighbour's granddaughter was a drug user and known to the Police. She became a frequent visitor to George's address, inviting along her friends and associates.

George was very vulnerable during this period and calls began coming through to the Police from his home. Early Intervention Officers became involved and over time George built up trust with them. George disclosed that drug dealers had moved into his bungalow – a situation known as 'cuckooing'.

Through this period George became drug dependent with a £70 a day crack cocaine addiction. He spent more than £70,000 of his life savings supporting not only his drug habit but also that of his neighbour's granddaughter. He became estranged from his family and lost all his friends.

George has been able to withdraw from drugs, initially with the support of the Community Drugs and Alcohol team. The Police Early Intervention Officer facilitated his getting back in touch with his family resulting in sustained and regular contact with his sons. The officer also supported a move from the bungalow into a retirement village. George was very excited with the move, made new friends and is feeling much safer there. He remains drug free and is enjoying renewed contact with his family.

**Case Study: CCG**

Following several safeguarding allegations relating to a local nursing and care home there was joint response from the Adult Safeguarding and Nursing Home Support Nurse from the Clinical Commissioning Group (CCG) and staff from the Local Authority Adult Social Care and Commissioning team to consider how the home could be supported to improve their provision of nursing and care.

The home was going through a period of management change and it was recognised that there were several staffing issues which were adversely impacting on the care received by residents.

Due to the concerns raised, the nursing home was also placed under an enhanced quality monitoring programme with the local authority. Joint quality visits (CCG/LA) were undertaken and contributions were made to the action plan by the nurse. This included signposting and support regarding best practice. The

home was able to use this information to improve their care delivery, reduce risks and improve their resident's quality of life.

As the enhanced quality monitoring programme continued, the partnership working between health, the local authority and the home helped to bring about improvements. When the regulator, the CQC inspected the home the rating had improved. The home acknowledged that the input from the two organisations had been invaluable in supporting them and enabling them to develop their care for the benefit of residents and achieve their improved CQC rating.

**Case Study: University Hospitals of Derby and Burton on Trent (Queens)**

'Bahati' was an elderly lady who lived with her family. She was of Pakistani origin and had recently returned to the UK after a lengthy period away. Bahati had physical health concerns and lived with anxiety and depression. She had been under the care of mental health services previously. An interpreter was required to support with the language barrier.

Bahati attended the Emergency Department of the University Hospitals of Derby and Burton (Queens) due to complexities with underlying health conditions. During the attendance she disclosed that she had been a victim of domestic abuse from two members of her family. She shared that this had been verbal abuse, and sometimes she was physically hurt. The family members had made threats to harm her with a knife and threats to kill her. They constantly informed her that they wished for her to die. Bahati was scared to go home and the fear was exacerbating her physical health. She disclosed that the two family members drank alcohol heavily and that this often made the abuse worse.

The Emergency Department Staff identified that Bahati was at significant risk of harm. She was isolated and had no support outside of the family network. Her physical needs also meant that she was unable to protect herself from this abuse. The Emergency Department Staff Nurse completed an Adult Social Care Referral with Bahati's consent. She shared that she wanted the abuse to stop and did not feel safe to return home. A discussion was held around informing the Police and although nervous of the outcome, Bahati provided her consent for this information to be shared. There were no concerns relating to her mental capacity to make these decisions. The Staff Nurse who was caring for her also identified that the CADDA (co-ordinated action against domestic abuse) DASH domestic abuse, stalking and 'honour'-based violence) / safelives checklist was required and completed this. Bahati scored 7/24. The Staff Nurse then contacted the Trust Safeguarding Team as was unsure if this would meet the score for inclusion at MARAC (Multi-Agency Risk Assessment Conference). After a case discussion, it was referred into MARAC on professional judgment due to the risk of honour-based violence and the many threats to kill.

As part of the safety plan Bahati was admitted to hospital to ensure her safety whilst the Police and Adult Social Care investigated the concerns. The Police interviewed Bahati on the ward and a plan made for her to be supported by the hospital to attend the Police Station upon her discharge.

During the admission the family had contacted the hospital on a number of occasions – They informed the ward staff that Bahati was making the allegations up and that her mental health meant she was "crazy". At this stage it was unclear if these calls were an attempt at further coercion and control from the abusers. Concerns were further raised when an anonymous call was received informing staff that everything that Bahati had shared was true and she was being abused by members of her family. On discharge Bahati was

supported to attend the Police station to provide a statement and also meet with the Social Worker. As a result her safety needs were met and she was supported to find alternative accommodation.

**Strategic Priority: Financial and Material Abuse**

Financial and Material Abuse includes theft, fraud, internet scamming, coercion in relation to an adult's financial affairs or arrangements, including in connection with wills, property, inheritance or financial transactions or the misuse or misappropriation of property, possessions or benefits.

It is strongly suspected that the number of victims of Financial or Material Abuse who have care and support needs is likely to be massively under reported. Nationally it is estimated that only 10-20% of incidents are reported. During 2019/2020 the proportion of Section 42 enquiries where Financial and Material Abuse was identified was 18% in Staffordshire and 15% in Stoke-on-Trent. The average for England in 2018/19 was 14%.

The activity around this priority is managed and co-ordinated by a sub-group chaired by the Safeguarding Team Leader Staffordshire County Council that reports to the Executive sub-group.

There is a key focus on raising awareness. Trading Standards have provided training to staff working at the Multi-Agency Safeguarding Hub. Training has also been provided to Staffordshire Trading Standards regarding Safeguarding duties of local authorities.

Throughout the year data has been collected and is being considered on an ongoing basis between agencies regarding their current work around financial and material abuse to help build a picture of what is happening locally.

Staffordshire County Council has worked with Staffordshire Police and Action Fraud to compare data and ensure that if an allegation is made by or on behalf of an adult with care and support needs to Action Fraud this is shared with the respective Local Authority.

Stoke-on-Trent City Council have examined their financial abuse referrals to identify the type of abuse and which pathways the referrals go through.

Arising from the learning from this activity financial abuse guidance has been amended and approved and distributed to partners. It has been posted on the SSASPB website for reference.

The data gathering exercise has raised a number of questions about the types of financial and material abuse. Staffordshire University has agreed to allow research projects to be initiated that will help to address questions related to vulnerability of victims to particular types of financial and material abuse including so called 'rogue trading' and 'doorstep crime'. The results of the research and action taken in response to conclusions and recommendations will be reported in the Annual Report for 2020/21.

The following case study provides an illustration of the positive action that is taken when financial and material abuse is reported.

**Case Study: Stoke-on-Trent City Council**

Within a period of 2 months two separate and anonymous adult safeguarding referrals were made reporting concerns about a woman called 'Andrea' who was suspected to be a victim of financial exploitation by a neighbour. The person believed to be financially abusing Andrea was known within the local community to be a drug user.

On each occasion Andrea had been spoken to by the same team member from 'First Contact' at Stoke-on-Trent City Council. Andrea said that she had no concerns but was grateful that her neighbours were looking out for her.

In August 2019 a senior safeguarding social worker made the link between Andrea's circumstances and those of others nearby. A joint approach between Staffordshire Police and Adult Social Care was agreed. On this visit Andrea once again reiterated that she had no concerns and that she helped the neighbour by giving her money for gas and food. Andrea was asked if her bank card and details were safe and she informed that they were. Andrea stated that the neighbour might become upset should the Police talk to her about the issues and she asked that the Police didn't visit the person thought to be exploiting her.

Andrea agreed to a referral to a support worker to help to manage the risk and the worker visited the following day to build rapport and to commence communications with Andrea's bank.

The following week the support worker invited Andrea to the neighbourhood Community Centre. Arising from her reflections Andrea began to recognise the risk posed to her from her neighbour. Andrea owns her own property and asked if she could be supported to move to another property, as she did not feel able to ask the neighbour to stop visiting her. She also disclosed that she was fearful that she may have her windows or her home damaged as a result of disclosing anything to the Police and was worried about how the situation will impact on her health. At that stage she still did not want to make a formal complaint.

The following week the support worker took Andrea to the bank for a meeting and it was established that approximately £10,000 had been taken from the bank account. Andrea made a full disclosure to the support worker and requested Police involvement. Andrea is happy with the outcome.

The following were examples of good social work practice using:

- Asset based Social Work Practice – making the most of local community support networks which were community support groups.
- Positive local links and relationships with the Police
- Making Safeguarding Personal, which enabled Andrea to be in control of the process and all decisions.
- Risk reduction was a key element of this work including supporting Andrea to visit the bank, purchase of a safe for her home to keep cards and money safe, emotional support from the stress of the situation, benefits check to increase current income, discussion with lifeline services to provide a 'safe word' should Andrea consider herself to be at risk from the neighbour so that they can contact the Police urgently.

# Staffordshire and Stoke-on-Trent 2019/20 performance report overview

**Number of safeguarding concerns received by the Local Authorities in 2019/20**

| Staffordshire | Stoke-on-Trent |
|---|---|
| 4150 | 3945 |

Staffordshire: 59%

Stoke-on-Trent: 47%

Of safeguarding referrals are regarding adults who are 75 or over.

**Most prevalent 4 types of abuse 2019/20**

| Staffordshire | | Stoke-on-Trent | |
|---|---|---|---|
| Emotional | 12% | 17% | Emotional |
| Financial Abuse | 18% | 21% | Financial Abuse |
| Physical abuse | 22% | 25% | Physical abuse |
| Neglect and acts of omission | 35% | 50% | Neglect and acts of omission |

**Percentage of Safeguarding Enquiries where the wishes of the adult were met and partially met**

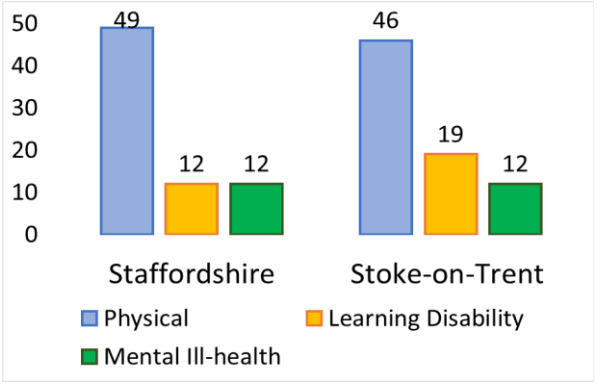
**Staffordshire**

| 2017/18 | 2018/19 | 2019/20 |
|---|---|---|
| 97 | 97 | 98 |

**Stoke-on-Trent**

| 2017/18 | 2018/19 | 2019/20 |
|---|---|---|
| 82 | 89 | 96 |

**Primary Support reason in percent for 2019/20**




**Number of SARs in 2019/20**

| SAR referrals | SARs |
|---|---|
| 5 | 2 |

## 8. ANALYSIS OF ADULT SAFEGUARDING PERFORMANCE DATA

This section provides commentary and analysis of safeguarding data from Stoke-on-Trent and Staffordshire.

At the beginning of 2019-20 Stoke-on-Trent Adult Social Care switched from using Care First to Liquid Logic. This has resulted in some process changes, data recording changes, and some manual transferring of data from one system to the new one. It has created some year on year changes in the data sets and this has been recorded and documented in the statutory returns 2019-20.

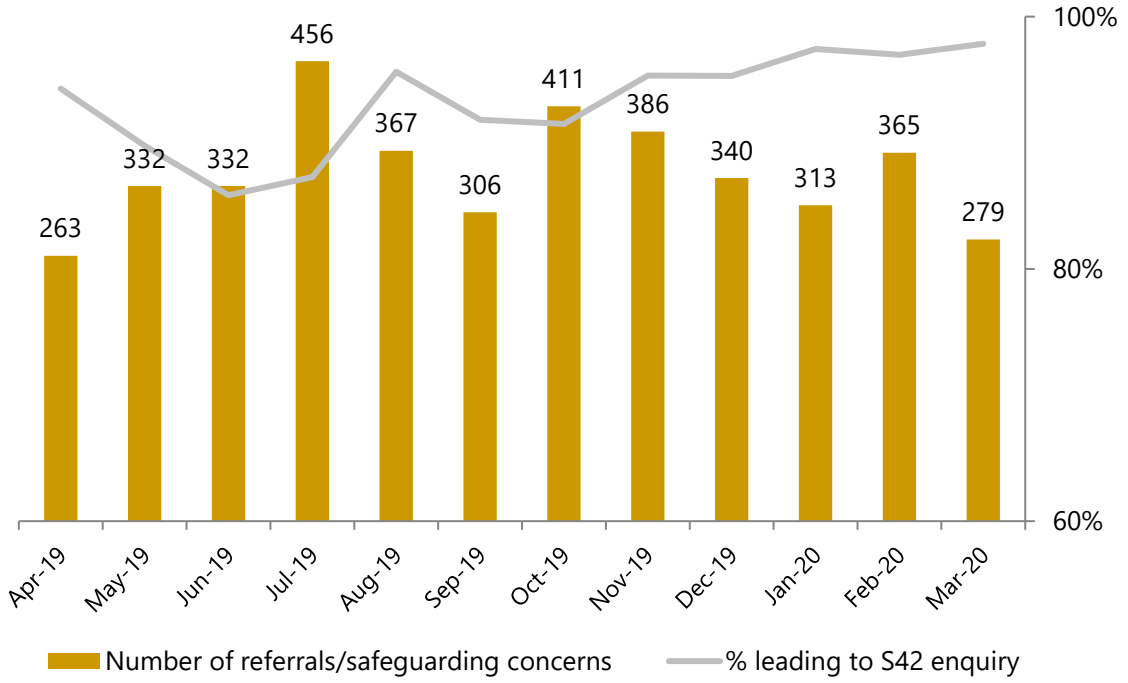
**Number and proportion of referrals/safeguarding concerns**

The safeguarding partners in Staffordshire and Stoke-on-Trent have established and widely publicised the procedures for reporting concerns that an adult with care and support needs may be experiencing or is at risk of abuse or neglect.

Reported concerns can progress to a formal enquiry under Section 42 of the Care Act 2014 if the criteria for the duty of enquiry requirement is met. In cases where a statutory response is not required the local arrangements ensure signposting and engagement as necessary with appropriate support services.

It should be noted that there is a difference between how both LAs capture and report this data. This accounts for similarities in the numbers between both LAs which could reasonably be assumed to vary more due to the difference overall population sizes.

Fig.1 - Staffordshire: number and proportion of referrals/safeguarding concerns

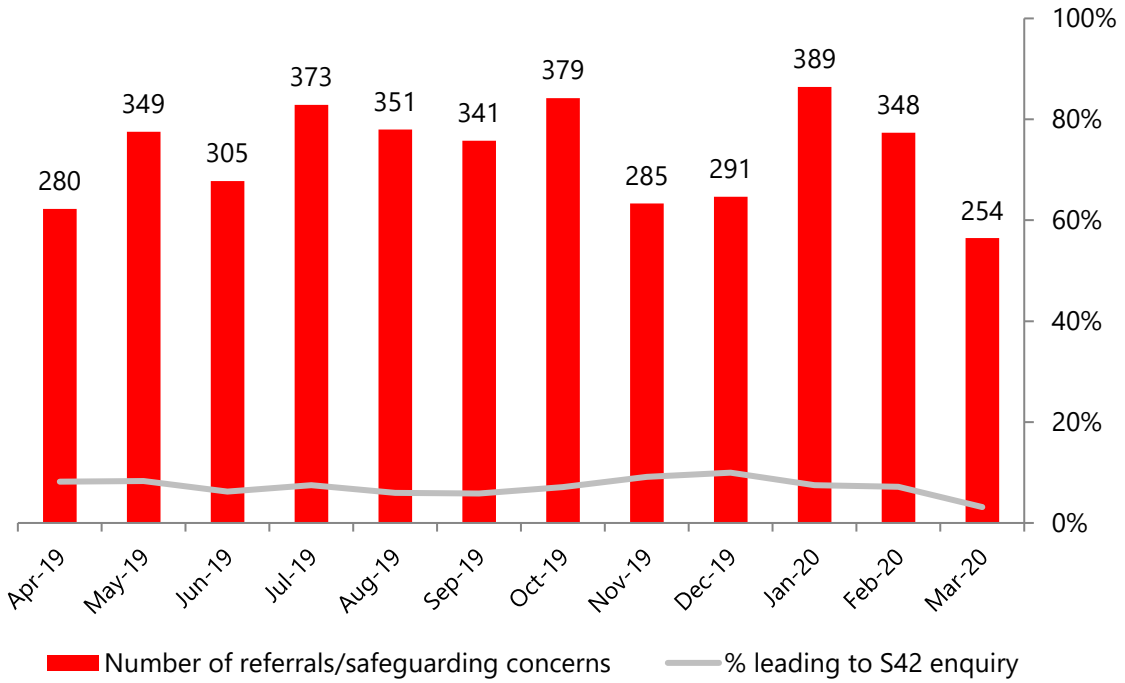



During the course of the year, in Staffordshire, there have been 4150 occasions when concerns have been reported that adults with care and support needs may be at risk of or are experiencing abuse or neglect. The total figure has increased by 439 (11%) occasions from 3711 in 2018/19. There has been a dip in referrals in

March 2020, this reflects a natural trend where the number of referrals increased from March to December but then falls from December to March.

The expected trend from 2018/19 was that there would be an increase in referrals that meet the threshold for a Section 42 enquiry with the intention that all referrals meet this threshold which would indicate better initial assessment. While there have been some dips overall, there is a trend towards the 100% goal. The average is 93% with the highest figure at 98% in March 2020.

Fig.2 - Stoke-on-Trent: number and proportion of referrals/safeguarding concerns




In Stoke-on-Trent there were 3945 reported safeguarding concerns in relation to adults with care and support needs during 2019/20. This is an increase of 911 from 3034 compared to 2018/19 which is an increase of 30%. The conversion rate has been reduced from 9% to 7% due to a much higher volume of concerns raised, the actual number of concerns that are converted into Section 42 enquiries remains at a similar rate. In Stoke-on-Trent the first contact workers carry out fact finding/information gathering on each safeguarding concern prior to being passed on to a manager who then makes the decision on whether or not the concern is moved onto a S42 enquiry or an alternative route to S42. Therefore a lot of work is done at first contact stage which may be viewed as an enquiry all be it a telephone call or further discussions with the provider and or adult at risk falling in line with Making Safeguarding Personal. Following initial assessment, it was determined that the duty of enquiry requirement was met on 7% of those occasions which has decreased from 9% in 2018/19.

The Board has asked for an explanation from the local authorities about the different methods of gathering and interpreting information in relation to safeguarding concerns. The responses are summarised below.

- Both authorities review information on the AS1 (initial safeguarding referral form)
- Both make a decision at this point to determine if the three stage criteria is met
  *a- does the adult have care an support needs,*
  *b- are they at risk or experiencing abuse*
  *c- and as a result of their care needs are they unable to protect themselves*

- If the three stage test is met then a decision is made by both authorities to gather further information (called a planning discussion).
- The planning discussion will involve information gathering from various sources, both professional and family and friends and the adults view where they have capacity to be involved.
- Following this information gathering both authorities make a decision if further enquiries and exploration of safeguards for the adult is required.
- If the decision is for no further enquiries, it is at this stage that Staffordshire and Stoke-on-Trent make a different recording decision –
- Stoke-on-Trent record this decision as – No Section 42 required (but also record what other actions either care assessment request, review etc. as a non-statutory Sec42)
- Staffordshire record this decision as – Section 42 enquiry completed (either no ongoing risk, closed at adult's request, concerns substantiated or unsubstantiated)

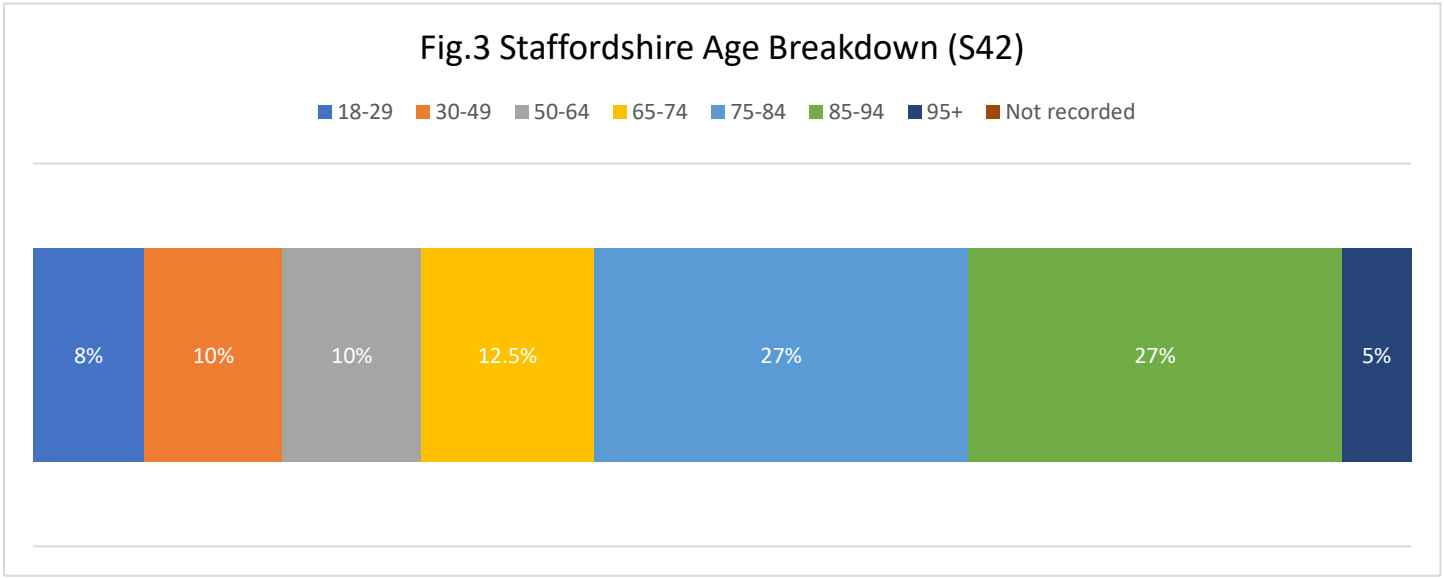
In essence Staffordshire and Stoke-on-Trent Local Authorities follow the same procedures but the recording on systems is an internal decision for each authority. This review has illustrated that both authorities are taking the same steps to ensure adults are safe and risks minimised.

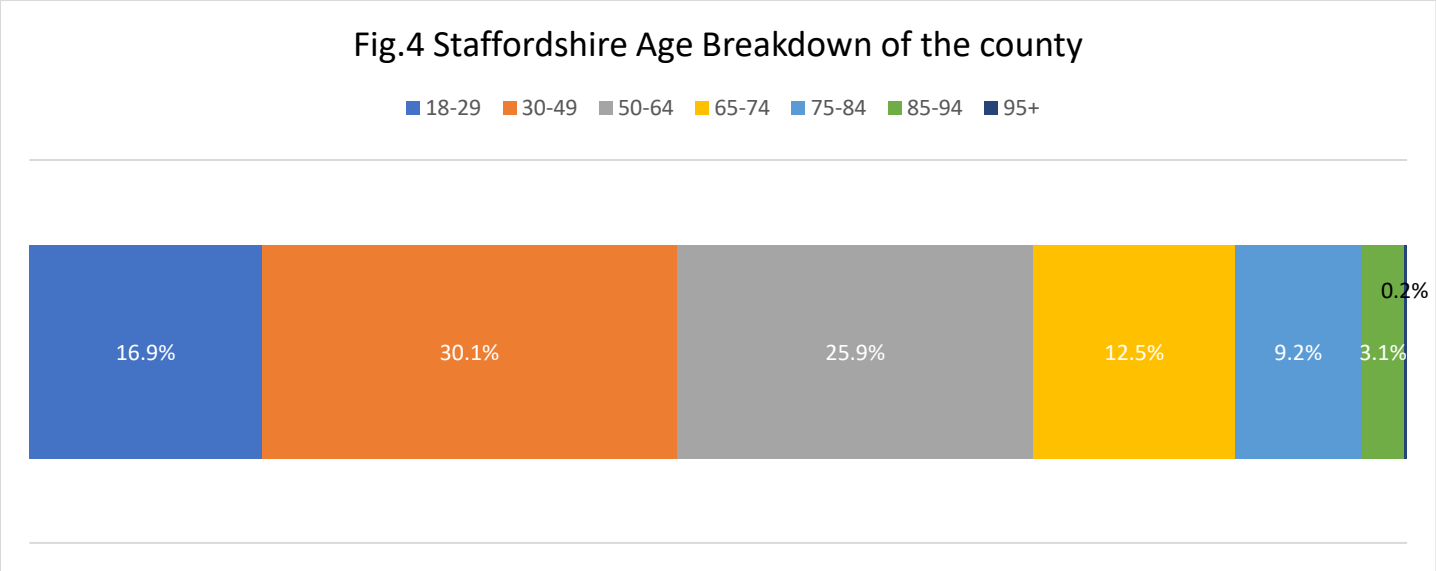
This difference in recording is replicated throughout the country with a wide variation in conversion rates for Section 42 enquiries between 12% and 69%. Both authorities have been involved in the work of the Local Government Association in an attempt to reduce this variance. The Local Government Association has announced that it will produce further guidance to make the process for recording a Section 42 clearer.

The following pages provide an analysis of the findings under various headings from the concerns that have resulted in a formal Section 42 enquiry.

**About the Person**

To give a picture of the personal circumstances of those at risk of abuse or neglect information is collected on the age, gender, ethnic origin and primary reason for adults needing for care and support and this information is provided below.



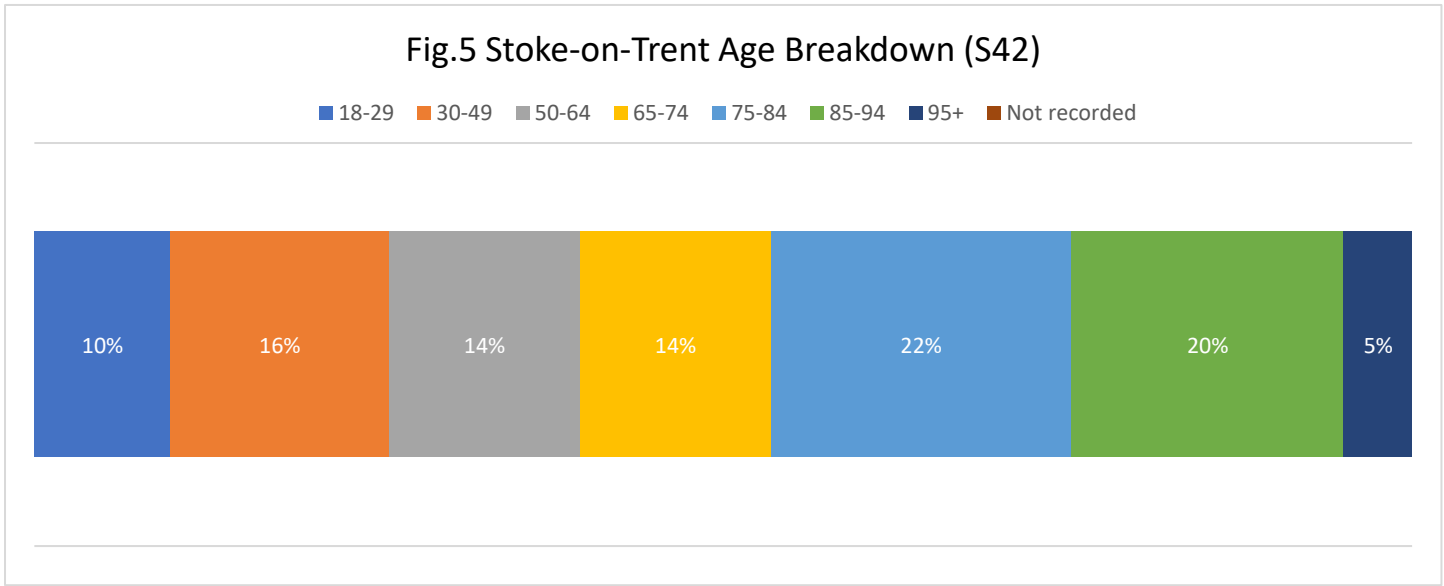


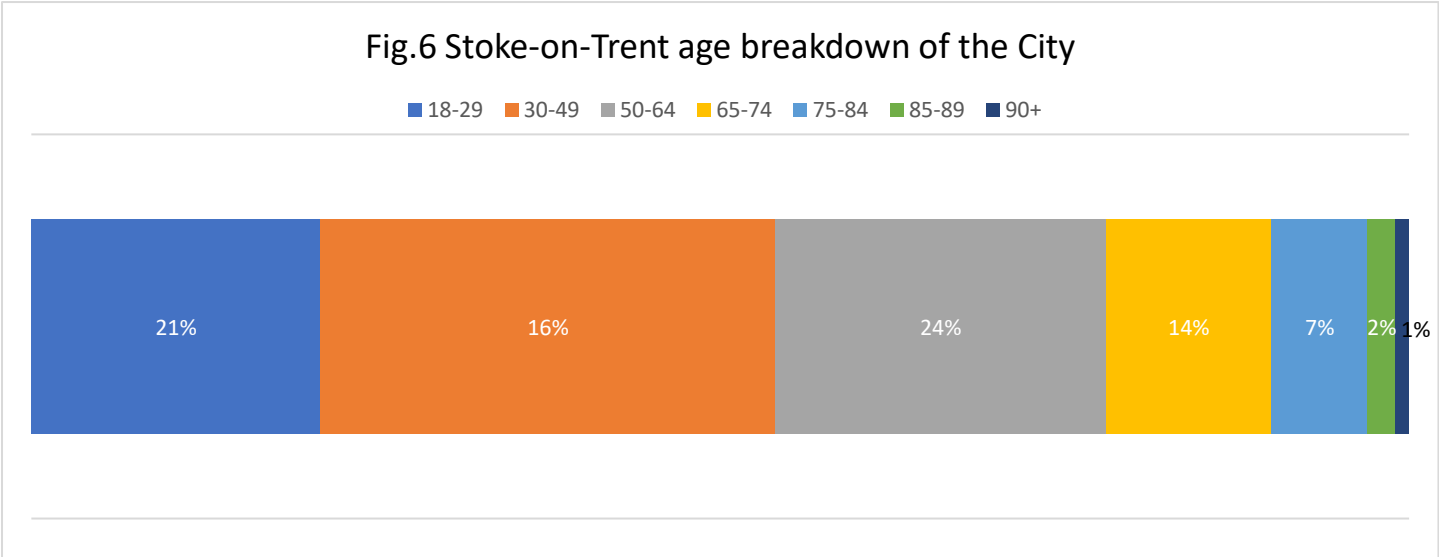

**Staffordshire**

Of the adults who have been subject of a Section 42 enquiry, those aged 75-84 and 85-94 (both 27%) represent the largest cohort, followed by 65-74 (12.5%), there has been very little change in the population this year compared to last year. Only in 0.5% of cases has no data been recorded. The number of safeguarding referrals counted by Staffordshire County Council reflect the number of safeguarding screens that are opened by staff and does not reflect the number of calls that come into the centre but are dealt with in other ways.

When comparing the age breakdown with general Staffordshire population statistics, it is evident that people in the 65+ age groupings are disproportionally overrepresented for Section 42 enquiries.

Please note that due to the age bands given by the Office of National Statistics the last two bands do not match the Section 42 breakdown above.



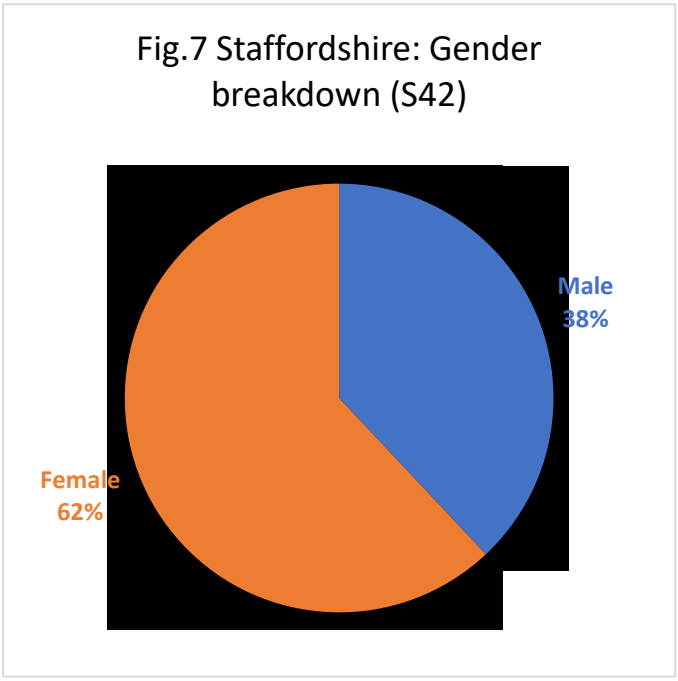


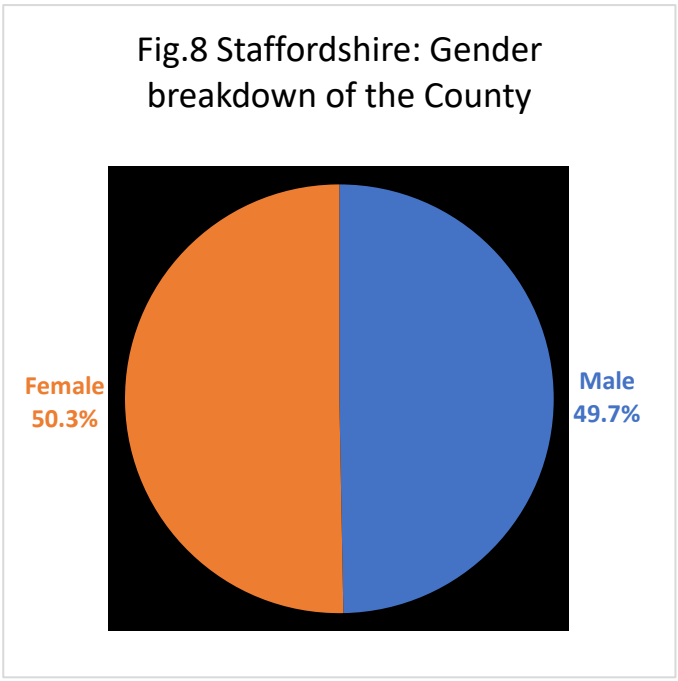

**Stoke-on-Trent**

For Stoke-on-Trent, the largest cohort represented is those aged 75-84 (22%), followed by 85-94 (20%), and then 30-49 (16%). There has been a slight increase in adults over 75 that have been subject of a Section 42 enquiry by 3%, which is in line with the 6% growth for the age cohort across Stoke-on-Trent. There can be a large variation in age breakdown in different quarters of the year, this is due to the comparatively small number of enquiries made which can move the age brackets a more significant amount than Staffordshire but there is not a very large variation generally year on year.

When comparing the age breakdown with the general Stoke-on-Trent population figures, it is apparent that people over 65 are disproportionally overrepresented for Section 42 enquiries.

**Gender**



**Staffordshire**

Females represent the majority of adults' subject of a Section 42 enquiry, with 62% over the year and males representing 38%; similar to last year. Females are overrepresented (by 11%) when compared to the overall Staffordshire gender breakdown.

Fig.9 Stoke-on-Trent: Gender breakdown (S42)

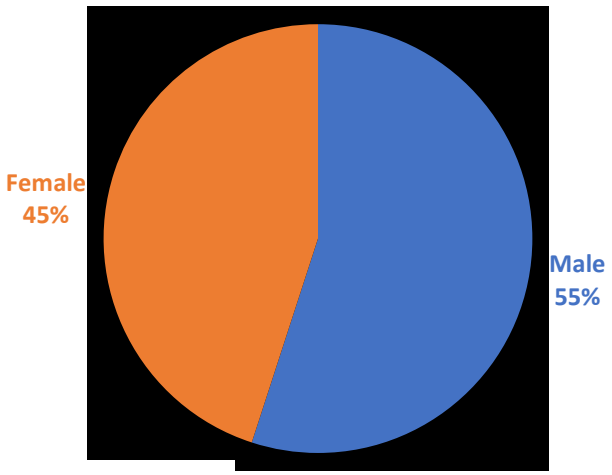
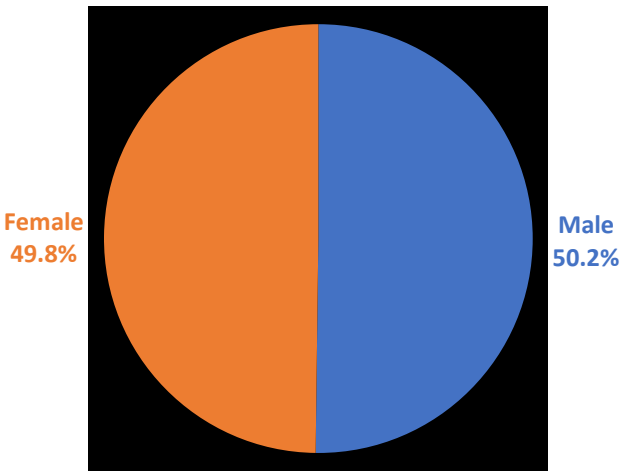



Fig.10 Stoke-on-Trent: Gender breakdown of the City




**Stoke-on-Trent**

Stoke-on-Trent has a lower proportion of females in their cohort compared to Staffordshire, and the proportion females have decreased compared to 59% last year with a corresponding increase for men. This is not an unusual statistical movement. Younger males are closely associated with the homeless population of Stoke-on-Trent. Tracking in 2020 had 74% of the cohort for known rough sleepers as being male, with the majority being under 40 years of age. This is key context for the higher proportions of males in the safeguarding system.

Note: Recording systems are currently unable to break down data further to reflect broader gender categories to be fully inclusive.

| Ethnicity | Stoke-on-Trent section 42 enquiries | Stoke-on-Trent overall population | | Staffordshire S42 enquiries | Staffordshire overall population |
|---|---|---|---|---|---|
| White British | 81.6 | 86.4 | | 88.6 | 93.6 |
| Not Known | 5.9 | - | | 7.6 | - |
| Pakistani | 2.7 | 4.2 | | 0.36 | 0.8 |
| Indian | 2.2 | 0.9 | | 0.39 | 0.8 |
| Black Caribbean | 2.2 | 0.3 | | 0.39 | 0.3 |
| Other White British | 1.6 | 1.9 | | 1.32 | 1.6 |
| White Irish | 1.1 | 0.3 | | 0.65 | 0.5 |
| Not Stated | 0.5 | - | | - | - |
| Bangladeshi | 0.5 | 0.4 | | 0.03 | 0.1 |
| Black African | 0.5 | 1.0 | | 0.03 | 0.2 |
| Any other Asian Background | 0.5 | 1.4 | | 0.18 | 0.4 |
| Gypsy /Roma | 0.5 | 0.1 | | 0.03 | 0.1 |
| Mixed White/Caribbean | - | 0.3 | | 0.03 | 0.5 |
| Any other Black Background | - | 0.1 | | 0.13 | 0.1 |
| Arabic | - | 0.2 | | 0.05 | 0.1 |
| Any other ethnic group | - | 0.5 | | 0.03 | 0.1 |

Please note that the table is presented in order of the most prevalent based on the Stoke-on-Trent figures.

**Staffordshire**

The majority of individuals (Section 42) are 'White British' (88.6%, a slight decrease from last year), followed by 'Other White British at (1.32%).

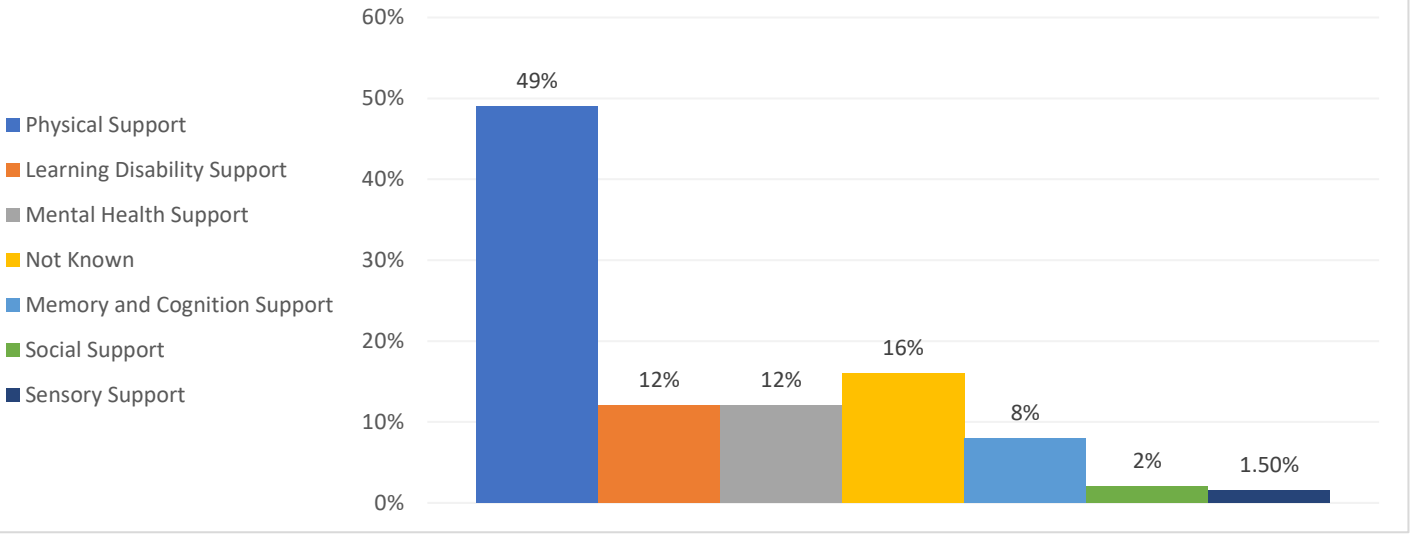
**Stoke-on-Trent**

The pattern is similar in Stoke-on-Trent, the majority of declared ethnicities are 'White' (81.6%, a slight decrease since last year), followed by Pakistani (2.7%)

Anecdotally, it is known that people from ethnic minority populations are disproportionally under-represented for Section 42 enquiries; however, for both local authorities (Staffordshire 7.6% and Stoke-on-Trent 5.9%), there are records where the adult do not have their ethnic background captured which limits the usefulness of any comparison to the wider population. There has been a decrease in the 'Not Known' category of ethnicity from 2018/19.

**Primary Support Reason:** the bar charts below illustrate the type of care and support need of the adult subject of abuse or neglect.

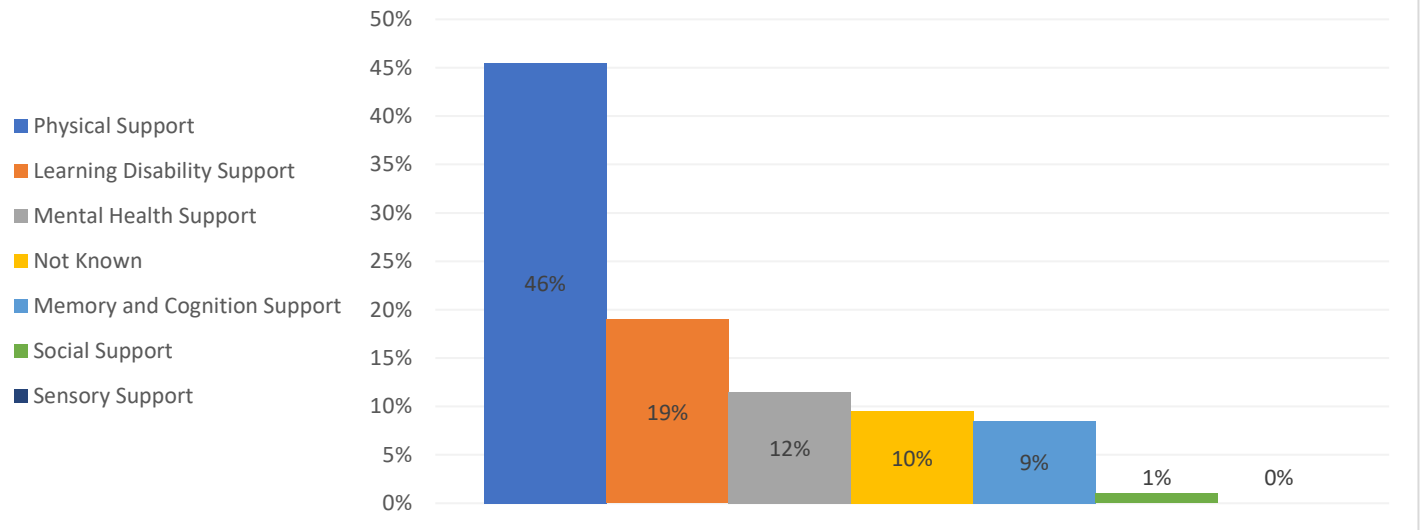
Fig.11 Staffordshire: Primary Support Reason (S42)




**Staffordshire**

Physical support continues to be the most common primary support reason in Staffordshire in 2019/20 (49%) a decrease of what was reported last year (61%) but in line with the year before at 49%. This is then followed by learning disability support (12%) and mental health support (12%). 'Not knowns' have increased from last year.

Fig.12 Stoke-on-Trent: Primary Support Reason (S42)



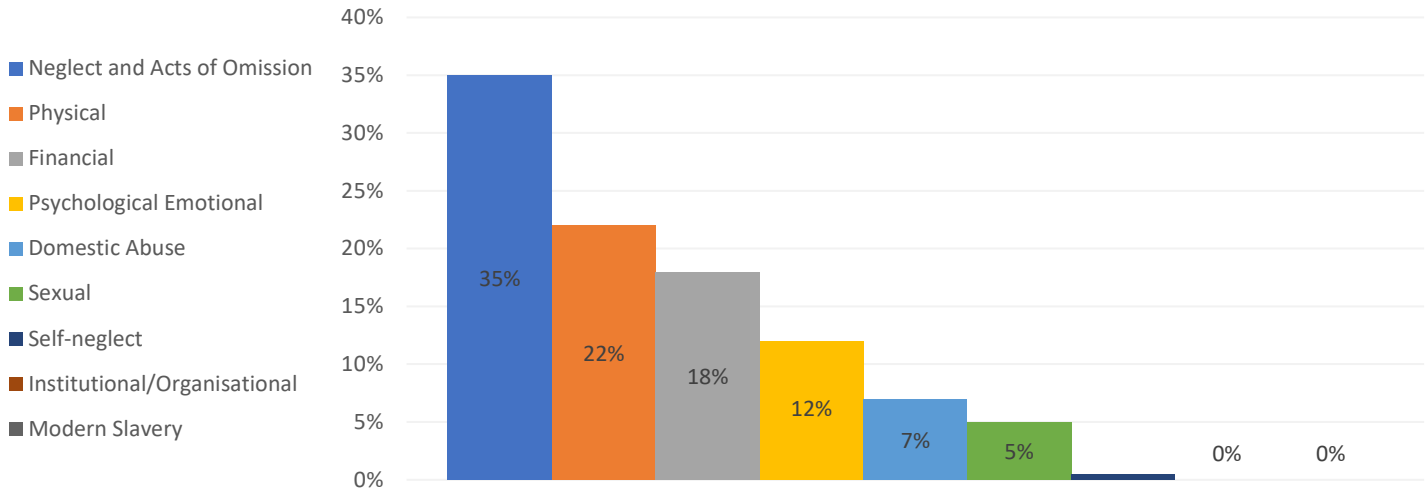

**Stoke-on-Trent**

Physical support similarly represents the largest proportion of primary support reasons recorded in Stoke-on-Trent at 45.5%, followed by learning disability support with 19%, a decrease of 2% since last year, mental health support accounts for 11.5% which has also decreased from last year. The unknown category has also increased from 5 last year to 28 this year, the matter has been acknowledged by the Council and there are plans in place to improve recording.

**Types of Harm or Abuse identified at Section 42 safeguarding enquiry**

The below information shows the types of abuse and neglect reported in comparative proportions:

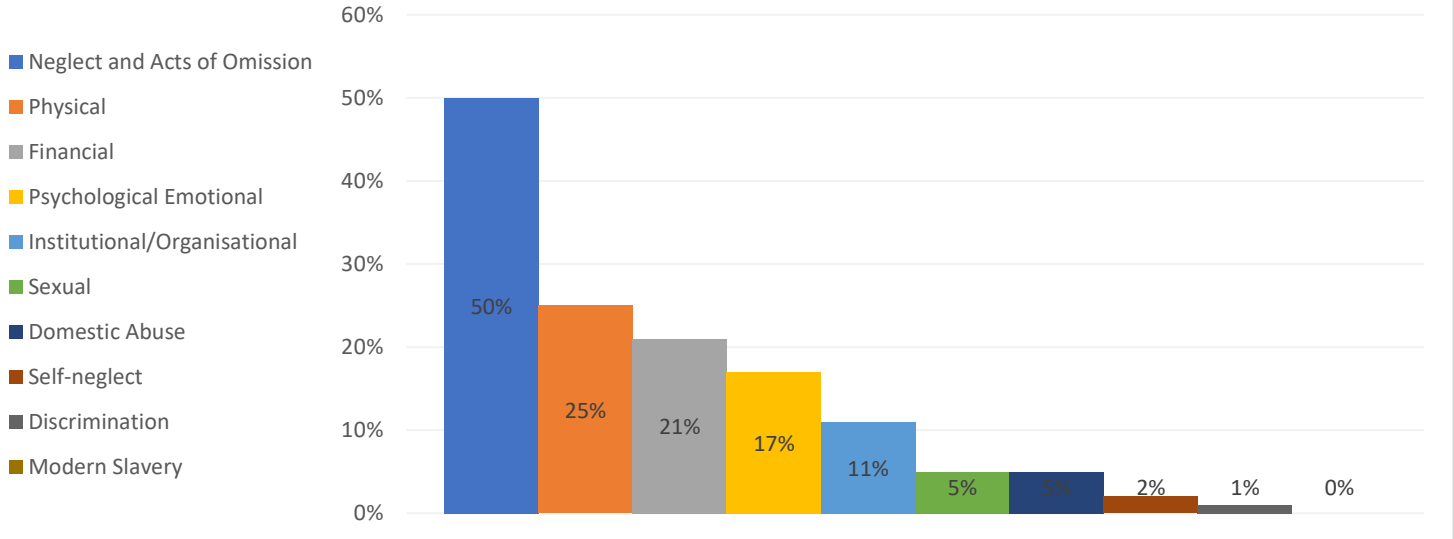
Fig. 13 Staffordshire: Types of harm or abuse identified at S42 safeguarding enquiry




**Staffordshire**

Neglect and Acts of Omission/Physical harm/financial abuse continue to be the most frequent types of harm and abuse identified for Section 42 safeguarding enquiries in Staffordshire, together accounting for 75% of all harm/abuse recorded. Neglect and acts of omission show a slight increase from last year; whilst financial abuse has decreased (2%) in 2019/20.

Fig. 14 Stoke-on-Trent: Types of harm or abuse identified at S42 safeguarding enquiry




**Stoke-on-Trent**

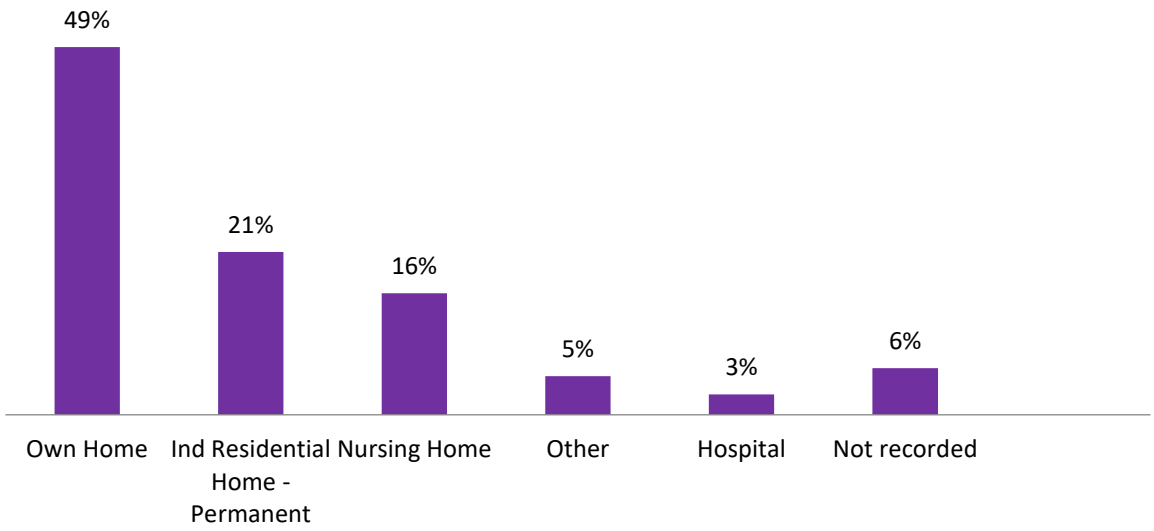
The percentage of neglect and acts of omission cases has increased from 2018/19, 45% to 50%. One Care Home has been subject of a Large Scale Enquiry and this has created a relative surge in referrals in the middle of the year. There is a comparatively large increase in institutional abuse as this has been better recognised and recorded separately from other types of abuse, from 0% in 2018/19 to 11% in 2019/20. The proportion

of adults with cases of financial abuse has reduced There can be relatively small numbers of adults in types of abuse which can cause a percentage change to appear more dramatic than it is in reality. In Stoke-on-Trent more than one type of abuse may be reported for a single case and therefore there are more than 100% of cases as there are cases where more than one type of abuse has been reported.

Since 2016/17 new categories of Sexual Exploitation, Discrimination and Modern Slavery have been included.

**Location of abuse**

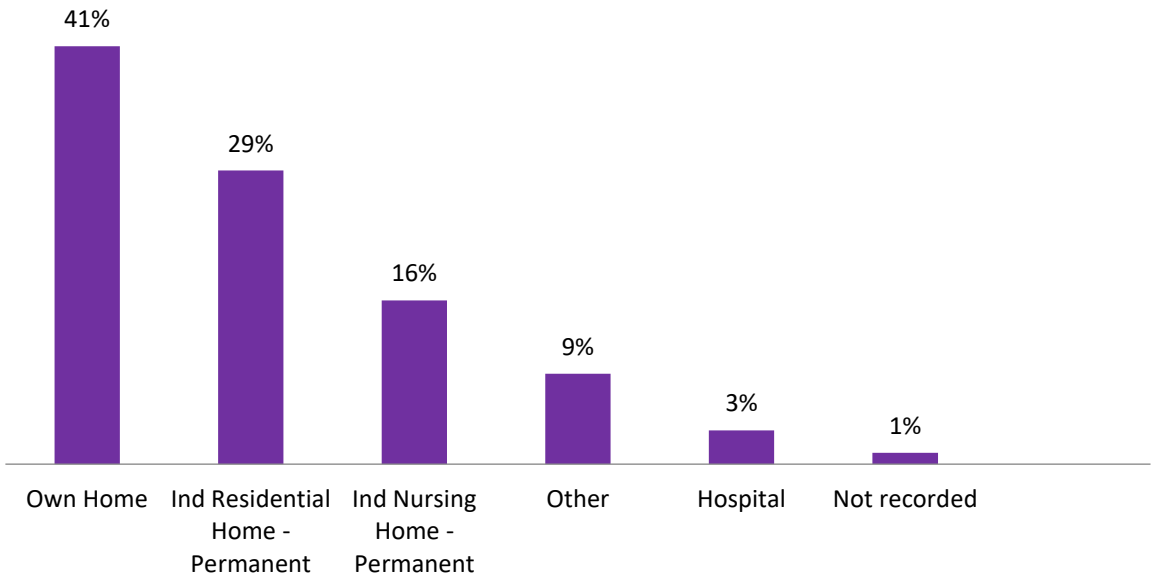
Fig.15 Staffordshire: Location of abuse (S42)




**Staffordshire**

Of those people subject of Section 42 enquiries, the most significant amount (49% were in the person's own home. The next most common locations in Staffordshire were residential homes (21%) and nursing homes (16%) which are the same percentages as last year.

Fig 16. Stoke-on-Trent: Location of abuse (S42)



**Stoke-on-Trent**

The most prevalent location of abuse in Stoke-on-Trent are the person's own home (41%) followed by Independent Residential Home (29%) and Nursing Home (16%). There has been a decrease in Abuse in the person's own home by 16 referrals from last year and a decrease of abuse reported in Nursing homes by 24 referrals.

Through audit it has been identified that some practitioners record a care home as a person's own home which may impact on this data.

## Findings of Concern Enquiries

The following section provides an overview of the findings of Section 42 enquires showing what is happening to referrals through to whether allegations were proven with a comparison to previous years.

| Staffordshire | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 |
|---|---|---|---|---|---|
| **Total Referrals** (% of referrals that are repeat) | 4457 (26%) | 5529 (22%) | 4908 (23%) | 3711 (18%) | 4150 (19%) |
| **Referrals that meet threshold** (% of total referrals) | 3194 (72%) | 3301 (60%) | 3198 (65%) | 3342 (90%) | 3861 (93%) |
| **Partially or fully proven allegations** (of outcomes recorded) | 1106 (30%) | 883 (24%) | 823 (26%) | 1405 (42%) | 904 (21%) |

| Stoke on Trent | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 |
|---|---|---|---|---|---|
| **Total Referrals** (% of referrals that are repeat) | 1872 (x) | 1953 (14%) | 2242 (14%) | 3034 (8%) | 3945 (6%) |
| **Referrals that meet threshold** (% of total referrals) | 409 (22%) | 373 (19%) | 248 (11%) | 248 (9%) | 191 (7%) |
| **Partially or fully proven allegations** (of outcomes recorded) | 145 (35%) | 204 (51%) | 158* (64%) | Data no longer collected | Data no longer collected |

X - Data not available *Based on cases with a recorded outcome

**Staffordshire:** Referrals have increased this year, and on average more have met the threshold of Section 42 enquiry. Repeat referrals have increased by 1% from last year from 18% to 19%. The proportion of referrals that meet threshold has increased by 3% to 93%. Partially or fully proven allegations have decreased in 2019/20 from 42% to 21%.

**Stoke-on-Trent**: Demand has continued to increase during 2019/20 for Stoke-on-Trent with the reported number of concerns rising by 30%. The percentage of repeat referrals has decreased from 8% to 6% with the percentage of cases that met threshold has continued a trend to decrease and dropped from 9% to 7%. Partially or fully proven allegations data is no longer collected by Stoke-on-Trent.

**Note:** There is an explanation for the reasons for variation in recording between Staffordshire and Stoke-on-Trent on page 24.

**Number and proportion of people who were involved in a Section 42 enquiry whose expressed outcomes were met.**

Fig.17 Staffordshire outcomes

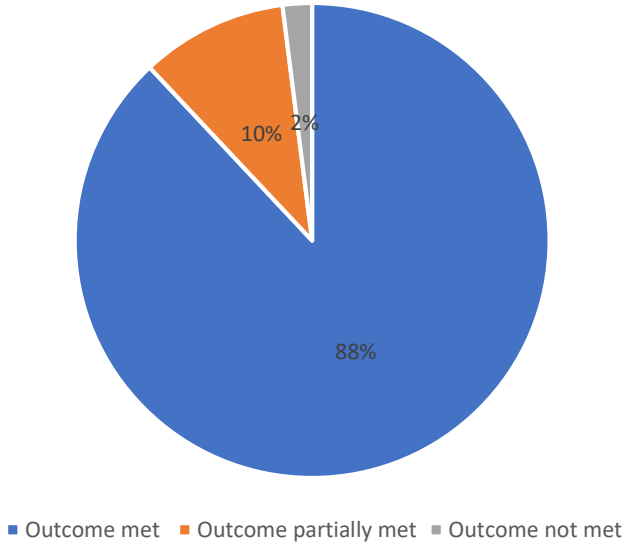
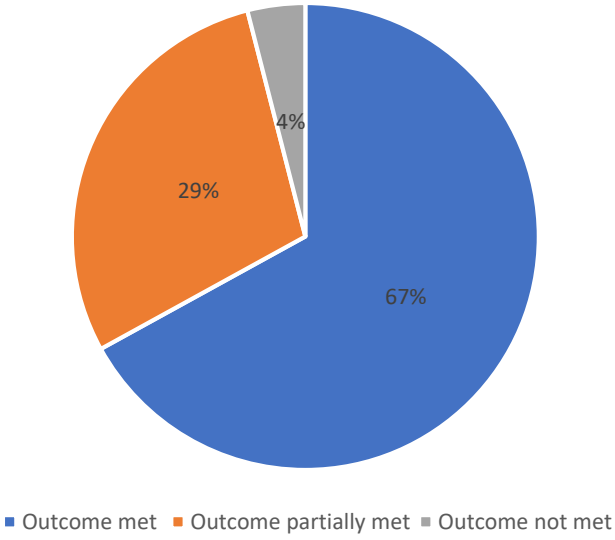



Fig.18 Stoke-on-Trent outcomes




**Staffordshire**

In Staffordshire the proportion of people subject of a Section 42 enquiry whose expressed outcome was met has increased from 80% last year, 98% of people expressing their desired outcomes as either fully or partly met has increased slightly from last year.

**Stoke-on-Trent**

The proportion of people subject of a Section 42 enquiry whose expressed outcome was met or partially met increased to 96% which shows an increase in the past two years.

**Managing Safeguarding Allegations Against Staff – Person in Position of Trust**

Safeguarding Adults Boards are required to establish and agree a framework and process for organisations to respond to allegations against anyone who works with adults with care and support needs.

People can be considered to be in a 'position of trust' where they are likely to have contact with adults at risk as part of their employment or voluntary work, and where the role carries an expectation of Trust and the person is in a position to exercise authority, power or control over an adult(s) at risk (as perceived by the adult at risk).

Where a person is experiencing or is at risk of abuse the multi-agency policy procedures should be followed. Each organisation is responsible for the management and handling of its own information and is also responsible for issues of disclosure.

Concerns may be raised through a variety of processes including:

- Criminal investigations
- Section 42 Enquiries
- Disciplinary investigations
- Regulatory action or quality assurance monitoring
- Reports from the public

If, following an investigation a Person in a Position of Trust is removed by either dismissal or permanent redeployment to a non-regulated activity, because they pose a risk of harm to adults with care and support needs, (or would have, had the person not left first), then the employer (or student body or voluntary organisation) has a legal duty to refer the person to the Disclosure and Barring Service (DBS). In addition, where appropriate, employers should report workers to the statutory and other bodies responsible for professional regulation such as the Health and Care Professions Council, General Medical Council and the Nursing and Midwifery Council.

If a person subject to an investigation attempts to leave employment by resigning in an effort to avoid the investigation or disciplinary process, the employer (or student body or voluntary organisation) is entitled not to accept that resignation and conclude whatever process has been utilised with the evidence before them. If the investigation outcome warrants it, the employer can dismiss the employee or volunteer instead and make a referral to the DBS. This would also be the case where the person intends to take up legitimate employment or a course of study.

The SSASPB has sought assurances that the multi-agency procedures are being complied with. This is monitored through the Audit and Assurance sub-group. The following information has been provided by Staffordshire Police in relation to the matters escalated for criminal investigations.

**Staffordshire Police information**

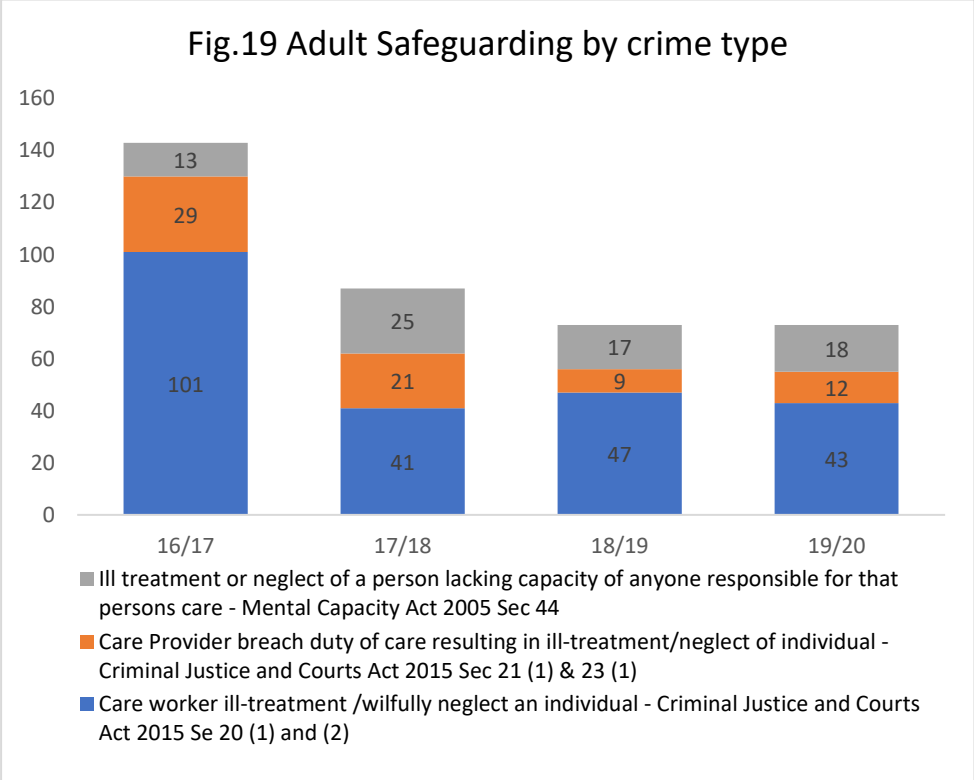



Figure 19 above illustrates that there were a total of 73 offences reported for criminal investigation in the 12 months period to 31 March 2020. The year is contrasted with previous years to indicate reporting rates over time. From analysis of 2019/20 reports:

- 1 of these offences was alleged to have occurred in 2016
- There was 1 repeat victim - both offences were at the same location
- There were 3 repeat perpetrators

- There were 10 repeat locations – 8 of these were care homes; 1 hospital; and 1 special school. 8 of these repeat locations had other adult safeguarding related offences in the previous 3 years
- 11 of the locations in the year 2019/20 were the same as adult safeguarding related offences in the previous 3 years

The analysis is used operationally to target preventative actions.

## 9. FINANCIAL REPORT

The Board is supported by a part-time Independent Chair, a full-time Board Manager and a full-time Administrator.

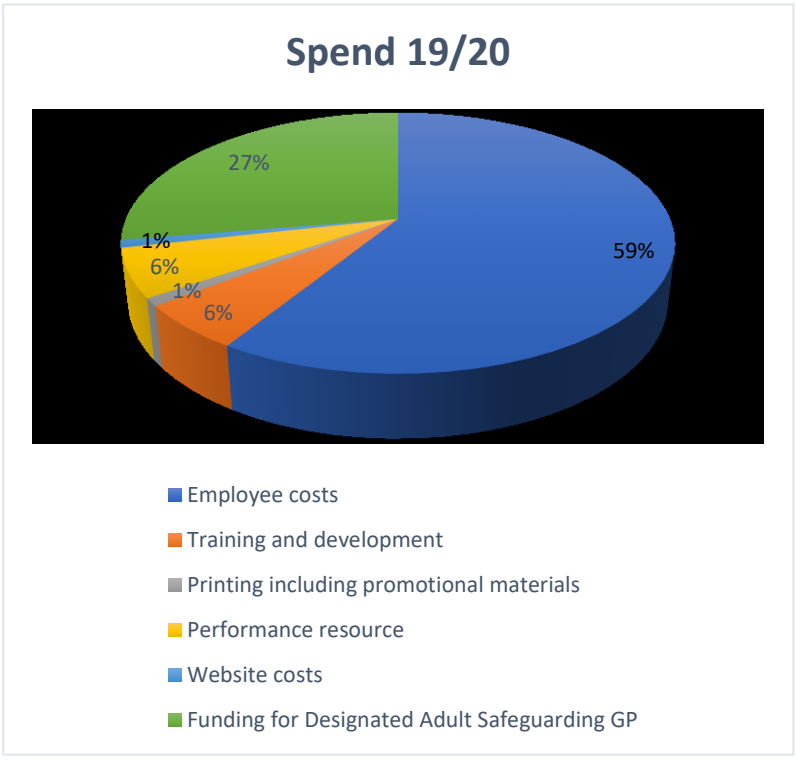
The Board wishes to acknowledge those partners who have provided rooms without cost which includes Staffordshire County Council, Stoke-on-Trent City Council, Staffordshire Fire and Rescue Service, the Clinical Commissioning Groups and Staffordshire Police.

**Income:** This was year 3 of a 3 year budget agreement which had been approved by the statutory partners in January 2017.

| | | |
|---|---|---|
| **Partner:** | Stoke-on-Trent City Council | £16,875 |
| | Staffordshire County Council | £50,625 |
| | CCGs | £67,500 |
| | Staffordshire Police | £15,000 |
| | **TOTAL** | **£150,000** |

**Spend:**

| | |
|---|---|
| Staffing *note (i)* | £112,091 |
| Training and development | £10,725 |
| Catering | £205 |
| Printing/stationery *note (ii)* | £1,803 |
| Performance Resource | £11,500 |
| Website costs | £1,800 |
| Designated Adult Safeguarding GP project *note (iii)* | £52,460 |
| **TOTAL:** | **£190,584** |




*Notes (i) All staffing costs including employment costs, mobile phone and travelling*

*(ii) Including promotional leaflets*

*(iii) This funding was a contribution towards the costs for a Designated Adult Safeguarding GP who supported the work of the Board between July 2018-July 2020. This was two year project and is not a recurring cost*

## 10. APPENDICES

### APPENDIX 1: BOARD PARTNERS

**Statutory Partners as of 31st March 2020**

- Local Authorities
  - Staffordshire County Council
  - Stoke-on-Trent City Council
- Staffordshire Police
- NHS
  - Staffordshire and Stoke-on-Trent Clinical Commissioning groups

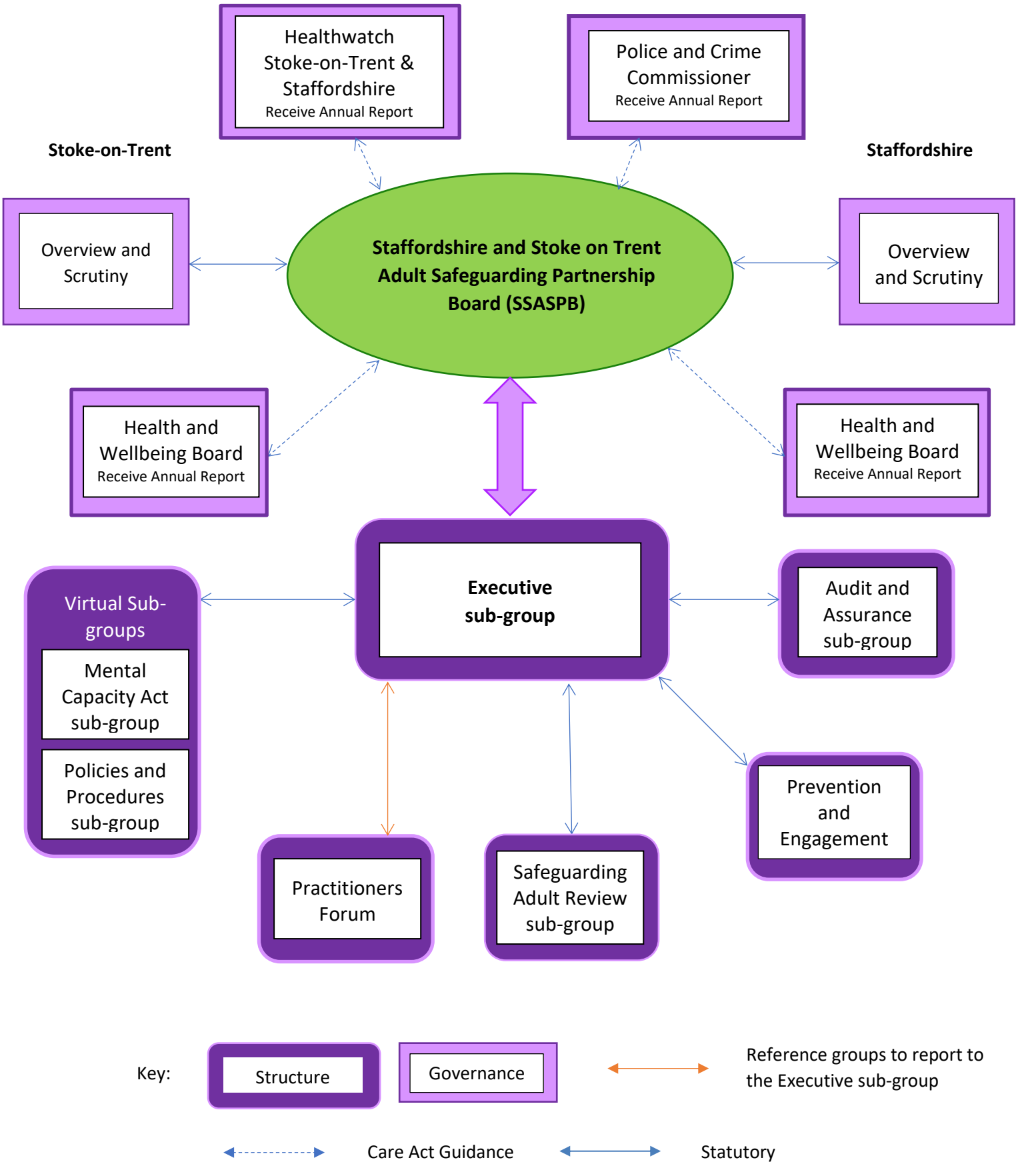
**Extended Partnership as of 31st March 2020**

- Brighter Futures
- Community Rehabilitation Company (CRCs) (Staffordshire and Stoke-on-Trent)
- Domestic Abuse Forum
- Healthwatch (Staffordshire and Stoke-on-Trent)
- Her Majesty's Prison Service (HMPS)
- Local Authority Lead members
- Midlands Partnership Foundation Trust (MPFT)
- National Probation Service (NPS) (Staffordshire and Stoke-on-Trent)
- North Staffordshire Combined Healthcare NHS Trust (NSCHT)
- Representatives from the voluntary sector
- Rockspur
- Staffordshire Association of Registered Care Providers (SARCP)
- Staffordshire Fire and Rescue Service (SFARS)
- Support Staffordshire
- Trading Standards (Staffordshire and Stoke-on-Trent)
- University Hospitals of Derby and Burton (UHDB)
- University Hospitals of North Midlands (UHNM)
- Virgin Care
- West Midlands Ambulance Service (WMAS)

**APPENDIX 2: GOVERNANCE STRUCTURE**

**From 1st April 2020**

## Governance and Structure



**APPENDIX 3: CATEGORIES OF ABUSE AND NEGLECT**

**Categories of abuse and neglect** - Section 14.17 of The Care Act statutory guidance describes the various categories of abuse and neglect:

**Physical abuse** – including assault, hitting, slapping, pushing, misuse of medication, restraint or inappropriate physical sanctions.

**Domestic violence** – including psychological, physical, sexual, financial, emotional abuse; so called 'honour' based violence.

**Sexual abuse** – including rape, indecent exposure, sexual harassment, inappropriate looking or touching, sexual teasing or innuendo, sexual photography, subjection to pornography or witnessing sexual acts, indecent exposure and sexual assault or sexual acts to which the adult has not consented or was pressured into consenting.

**Psychological abuse** – including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, cyber bullying, isolation or unreasonable and unjustified withdrawal of services or supportive networks.

**Financial or material abuse** - including theft, fraud, internet scamming, coercion in relation to an adult's financial affairs or arrangements, including in connection with wills, property, inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits.

**Modern slavery** - encompasses slavery, human trafficking, forced labour and domestic servitude. Traffickers and slave masters use whatever means they have at their disposal to coerce, deceive and force individuals into a life of abuse, servitude and inhumane treatment.

**Discriminatory abuse** - including forms of harassment, slurs or similar treatment; because of race, gender and gender identity, age, disability, sexual orientation or religion.

**Organisational abuse** – including neglect and poor care practice within an institution or specific care setting such as a hospital or care home for example, or in relation to care provided in one's own home. This may range from one off incidents to on-going ill-treatment. It can be through neglect or poor professional practice as a result of the structure, policies, processes and practices within an organisation.

**Neglect and acts of omission** – including ignoring medical, emotional or physical care needs, failure to provide access to appropriate health, care and support or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating

**Self-neglect** – this covers a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding.

**APPENDIX 4: TIER 2 AUDIT QUESTIONS**

| Category and Ideal Service/standard |
|---|
| **1 Leadership, Management and Governance** |
| 1.1 The organisation has a nominated Executive lead for Adult Safeguarding |
| 1.2 There is an operational/professional lead for adult safeguarding identified within the organisation that can provide support to staff. |
| 1.3 This is explicitly contained within their role profile or job description |
| 1.4 The organisation has a safeguarding policy to which staff have access |
| 1.5 There is recognised and active leadership to safeguard adults in the organisation |
| 1.6 Safeguarding adults is written into strategic plans within the organisation |
| 1.7 The organisation demonstrates commitment to the delivery of the strategic priorities of the SSASPB |
| 1.8 The organisation contributes to the SSASPB Annual Report |
| 1.9 The organisation provides appropriate representation both in position in organisation and attendance frequency at those SSASPB meetings it needs to attend |
| 1.10 Commissioners of services have appropriate arrangements In place to ensure oversight of safeguarding governance arrangements within organisations they commission service from |
| 1.11 The organisation can demonstrate that it has a quality auditing system that checks policy compliance and the learning informs practice, performance and policies. |
| **2 Safe Recruitment and PiPOT Management** |
| 2.1 Robust recruitment and employment practices are adopted which include taking up references and, where applicable, DBS checks - including when changing roles within the organisation |
| 2.2 There is a clear standard of conduct setting clear standards for relationships between people in positions of trust and service users/adults at risk. |
| 2.3 There are mechanisms for service users/adults at risk or their representative to make a complaint about the conduct of a member of staff |
| 2.4 There is a whistle-blowing policy to enable staff to raise concerns outside their own chain of line management |
| 2.5 There is a clear allegations management process through which abuse and neglect by staff is investigated thoroughly |
| 2.6. There is a process for reviewing any concern made about any of the organisation's services. |
| 2.7 There is evidence to indicate that lessons are learned from Person in Position of Trust (PiPOT) investigations and improvements made to policy and operational practice |
| **3 Policy and Procedure** |
| 3.1 There is an easily accessible policy/procedure which states the importance of taking ownership and responding to allegations of adult abuse or neglect. |
| 3.2 The above policy acknowledges and signposts to the Board's policies and procedures. |
| 3.3 The policy has a review schedule which is monitored. |
| 3.4 The individual organisation policy/procedures clearly outlines individual roles and responsibilities |
| 3.5 Adult safeguarding is cross-referenced in other relevant policies. |
| 3.6 The organisation has a multi-agency Information sharing Policy/procedure or uses the SSASPB one. |
| 3.7 The organisation makes the Board's Escalation Policy accessible to |

| |
|---|
| those staff who need to use it. |
| 3.8 The organisation has a Mental Capacity Act/DoLS Policy |
| 3.9 This policy is easily accessible to anyone who needs to refer to it |
| 3.10 The MCA documentation is available to staff who need to use it |
| 3.11 The organisation audits the use of the MCA by its staff |

### 4 Training and Workforce Development

| |
|---|
| 4.1 The organisation has a training plan which ensures that staff and volunteers at all levels have appropriate knowledge of safeguarding and competencies in relation to their role. |
| 4.2 There is a mechanism by which to report the number of staff trained to the SSASPB by quarter or (at a minimum) at the end of the financial year. |
| 4.3 Adult safeguarding awareness training is made mandatory to those required to receive it, this is clearly stated within the organisation. |
| 4.4 MCA awareness training is available to those staff needing it (as identified in the organisations training plan). |
| 4.5 Staff have access to supervision for safeguarding concerns. |
| 4.6 Staff within the organisation who carry out safeguarding enquiries have appropriate training and competencies. |

### 5 Practice

| |
|---|
| 5.1 The organisation can demonstrate that it promotes a person-centred approach to adult safeguarding. |
| 5.2 The organisation can demonstrate that it includes service users/victims of abuse and neglect in decision making where appropriate. |
| 5.3 The organisation can demonstrate that it invites service users to participate in reviews about their care and support where appropriate and are kept updated. |
| 5.4 The organisation can demonstrate that it appropriately uses advocacy as part of any safeguarding enquiries or calls for the services of an appropriate adult (Police) |
| 5.5 The organisation can demonstrate that the service user is central to the safeguarding plan and involved in the review process? |
| 5.6 The organisation has clear protocols for managing service user's disengagement from support |
| 5.7 The organisation seeks feedback from service users/ adults at risk |

## 11. GLOSSARY

| Glossary | |
|---|---|
| **CCG** | Clinical Commissioning Group |
| **CPS** | Crown Prosecution Service |
| **CQC** | Care Quality Commission |
| **CRC** | Community Rehabilitation Company |
| **DA** | Domestic Abuse |
| **DHR** | Domestic Homicide Review |
| **DBS** | Disclosure and Barring Service |
| **DoLS** | Deprivation of Liberty Safeguards |
| **GDPR** | General Data Protection Regulation |
| **HMIC** | Her Majesty's Inspectorate of Constabulary |
| **HMIP** | Her Majesty's Inspectorate of Prisons |
| **MAPPA** | Multi-Agency Public Protection Arrangements |
| **MARAC** | Multi-agency Risk Assessment Conference |
| **MASH** | Multi-agency Safeguarding Hub |
| **MCA** | Mental Capacity Act (2005) |
| **MPFT** | Midlands Partnership Foundation Trust |
| **NHSE** | National Health Service England |
| **NPS** | National Probation Service |
| **NSCHT** | North Staffordshire Combined Healthcare Trust |
| **OPG** | Office of the Public Guardian |
| **PiPoT** | Persons in Position of Trust |
| **QA** | Quality Assurance |
| **QAF** | Quality Assessment Form |
| **QSISM** | Quality Safeguarding and Information Sharing Meeting |
| **SAB** | Safeguarding Adults Board |
| **SAR** | Safeguarding Adults Review |
| **SARCP** | Staffordshire Association of Registered Care Providers |
| **SCC** | Staffordshire County Council |
| **SCR** | Serious Case Review |
| **SFARS** | Staffordshire Fire and Rescue Service |
| **SSASPB** | Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board |
| **SSSCB** | Stoke-on-Trent and Staffordshire Safeguarding Childrens Board |
| **SoTCC** | Stoke-on-Trent City Council |
| **TS** | Trading Standards |
| **UHDB** | University Hospital of Derby and Burton |
| **UHNM** | University Hospitals of North Midlands |
| **WMAS** | West Midlands Ambulance Service |

Please use the link below to the SSASPB website for more detailed descriptions and additional glossary items.

https://www.ssaspb.org.uk/Professionals/Glossary.aspx

# What do I do If I have an Adult Safeguarding concern?

## Report it

Please visit the SSASPB website for more ways to report a concern

www.ssaspb.org.uk/reporting-abuse


If the adult lives in Stoke-on-Trent

**0800 561 0015**

If the Adult lives in Staffordshire

**0345 604 2719**

# WORK PROGRAMME
# Safe and Strong Communities Select Committee 2020/21

This document sets out the work programme for the Safe and Strong Communities Select Committee for 2020/21.
The Safe and Strong Communities Select Committee is responsible for scrutinising: children and adults' safeguarding; community safety and Localism. The Council has three priority outcomes. This Committee is aligned to the outcome: The people of Staffordshire will feel safer, happier and more supported in and by their community.

We review our work programme at every meeting. Sometimes we change it - if something comes up during the year that we think we should investigate as a priority. Our work results in recommendations for the County Council and other organisations about how what they do can be improved, for the benefit of the people and communities of Staffordshire.

**Councillor John Francis**
Chairman of the Safe and Strong Communities Select Committee
If you would like to know more about our work programme, please get in touch with Nick Pountney, Scrutiny and Support Manager on 01785 276153 or by emailing nicholas.pountney@staffordshire.gov.uk

**Membership – County Councillors 2020-21**

John Francis (Chairman)
Bob Spencer (Vice Chairman)
Ann Beech
Ron Clarke
Ann Edgeller
Trevor Johnson
Bryan Jones
Jason Jones
Paul Snape
Mike Worthington

**Calendar of Committee Meetings - 2020-2021**

| |
|---|
| 28 May 2020 at 10.00 am **cancelled due to Covid 19** |
| 7 July 2020 at 10.00 am **virtual meeting held on Teams** |
| 1 September 2020 at 10.00 am **virtual meeting held on Teams** |
| 13 October 2020 at 10.00 am – Extra meeting **virtual meeting held on Teams** |
| 5 November 2020 at 10.00 am – **virtual meeting held on Teams** |
| 6 January 2021 at 10.00 am (moved from 11 January 2021) - **virtual meeting held on Teams** |
| 1 March 2021 at 10.00 am |
| 22 April 2021 at 10.00 am |

Meetings usually take place in the Oak Room in County Buildings.

# Work Programme 2020-21

| Date of meeting | Item | Details | Action/Outcome |
|---|---|---|---|
| 28 May 2020<br>10.00 am | **Progress with the Children's Services Improvement Plan**<br>Cabinet Member: Mark Sutton<br>Lead Officer: Helen Riley | Requested at their 28 May meeting – Members wish to see progress made with the Plan following their consideration at the May meeting. | **Meeting cancelled due to Covid 19**<br><br>*Briefing notes were requested after the 7 July meeting to update members on these items and help prioritise future work programme planning.* |
| | **Domestic Abuse**<br>Cabinet Member: Gill Heath<br>Lead Officer: Trish Caldwell | At their meeting of 1 October 2019 Members requested a six-monthly update on progress made with the newly commissioned New Era services<br>Note that following the 7 November Triangulation meeting the Cabinet Member requested that this be considered in light of the new DA Act.<br>The report needs to focus on the effectiveness of the new contract and the current shortfall in funding | |
| | **Catch 22**<br>Cabinet Member: Mark Sutton<br>Lead Officer: | Having met with members of the Catch 22 team the Vice Chairman and Members updated the select Committee on their work at their 1 October meeting. Members requested an update from Catch 22 in six month time | |
| 7 July 2020<br>10.00 am<br>**Virtual Teams Meeting** | **Update on Children's Transformation** | The Select Committee to receive an update on Children's Transformation in light of the impact of Covid 19 and the County Council's response to this. | The Children and Families Services approach and response to Covid-19 was endorsed and Members congratulated officers on their understanding of the impact and risks associated with the Covid-19 and responding to these.<br>Members also asked for a letter of thanks be sent to Catch22 for their continued professionalism and commitment throughout the crisis. |
| 1 Sept 2020<br>10.00am<br>**Virtual Teams Meeting** | **Staffordshire & Stoke-on-Trent Safeguarding Children's Board – response to Covid-19**<br>Cabinet Member: Mark Sutton<br>Lead Officer: Helen Riley | Following the 7 July Select Committee Members requested another opportunity to consider the response to Covid-19 by the Staffordshire & Stoke-on-Trent Safeguarding Children's Board in more detail. | Officers were commended on the work undertaken and on their risk and recovery planning. The refreshed risk and recovery plan will be shared with the Select Committee once it has been updated to include demand following the return to school. |
| 13 Oct 2020<br>10.00 am | **Children & Families Transformation –** | An extra meeting requested for pre-decision scrutiny to look at progress with the Children and | An update on the 50% increase in EHE numbers and the impact of Covid 19 on these be include on the work programme. |

| | | | |
|---|---|---|---|
| **Extra meeting Virtual Teams Meeting** Healthy Staffordshire Select Committee Members invited to attend | **update** Cabinet Member: Mark Sutton Lead Officer: Helen Riley | Families Transformation prior to the October Cabinet. | Members noted the progress made and recognised the impact of delays on both outcomes and the MTFS. Members comments on the update will be fed back to the October Cabinet meeting. |
| 5 Nov 2020 10.00am | **Customer Feedback and Complaints Annual Report 2019-20 – Adults Social Care** Cabinet Member: Johnny McMahon Officer: Kate Bullivant | Reports brought annually. | They heard that the number of complaints received during the year was as follows:- (i) 187 Stage 1 – Local Investigation complaints and; (ii) 35 Stage 2 - Local Government and Social Care Ombudsman complaints. However, there had been no complaints requiring independent investigation. Members noted the main areas for complaint and were satisfied that the Authority had taken appropriate steps to improve service delivery where necessary. Also, they were encouraged that the volume of complaints had been relatively small having regard to the extent of Adult Social Services provided by the Authority during 2019/20. |
| | **Customer Feedback and Complaints Annual Report 2019-20 – Children's Social Care** Cabinet Member: Mark Sutton Officer: Kate Bullivant | Reports brought annually. | They gave preliminary consideration to a report of the Cabinet Member for Children and Young People on Customer Feedback and Complaints Service – Children's Social Services Annual report 2019/20 and requested that the matter be brought back to their next meeting in January 2021 for proper scrutiny. |
| | **Court Backlogs: Impact on Children's Social Care** Cabinet Member: Mark Sutton Officer: Deborah Ramsdale | Requested by Members following concerns around the backlog that has resulted from Covid 19 restrictions | They heard that the 2020 Covid-19 pandemic had exacerbated a pre-existing backlog in the family and criminal justice systems which, unfortunately, had significant implications for those families and individuals concerned. In addition, there were considerable financial pressures on the County Council from delays in cases being heard. However, they were satisfied that appropriate action had been taken by the Authority to highlight the difficulties caused by delays, with Central Government, the judiciary, independent sectors and other stakeholders, as appropriate and looked forward to an improvement in the current situation, as soon as possible. |
| | **Impact of Covid on Children appearing in Criminal courts** Cabinet Member: Mark Sutton Officer: Hazel Williamson | Requested by Members following concerns around the backlog that has resulted from Covid 19 restrictions | *See above* |
| 6 January 2021, 2.00 pm (moved | **Staffordshire and Stoke-on-Trent Adult** | Consideration requested by the SSASPB to give assurance and an opportunity for the Committee | |

| | | | |
|---|---|---|---|
| from 11 January 2021, 10.00 am) | **Safeguarding Partnership Board (SSASPB) – Annual Report**<br>Cabinet Member: Johnny McMahon<br>Officer: | to reflect on adult safeguarding and seek answers to any questions. Inclusion in Work Programme agreed by Chairman 22 October 2020. | |
| | **Customer Feedback and Complaints Annual Report 2019-20 – Children's Social Care (including learning from Complaints)**<br>Cabinet Member: Mark Sutton<br>Officer: Kate Bullivant | Reports brought annually. First considered at meeting on 5 November but further report to include additional information. | |
| | **Elective Home Schooling**<br>Cabinet Member: Mark Sutton<br>Officers: Jenny Dodd, Karl Hobson | | |
| tbc | **Safeguarding Adults on the cusp of care**<br>Cabinet Member: Johnny McMahon<br>Lead Officer: Jo Sutherland | At the 7 November Triangulation meeting it was proposed to look at any gaps in provision between what is happening in the community for adults on the cusp of care, the **neighbourhood coaches/provisions** and any safeguarding issues this may present. | |
| tbc<br>6 monthly update from 7 November meeting (May/June 2020) | **Regional Permanency Partnership**<br>Cabinet Member: Mark Sutton<br>Lead Officer: Deborah Ramsdale & Jo Sullivan | Following consideration of the arrangements at their 7 November Select Committee Members had requested an up-date on progress with the arrangements in six months' time. | |
| tbc | **Contextual Safeguarding Review**<br>Cabinet Member: Mark Sutton<br>Lead Officers: Vonni Gordon<br>Hazel Williamson | Following the introduction of the Contextual Safeguarding approach a review at the end of its first year will consider progress made and the Select Committee will consider the results of this review. | |



| Standing Items 2020-21 | | |
|---|---|---|
| **Item** | **Details** | **Action/Outcome** |

| | | |
|---|---|---|
| **Themes emerging from Serious Case Reviews**<br>Cabinet Member: Mark Sutton<br>Lead Officer: | Where Serious Case Reviews have taken place the Select Committee will consider any learning that can be taken from the Review | Some areas picked up by the DHR review process |
| **MTFS Reforms and assessing the "no impact claims"** | Suggested at the 29 May Triangulation meeting.<br>To scrutinise those areas of the MTFS that promise "no impact" from the changes made to assess if this was accurate and/or whether the identified mitigating action has been effective.<br><br>This is routinely scrutinised by Corporate Review, with that Committee referring specific issues to the appropriate Select Committee for further scrutiny as and when necessary. | |

## Briefing Notes/Updates/Visits 2020-21

| Date | Item | Details | Action/Outcome |
|---|---|---|---|
| | **Progress with the Children's Services Improvement Plan** | Requested at their 28 May meeting – Members wish to see progress made with the Plan following their consideration at the May meeting.<br><br>*One of the items from the cancelled meeting due to the pandemic* | Special Meeting 13 October 2020 |
| | **Domestic Abuse** | At their meeting of 1 October 2019 Members requested a six-monthly update on progress made with the newly commissioned New Era services<br>Note that following the 7 November Triangulation meeting the Cabinet Member requested that this be considered in light of the new DA Act.<br>The report needs to focus on the effectiveness of the new contract and the current shortfall in funding.<br><br>*One of the items from the cancelled meeting due to the pandemic* | Circulated to Members 14 October 2020 |
| | **Catch 22** | Having met with members of the Catch 22 team the Vice Chairman and Members updated the select Committee on their work at their 1 October meeting. Members requested an update from Catch 22 in six month time.<br><br>*One of the items from the cancelled meeting due to the pandemic* | Circulated 21 September 2020 |

# Working Group and/or Inquiry Days 2020-21

| Date | Item | Details | Action/Outcome |
|---|---|---|---|
| January 2021 | **Transition & Preparation for Adulthood**<br>Cabinet Member: Mark Sutton<br>Lead Officer: Deborah Ramsdale | At their 22 January 2019 meeting Members requested this issue be included on their work programme – with consideration to be given to whether this should be considered by a working group.<br>In particular they wanted to look at the transition between children's and adult services, the gaps, those that remained vulnerable but under the Care Act did not meet the criteria to receive adult services and how to prepare individual's to be resilient and prepare for as independent an adulthood as possible. | Deborah Ramsdale is working on adults' transition, including transition clinics. TSU have undertaken a piece of work in this area. A Peer Review on Adults is due in October 2019. Proposed to stall working on this until post the Peer Review.<br><br>A protocol has now been agreed and will be implemented in November 2019.<br><br>Following their meeting of 13 January, the Select Committee agreed to postpone a decision on establishing this working group to allow the protocol, which went live in November 2019, to bed in. A report will be brought to the Select Committee in 12 months' time (January 2021) to evaluate progress made and Members can consider whether there remains a need for a working group at that point. |
| ongoing | **Children & Families Transformation System progress**<br>Cabinet Member: Mark Sutton<br>Lead Officer: Janene Cox/Helen Riley | To scrutinise progress made with the Transformation programme on a monthly (or as appropriate) basis. | At their 13 January 2020 meeting Members agreed that the Chairman (and/or Vice Chairman or Shadow Vice Chairman) will attend the monthly Children's Improvement Board and report back to the Select Committee rather than duplicating work already underway by establishing a separate working group.<br><br>Consequently, an oral report will be given by the Chairman (and/or Vice Chairman or Shadow Vice Chairman) to the Select Committee reporting on progress. |
| March 2019 - | **SEND Working Group**<br>Cabinet Member: Mark Sutton<br>Lead Officer: Tim Moss | Following the joint Ofsted and Written Statement of Action (WSoA) a joint working group was established with Members from the Prosperous Staffordshire, Healthy Staffordshire and Safe and Strong Communities Select Committees to look at progress in implementing the WSoA. | |
| | **Children's Improvement Board informal briefing**<br>Cabinet Member: Mark Sutton<br>Lead Officer: Helen Riley | At the 7 July Select Committee the Chairman requested an informal briefing for all Members to update them on the work of the Children's Improvement Board. | |

| **Children's Improvement Board – monitoring of the Children & Families Transformation System progress** | | | |
|---|---|---|---|
| Date | Who attended from the Select Committee | Items discussed | Information |
| 30 January,<br>25 February,<br>29 June 2020 | Cllr Francis | 1. Focus area for discussion<br>• Tribunals and the cost implications of SCC conceding/losing at tribunal<br>• Progress overview<br>2. Performance – EHCP data<br>3. Emergent risks<br>4. Forward plan | To be reported at the meeting.<br>At the 7 July Committee meeting members asked for an informal workshop to discuss the improvement plan in detail. |