County Buildings, Stafford
DDI 01785 276143
Please ask for Helen Phillips
Email: helen.phillips@staffordshire.gov.uk

Safeguarding Overview and Scrutiny Committee

Thursday 5 January 2023
10:00
Oak Room, County Buildings, Stafford

The meeting will be webcast live which can be viewed at any time here:
https://staffordshire.public-i.tv/core/portal/home

John Tradewell
Director of Corporate Services
23 December 2022

A G E N D A

1. **Apologies**

2. **Declarations of Interest**

3. **Minutes of the Safeguarding O&S meeting held on 24 November 2022** (Pages 1 - 6)

4. **Adult Safeguarding Transformation Project** (Pages 7 - 10)

   Report of the Cabinet Member for Health and Care

5. **Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board (SSASPB) Annual Report 2021/2022** (Pages 11 - 62)

   Report of the Adult Safeguarding Partnership Board

6. **Staffordshire Safeguarding Children's Board Annual Report** (Pages 63 - 88)

   Report of the Safeguarding Children's Board

7. **Work Programme** (Pages 89 - 100)

8. **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 Schedule 12A (as amended) of the Local Government Act 1972 indicated below".

Part Two
(All reports in this section are exempt)

nil

Membership

Gill Burnett (Vice-Chair (Overview))	Gillian Pardesi
Janet Eagland	Kath Perry, MBE
Richard Ford (Vice-Chair (Scrutiny))	Bob Spencer (Chair)
Derrick Huckfield	Mike Wilcox
Johnny McMahon	Conor Wileman

Notes for Members of the Press and Public

Filming of Meetings

Staffordshire County Council is defined as a Data Controller under the Data Protection Act 2018. The County Council has agreed that Public meetings should be the subject of live web transmission 'webcasting'. Fixed cameras are located within meeting room for this purpose.

The webcast will be live on the County Council's website and recorded for subsequent play-back for 12 months. The recording will also be uploaded to YouTube. By entering the meeting room and using the seats around the meeting tables you are deemed to be consenting to being filmed and to the possible use of those images and sound recordings for the purpose of webcasting.

If you have privacy concerns about the webcast or do not wish to have your image captured then please contact the Member and Democratic Services officer named at the top right of the agenda.

Recording by Press and Public

Recording (including by the use of social media) by the Press and Public is permitted from the public seating area provided it does not, in the opinion of the chairman, disrupt the meeting.

Minutes of the Safeguarding Overview and Scrutiny Committee Meeting held on 24 November 2022

Present: Bob Spencer (Chair)

Attendance	
Gill Burnett (Vice-Chair (Overview))	Kath Perry, MBE
Janet Eagland	Mike Wilcox
Gillian Pardesi	

Also in attendance: Mark Sutton

Apologies: Richard Ford, Johnny McMahon and Conor Wileman

PART ONE

33. Declarations of Interest

There were none at this meeting.

34. Minutes of the Safeguarding Overview & Scrutiny Committee held on 24 October 2022

Resolved: That the minutes of the Safeguarding Overview and Scrutiny Committee meeting held on 24 October 2022 be confirmed and signed by the Chairman.

35. Regional Permanency Partnership and pilot project outcomes

In July 2021 the Committee had considered arrangements for delivery of the new Regional Adoption Agency for Staffordshire County Council, Stoke-on-Trent City Council, Shropshire Council and Telford & Wrekin Council, called the Together4Children Permanency Partnership. This had been developed in response to the Government's Regionalising Adoption agenda.

The Partnership vision went beyond the delivery of Adoption Services and focused on a broader range of activities to ensure that children entering care achieved permanency. The Partnership worked together to improve outcomes for those children who entered care and were not able to return to their birth parents, aiming to:

i) make best use of the collective resources to recruit, assess and support prospective adopters across the region;

ii) improve the quality and speed of matching for children through better planning and by having a wider choice of adopters;
iii) provide high quality support to children and their families delivered through a combination of direct provision and effective partnerships; and
iv) provide all children and their families the right support at the right time through a consistent permanency support offer across the region.

The Committee were aware that the Partnership had been launched in September 2020, with the first key deliverables focusing on the Adoption Service. However, unlike most regional agencies, the Together4children Partnership is delivered via a hub and spoke model. This is a combination of core central functions and networked regional delivery (via a Central Permanency Hub) enabling Partner Councils to retain direct service delivery functions within Locality Permanence Hubs, working within the Together4Children practice framework whilst maintaining clear links to local Children & Families Services.

The Committee received details of the functions, governance, operational structure and legal and financial arrangements for the Partnership. Members were informed that the recruitment of potential adopters had been supported by strong and effective marketing activity. This had led to strong levels of enquiry and referrals through to the 3 assessment teams, with 720 enquiries for people considering adopting a child leading to 140 referrals through to the assessment teams and 83 approvals. Having a good pool of regional adoption families supported positive transition for children and enabled better support for their families moving through the adoption process. During 2021-22 93% of the children placed for adoption had been with families assessed and approved within the Together4Children region. Members were pleased to note that, where families were not identified regionally to meet the specific needs of a child or children within the region, work with agencies across the Midlands and, where necessary, nationally was undertaken to ensure every possibility was explored to find the right adoptive family.

Members considered data comparisons in time taken to place a child, noting that care proceedings through court took six months. Together4Children performed well against national statistics. Members also considered the support for adopter families, and in particular considered developments in the delivery of "TESSA". This initiative had been reviewed and was now offered to families much earlier in the process. The support offered included:

i) Clinical Psychologist-led assessment and support plans, family support, and core training;

ii) Innovative group therapy, counselling, coaching, and mentoring, enhanced training, school consultation.; and
iii) Support in accessing statutory and voluntary provision, specialist and medical support and community groups.

Members heard that since TESSA went live in October 2020 50 families across the Together4Children region had received support through this provision.

The Committee were also informed that Together4Children was the first ever Local Authority Partnership to jointly launch the Mockingbird Fostering Model by working together across the four fostering services. Over two years this innovative fostering model had been successfully delivered across 3 regional pilot sites, with the fourth and final pilot to go live in November 2022. Mockingbird is a successful evidence-based support offer creating a network of foster carers sharing experience, advice and expertise.

Members queried whether the current cost of living pressures would have an impact on families considering adoption. They heard that in general those choosing to adopt were differently motivated, seeking to increase their family. In specific cases some financial support could be offered, for example where a sibling group was placed together, however such decisions were made on a case-by-case basis.

On querying the resource available to the Partnership, Members were informed that adoption was not necessarily the best option for every child or young person. Court decisions around adoption were individual, based on that specific child and family, and therefore the number and pattern of adoptions would not necessarily be changed by additional resource.

Of the 104 adoption orders granted regionally last year, 63 were "priority children", i.e. those children that were more challenging to find the right families for because they were either over five years, needed sibling placements, were from ethnic backgrounds other than "white British" or had a disability. The Committee welcomed the work to improve the diversity of prospective adopters and the wider work across the Midlands to enable broader placement options. Members were reassured when hearing the work undertaken to ensure the right family placement was found, hearing about the family finding team and permanence coordinators. As necessary a national service "linkmaker" was used which looked for suitable placements at a national level.

Members raised concerns around the use of agency staff and were assured that there was a clear vetting process and rigorous recruitment for all staff. They were also pleased to note that almost all adoption agencies were judged by Ofsted as good or outstanding.

The effectiveness of performance data was queried, with Members concerned that nuances of the individualised work involved were lost in flat figures. Benchmarking trends over three years helped give an understanding of performance. However, the priority was always the individual child, with some necessarily taking longer to place successfully and it was important to understand the range of factors involved and not just the blunt average figures.

Members thanked Officers for this work which was making a real difference.

Resolved: That the work of the new Together4Children Permanency Partnership and the development of the TESSA and Mockingbird projects be welcomed and Officers be congratulated for the effectiveness of this work.

36. Young Carers

As part of their work planning in June 2021 the Safeguarding Overview and Scrutiny Committee included the role of young carers in their 2021/22 work programme. Members wanted to scrutinise the support given to Staffordshire young carers and consider the level of caring roles undertaken, seeking reassurance that these were not at a level that should be provided by social care.

Following a presentation to the Committee a group of four Members, undertook to meet with young carers to hear first-hand about the support they received.

The Members involved were Mrs J Eagland, Mrs G Pardesi, Mrs K Perry and Mr B Spencer. These Members shared their experiences from their meeting with young carers, including the excellent work by some schools. They also noted the support and training offer from the Young Carers Service and the need to raise awareness in schools of this offer and ensure schools take advantage of this support.

The Committee welcomed the report. They considered in more detail the recommendation for Members to become young carers service advocates, agreeing that this would include:

a) Councillors taking every opportunity to raise the profile of the Young Carers Service
b) Raising awareness of the Young Carers Service Offer in schools
c) Where Members are school governors, they:
    i) Ensure schools have fully considered and taken advantage of the Young Carers offer; and
    ii) Assure themselves of the support and provision for young carers within school.

Members also suggested that the Chairman discuss with the Cabinet Member for Education ways to raise the profile of the Young Carers Service offer within schools and to extend the Member Young Carers Advocate initiative more broadly across the Council.

Resolved: That:

a) The sub-group's report be accepted, having particular regard to:
    i. reassurances that the initial in-house assessment of young carers is robust,
    ii. performance data development with regard to the young carers service should more accurately evidence the types of care, ages and hours of care given, and
    iii. more proactive signposting to the broad range of support services for young carers is being developed by the Young Carers Service;
b) Members become young carers service advocates, raising the profile of the services available within schools and the benefits to both schools and their pupils in taking advantage of these services;
c) the Chairman write again on behalf of the Committee to inform the young carers of the activity resulting from this work and specifically from their meeting with Members, thanking them again for the part they played;
d) the Chairman write to Cathryn Rayner at the Young Carers Service thanking her for the excellent work she and her team undertake in supporting young carers; and
e) the Chairman discuss with the Cabinet Member for Education ways to extend the Member Young Carer Advocate initiative and more generally raise the profile of the Young Carers Service offer in schools.

37. Work Programme

The Committee received an update on their work programme as follows:

a) the Staffordshire Safeguarding Children's Board Annual report had been moved back to 5 January meeting to enable the new independent chairman to attend;
b) Members had received an email explaining the reasons for the cancellation of the Family Improvement Boards, which had been to align with the Family Hub process. Detail on Family Improvement Boards will be included as part of the work programme item on Family Hub development;
c) a pre-decision scrutiny item on the House Project to be added to the work programme for February; and,
d) a joint meeting between the Police Fire and Crime Panel (PFCP) and the Safeguarding Overview and Scrutiny Committee had been

suggested, to consider the outcome of the PEEL inspection and the improvements being made. Following discussions between the Chairmen of the respective committees and the Commissioner it had been agreed that the PFCP will consider this issue, with the Safeguarding O&S Committee Chairman invited to that meeting. Subsequently the Commissioner and Officers will attend a meeting of this Committee to consider specific issues raised as part of the Committee's crime and disorder role.

Resolved: That the amendments to the work programme be agreed.

Chairman

Staffordshire County Council

Safeguarding Overview and Scrutiny Committee - Thursday 05 January 2023

Adult Safeguarding Transformation Project

Recommendation

I recommend that the Committee:

a. note the update on the Adult Safeguarding Transformation including update on the Key Performance Indicators

Local Member Interest: N/A

Report of Cllr Julia Jessel, Cabinet Member for Health and Care

Summary

What is the Overview and Scrutiny Committee being asked to do and why?

1. The Safeguarding Overview and Scrutiny committee is asked to consider the update on the adult safeguarding transformation project following the previous report in September 2021.

Report

Background

2. The Care Act (Section 42) places a duty on Local Authorities to make enquiries into concerns where adults who have care and support needs and who are unable to protect themselves, may be at risk of abuse and/or neglect. Abuse includes concerns about physical, sexual and financial abuse. Neglect includes concerns such as inadequate nutrition, medical treatment or personal care.

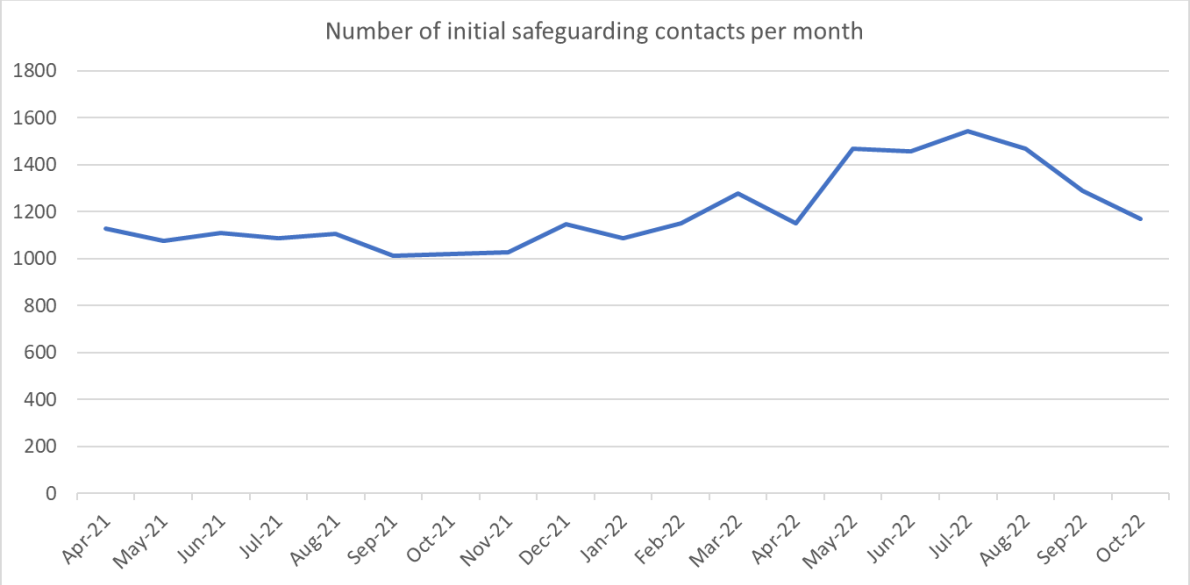
3. Initial contacts to report Safeguarding concerns come through to Staffordshire Adult Safeguarding Team (SAST), which is based in the Multi agency Safeguarding Hub (MASH). SAST will arrange for immediate action to protect the adult where appropriate. They also make the decision as to whether a Section 42 Safeguarding enquiry is required to investigate and address more serious concerns. Where a Section 42 enquiry is required, this will go to adult social work teams or other organisations for completion.

4. All Safeguarding concerns are reviewed by SAST on the day they are received, and risk assessed by a qualified social worker (Advanced Practitioner) working with other professionals in the MASH. We respond to concerns assessed as high risk as a priority.

5. The Council has seen an increase in the number of Safeguarding concerns reported over the last few years, as shown below, although this has not required a greater number of Section 42 enquiries.

Year	Safeguarding concerns	Section 42 enquiries
2017	10,925	3,102
2018	11,356	3,100
2019	14,769	3,797
2020	16,165	3,102
2021	14,602	2,792
2022 (Excluding December)	14,182	2,405

6. This year there was an increase in the number of Safeguarding concerns reported between May and September, as shown below. This led to a backlog of work for a period.



7. Through the transformation project this backlog has now been addressed and the number of concerns outstanding has been reduced to around 250 with the longest waiting for less than a month and most of these not requiring a Section 42 enquiry.

Staffordshire County Council

Adult Safeguarding Transformation Project Update

8. The adult safeguarding transformation project began in February 2020 to ensure the correct processes and capacity were in place to deliver the Council's statutory responsibilities for safeguarding. The Covid pandemic delayed progress however the transformation has now been completed.

9. We have completed a wholescale review of processes and forms, removing duplication and repetition. This has had the desired impact of reducing administrative tasks that have assisted the flow of work. It includes:

    a. SAST now receive all adult safeguarding concerns including those that previously went to mental health teams.
    b. SAST gather relevant information earlier in the process which ensures that adults receive the necessary protection as quickly as possible, and that there is a clear plan in place if any further enquiries are required.
    c. Where people contact the Council to report concerns about self-neglect a Care Act assessment is now completed in the first instance and appropriate care and support identified, with higher risk concerns referred to SAST, as necessary.
    d. Work has commenced with the Quality Assurance team to support care providers to make appropriate safeguarding referrals. We are now able to link concerns to care providers in Care Director so we can monitor for patterns and target responses more effectively.

10. We have also reviewed and augmented capacity. SAST is now fully staffed with seven substantive Advanced Practitioners in post.

11. Key Performance indicators for timeliness of decision making are in place. We aim to make an initial decision in relation to concerns within 5 working days 'contact closed' and ideally with 2 working days. Performance is improving month by month and currently:

    a. Contacts closed within 0-2 days 32%
    b. Contacts closed within 2-5 days 14%
    c. The remaining 54% of contacts are, on average, closed within 27 days.

12. Work is ongoing to develop contingency plans to reduce the risk of delays caused by any further increases in demand. This will include quicker identification of surges in demand and consideration of prioritisation and/or given temporary increase in capacity at certain points.

Link to Strategic Plan

13. The Adult Safeguarding function contributes to the Health & Care Strategic Delivery Plan by:

    a. Promoting good health and independence, and encourage and enable people to take personal responsibility for maintaining their well-being
    b. Ensuring effective and efficient assessment of needs that offers fair access to services
    c. Ensuring the best use of resources, people, data and technology

Link to Other Overview and Scrutiny Activity

N/A

Community Impact

No Impact

List of Background Documents/Appendices:

N/A

Contact Details

Assistant Director: Jo Cowcher, Assistant Director for Adult Social Care

Report Author: Ruth Martin
Job Title: Principal Social Worker and Safeguarding Lead
Telephone No.: 01785 895150
E-Mail Address: ruth.martin@staffordshire.gov.uk

Staffordshire County Council

Safeguarding Overview and Scrutiny Committee - Thursday 05 January 2023

Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board (SSASPB) Annual Report 2021/2022

Recommendations

I recommend that the Committee:

a. receives the SSASPB Annual Report in accordance with the requirements of the Care Act 2014 Statutory Guidance (02.09.2022): Chapter 14 Paragraph 160)

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

Local Member Interest: N/A

Report of Mr John Wood, Independent Chair of the Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board

Summary

What is the Overview and Scrutiny 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: 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 several 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 2020 to March 31st, 2021. 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 overview for the reporting period 1st April 2021 to 31st March 2022:

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.

Concerns Reported

9. There have been 13,227 occasions where concerns have been reported that adults with care and support needs may be experiencing or at risk of abuse and neglect. This number has increased by 1,051 from 2020/21

which was reported as 12,176. Following initial assessment it was determined that the duty of enquiry requirement was met in 21% of those reported concerns, a decrease of 4% from 2020/21.

10. In the context of rising numbers of reported concerns and the lower proportions of these meeting the duty of enquiry requirement the reasons for the fluctuations have been explored by safeguarding partners. Safeguarding concerns range from the very serious to the relatively trivial. A safeguarding concern is recorded as such on receipt of the information from the referrer.

11. From examination and assessment a proportion of concerns are found to be low level incidents which have led to no harm to the individual. Concerns such as these are triaged early and with no other actions being needed, they will be closed. Examples include concerns regarding medication errors, service user incidents, missed and late care calls. In other situations, appropriate actions have been taken by others to reduce the risk and therefore a Section 42 enquiry is not required.

12. Arising from the increasing number of reported concerns there are discussions currently amongst safeguarding partners to develop a mutual understanding of what constitutes a safeguarding concern with the aim of ensuring proportionate ongoing management to protect resources to deal with the more serious cases.

Age

11. Of the people subject of a S42 enquiry, those aged 85 to 94 yrs (25.2%) represent the largest cohort, very closely followed by 75 to 84yrs (24.9%). There has been very little change when compared to last year's figures. When drawing comparison with the population statistics of Staffordshire it is evident that adults in the 75yrs+ age groupings are disproportionally over-represented for Section 42 enquiries.

Gender

12. The majority of Section 42 enquiries involve females – 64%. This is disproportionately above the population average for females in Staffordshire which is 50.3%. Females above the age of 75 years are consistently found to be most at risk of abuse or neglect.

Ethnicity

13. The majority of adults involved in a Section 42 enquiry are white - 87.8%. The percentage of the population of Staffordshire who self-identified as white is 93.6%. In 6.2% of the Section 42 enquiries the

ethnicity is 'not known'. This may in part be due to the adult being unable to self-identify. Recording may also contribute to this figure. In future the recently updated version of the Information Management System used by SCC – 'Care Director' may assist in reducing the not knowns.

Primary Support Reason (PSR)

14. Physical support continues to be the most common PSR in Staffordshire at 48%. This is followed by mental health support at 14% and learning disability at 9%. It is difficult to accurately interpret these figures because 17% were recorded as 'not known'. This is a reduction when compared to 29% in the previous reporting year. The reasons for the 'not known' are not clear. In part this may be due to cases that are closed at an early stage when the PSR is not known.

Type of Abuse

15. Neglect and Acts of Omission (37%), Financial Abuse (19%) and Physical Harm (17%) continue to be the most prevalent types of abuse and neglect in Staffordshire. This is broadly similar to the figures reported last year.

16. Pages 17 - 23 of the Annual Report contain case studies which exemplify some types of abuse and neglect and the multi-agency response.

Location of Abuse

17. The most reported location of abuse in Staffordshire was the adults' own home at 62%. The next most prevalent locations were nursing home 16% an increase of 5% from 2020/21 and independent residential home 11% which is similar to last year. Put into context the adult may consider their care/residential or nursing home as their 'own home'.

Expressed Outcomes met

18. In Staffordshire 67% of adults subject of a Section 42 enquiry provided a response to the question of whether their desired outcomes from the enquiry had been met in full, partially met or not met. A total of 97% adults of those responding stated that their desired outcomes were fully met or partially met. This is a slight reduction from 98% last year.

19. The reasons why the adults' desired outcomes have not been met have been explored. Amongst the reasons are situations where the outcomes set by the adult are not always achievable. By way of example, in financial abuse cases the adult may want their property/money returned but it cannot be recovered. In some instances, the adult may want staff

members disciplined or sacked etc. and again this is not possible. In some situations, it is because the adult wants to move away from or stay with family but the risks are too high and there is a need for appropriate proportionate action to reduce the risks.

The COVID-19 Pandemic

20. This Annual Report covered the period 1st April 2021 to 31st March 2022. At the beginning of the year care homes and adults with care and support needs who were not visible, or unable to receive their usual support, were of huge concern due to the stringent restrictions on social interaction.

21. Safeguarding partners adapted their approaches to become more supportive of front-line operations whilst at the same time remaining vigilant as to the implications for hidden adults arising from shielding; homeless adults and rough sleepers with care and support needs; and the experiences of those adults with care and support needs at increased risk of exploitation and domestic abuse.

22. The Board has adapted its approaches to seeking assurances as to the effectiveness of safeguarding arrangements using a range of methods to communicate and engage. The response to the necessary changes has demonstrated the strength of local partnership working which has become even more cohesive and visible over time.

Link to Strategic Plan

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

24. Encourage good health and wellbeing, resilience and independence

Link to Other Overview and Scrutiny Activity

25. Deprivation of Liberty Safeguards

Community Impact

26. 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 2021/22

Contact Details

Assistant Director:	Jo Cowcher, Assistant Director for Adult Social Work and Safeguarding
Report Author:	Mr John Wood
Job Title:	Independent Chair of the Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board
Telephone No.:	via 07887 822003
E-Mail Address:	john.wood1@staffordshire.gov.uk

SSASPB Annual Report 2021 to 2022

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

2. Independent Chair Foreword

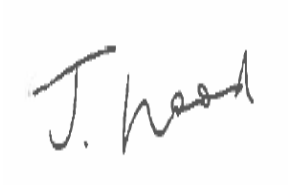
It is my privilege as Independent Chair to write the foreword to this Annual Report of the Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board. This report provides a look back at the work by the partners of the Board and its sub-groups over the year 1st April 2021 to 31 March 2022. It illustrates the enormous range and amount of safeguarding activity done in partnership, much of which builds on learning from good practice as well as where things have gone wrong.

This has been a second consecutive year where the COVID-19 pandemic has provided a dominant context adversely impacting on the health and wellbeing of millions of people both here in the United Kingdom and throughout the world. I again take this opportunity to offer, 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 also acknowledge the enormous role of all professionals who delivered services to adults with care and support needs, often at considerable personal cost.

In the last 12 months the strength and maturity of local partnership working has been demonstrated in the constructive way that connected partners have shown a willingness to challenge each other and be challenged as to the effectiveness of safeguarding arrangements. Consequently, the Board has adapted its approaches to seeking assurances and these are reflected in the revisions to the Strategic Plan that was being reviewed at the time of writing this Foreword. The Annual Report next year will provide details on how the Strategic Plan has been implemented and what has been achieved.

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



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
- It must conduct a Safeguarding Adult Review where the threshold criteria have been met and share the detailed findings and on-going reviews within the annual report

Composition of the Board

The Board has a broad membership 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 can be found here.

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 and can be found here.

Safeguarding Adults – A Description of What It Is

The statutory guidance[2] 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 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 here. The Board has taken account of the statutory guidance in determining the following vision.

[1] Care Act 2014: http://www.legislation.gov.uk/ukpga/2014/23/contents
[2] Care and support statutory guidance: https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

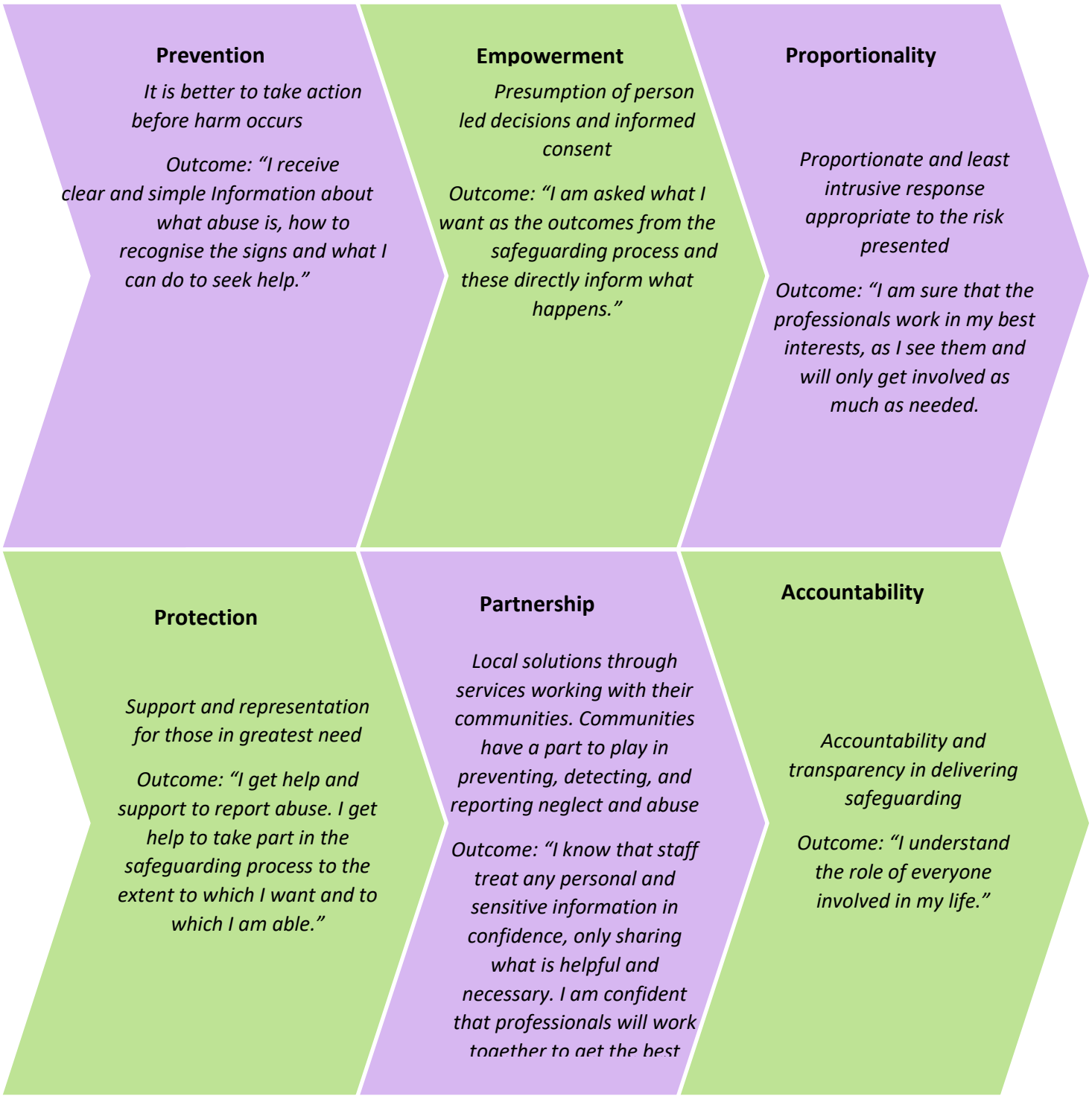
Vision for Safeguarding in Staffordshire and Stoke on Trent

'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 2011 (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. The principles can be found here.



5. What we have done

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.

Board

Independent Chair: John Wood

Vice Chair: Lisa Bates, Designated Nurse for Adult Safeguarding, Staffordshire and Stoke-on-Trent Clinical Commissioning Groups (now Integrated Care Board – ICB)

The Board oversees and leads adult safeguarding across our area and is interested in a range of matters that contribute to the prevention of abuse and neglect. These include the safety of patients in the local health services, quality of local care and support services, effectiveness of prisons and approved premises in safeguarding offenders.

At each quarterly meeting the Chair sets the tone reminding Board members of their statutory responsibility to seek assurances that there are effective arrangements in place to protect adults with care and support needs who are at risk of abuse and neglect and unable to protect themselves. The Chair helps to create an environment where constructive discussion and mutual challenge is welcomed and encouraged.

During 2022/22 the Board has:

- Consulted a wide range of connected partners and practitioners to review, revise and approve the Board Strategic Plan. The Plan has a new priority that seeks assurances from partners that there is Effective Practice around mutually agreed key safeguarding themes.
- Sought and received assurances from partners that risks of abuse and neglect were being identified and addressed where there is the potential for adults with care and support needs in a variety of situations to be subject to 'hidden harm'. On this theme there have been discussions with members of the Domestic Abuse Commissioning and Development Board and an action agreed to improve partner recording systems to better identify adults with care and support needs who are subject to Domestic Abuse.
- Received a presentation about the Serious Violence strategy from Jon Rouse City Director, Stoke-on-Trent City Council and Naomi Smith Office of the Staffordshire Police and Crime Commissioners Office, Programme Lead for Serious Violence Strategy to discuss and agree responses on matters of relevance.
- Considered, approved and published on the SSASPB website three Safeguarding Adult Reviews (SARs) which were finalised in 2022. (Andrew, Anne and Heather)
- Tasked the chair of the Practitioners' Forum with ensuring that the lessons to learn from all 3 published SARs are included in the practitioners' development programme
- Received two detailed presentations from Care Quality Commission (CQC) Inspectors:
  - Safeguarding adults within regulated independent hospital settings
  - The CQC perspective on safeguarding adults within regulated care settings

  The CQC inspectors are regular presenters to the Board. The CQC input helps to confirm the current themes and trends to help facilitate learning and to help inform a preventative approach to learning events, publications and themed audits.

- Sought and received assurances from the local Clinical Commissioning Groups on their response to safeguarding concerns arising from significant events at Independent and Private Hospitals within Staffordshire and Stoke-on-Trent
- Received detailed presentations on the learning from the lives and deaths of adults with a learning disability and autistic people (LeDeR) programme and strengthened alignment of working on mutually relevant themes. On a related theme, considered the recommendations from the Norfolk Safeguarding Adult Review into the deaths of three young adults with learning disabilities which was published in September 2021, and subsequently seeking assurances from relevant agencies locally in relation to the recommendations.
- Participated in two national research projects:
  - Strengthening Adult Safeguarding response to homelessness and self-neglect, by Jess Harris, Research Fellow, King's College London
  - COVID-19 and Adult Social Care and Safeguarding, by Dr Laura Pritchard-Jones, Director of Taught Post-Graduate Programmes Keele University, Staffs.
- Received the findings from the research projects at Board meetings. The relevant local themes have subsequently been incorporated into the Board work programme, for example, the Engagement Strategic priority and the 'Andrew' SAR action plan
- Sought and received assurances that operational demands caused by COVID-19 and other winter pressures were identified and risks mitigated as far as possible in the context of significant operational challenges.
- Considered and contributed to the review of the arrangements and working of the Multi-Agency Safeguarding Hub (MASH)
- Through constructive links developed with National and Regional Safeguarding networks contributed to the development of a variety of work. Examples include the production of a National Data Toolkit, the consultation on the revision of the Safeguarding Adult Review Quality Markers, membership of the reference group for the national Safeguarding Adult Review improvement plan, production of regional policies and guidance and the production of guidance on how to better engage adults who are often referred to as 'non-engaging'
- Attended various national webinars, many of which involving lessons learned from important national research, with learning shared amongst local partners.
- A standing agenda item for inspection, organisational review and peer review updates from partners that facilitates open discussion about areas of good practice and offers of support to meet organisational challenges.
- A standing agenda item on matters arising from links with others partnership boards and fora enables visibility and alignment on matters of safeguarding relevance.

Executive sub-group

C hair: Lisa Bates, Designated Nurse for Adult Safeguarding, Staffordshire and Stoke-on-Trent Clinical Commissioning Groups August 2020 to present

Vice Chair: Carl Ratcliffe Staffordshire Police Superintendent June 2021 to July 2021, Sharon Conlon, Head of Strategic Safeguarding, Midlands Partnership Foundation Trust August 2021 to present

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 sub-groups, Officers to the Board, the Board Manager and the Board Independent Chair. Organisations represented include the Statutory partners (which are Stoke-on-Trent City Council, Staffordshire County Council, Staffordshire Police and the local Clinical Commissioning Groups); also the Midlands Partnership Foundation Trust (MPFT).

During 2021/22 the sub-group has:

- Monitored progress against the SSASPB strategic priorities (Engagement and Financial and Material Abuse)
- Co-ordinated the work undertaken to review the strategic priorities in preparation for the Board approval of the 2022/2025 Strategic Plan
- Sought and received assurances that partner responses to the COVID-19 pandemic and associated pressures on front line services were being monitored and mitigated on matters relating to adult safeguarding
- Checked local activity against the National COVID Assurance framework that had been distributed through the National Board Business Manager network
- Monitored the progress of all Safeguarding Adult Reviews raising constructive challenges around practice where appropriate
- Approved funding to participate in the Alcohol Change project 'Cognitive Impairment in Dependent drinkers' to support the delivery of the improvement plans following the publication of the Safeguarding Adult Review 'Andrew'
- Received updates on local matters of concern in connection to Independent Hospitals and changes to oversight arrangements arising from learning from hospital closure
- Strengthened links with the Learning from Lives and Deaths Programme (LeDeR) through the attendance of and discussion with the Chair of the Strategic Group. Discussions followed up with further updates and discussions at SSASPB
- Examined assurance updates from both Local Authorities regarding Large Scale Enquiries (LSEs) and Deprivation of Liberty Safeguards (DoLS) authorisation backlogs
- Monitored the activity towards mitigation of risk using the SSASPB Risk Register. Approach to the management of risk has been revised within a new strategic priority (2022-2025) seeking assurances around Effective Practice in 5 key risk areas
- Received regular updates on the progress of the transformation from Clinical Commissioning Groups to the Integrated Care Board and developing early links to the planned arrangements
- Received updates on the progress of the Stoke on Trent Multi-Agency Resolution Group which is a multi-agency forum to discuss adults who have multiple needs and advocated for a similar forum in Staffordshire, whilst acknowledging the complexities of a layered and geographically large authority
- Worked with leads/chairs of Safeguarding Children Boards and Health and Wellbeing Boards to plan for a Staffordshire Strategic Partnership Protocol. The aim is to strengthen alignment of working on mutually relevant themes
- Received updates from Regional and National Adult Safeguarding fora through membership at various meetings
- Planned the partnership contributions to the Ann Craft National Adult Safeguarding week (15 to 19 November 2021). From the subsequent local evaluation acknowledged the excellent work done by many partners to support the awareness raising initiative

- Strengthened links with the Domestic Abuse Commissioning Board with shared partners reporting matters of relevance to each Board
- Monitored progress of the forthcoming Liberty Protection Safeguards and its interface with Safeguarding
- Reviewed the membership of the Board and managed the Board membership process
- Managed and monitored the SSASPB budget
- Reviewed the SSASPB Constitution
- Approved the Information Retention and Disposal Policy for the Board
- Considered the position of the Board against the NICE Guidance: 'Safeguarding in Care Homes'
- Considered the local requirements of work nationally to produce a joint Protocol between Her Majesty's Coroners and SABs with reference to co-operative working in SARs and Coronial processes
- Overseen the development of the SSASPB Annual Report

Safeguarding Adult Reviews sub-group:

Chairs: Staffordshire Police Superintendents Carl Ratcliffe to September 2021, and Jason Nadin to April 2022

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

The Safeguarding Adult Reviews (SAR) sub-group has responsibility for management of SAR referrals from the point of receipt to the approval of the final report and delivery of the improvements action plan. The sub-group also has responsibility for identifying and cascading the lessons learnt from any reviews conducted by other SABs.

During 2021/22 a total of 4 SAR referrals were received. None of these met the criteria for a Safeguarding Adult Review.

It was concluded that one of the referrals would be dealt with through a single agency learning review. In one of the referrals Her Majesty's Coroner had issued a 'Prevent Future Deaths Report' under Regulation 28 of The Coroners (Investigations) Regulations 2013. The SAR sub-group was satisfied that there would be lessons learned in response to HM Coroner's request without a requirement to duplicate the review and learning process.

In response to the referrals not meeting the SAR criteria the SSASPB has further raised awareness of the criteria for SARs through the SSASPB newsletter and Practitioners' Forum.

During the year the following SAR was approved by the Board and published on the SSASPB website.

Heather – A SAR conducted under S44(4) Care Act 2014 – Discretionary Review (Stoke-on-Trent)

Brief overview of the circumstances of death and why a Discretionary SAR was undertaken:

Heather had been in hospital for a short period in the autumn of 2019. She was subsequently transferred to a 'discharge to assess' unit where it was determined that she was able to be cared for at home.

Prior to going home her capacity had deteriorated so a Best Interests meeting was held on 13th February 2020. The outcome of the meeting was that the Multi-Disciplinary Team agreed that they needed to honour

Heather's previous wishes that she did not want to go into a residential care setting, and she did not want to receive intensive treatment for her cancer diagnosis. An advocate was present at this meeting.

Heather returned home on 16th March 2020 with a self-funded care package which provided for a carer to live full-time at Heather's home address.

The allocated social worker mistakenly identified the care broker as a care provider. A broker is not a registered care provider. This meant that on discharge the responsibility to manage the care provided lay with the social worker. It was subsequently recognised that the social worker, carer, and broker were not sure of each other's roles and responsibilities.

The timing coincided with the early days of the COVID 19 pandemic and shortly before the first national lockdown. There was uncertainty about how the virus would impact on the population and the accordingly the carer lived with Heather for 7 weeks without a break to minimise the risk of COVID infection.

Heather had leg ulcers which were attended to frequently by District Nurses. On 28th April 2020 Heather was seen to have a low body temperature and was shivering. On 29th April 2020, the carer called Heather's GP as she identified that Heather may have sepsis. An ambulance and paramedics attended. Sepsis was suspected and she was taken to hospital but sadly died the following day.

Following investigation by the Police it was determined that there was no evidence of abuse or neglect of Heather, but there may be learning for the organisations involved. The published report and recommendations illustrated the learning that:

- It would have provided better continuity for Heather's care if someone from the District Team where she lived had attended the Best Interest meeting.
- There should be better awareness across SAB partner organisations concerning the symptoms of sepsis and the importance of early medical intervention.
- More detailed and more timely information sharing may have negated the need to detain the carer on suspicion of causing neglect.
- More detail should be included in records demonstrating clear rationale for decision-making.
- Where there is a multi-agency approach to the care and support needs of an adult, professionals and other frontline staff/volunteers should make sure that others understand their individual roles and responsibilities to negate assumptions.

Update on the Anne SAR from the 2020/21 Annual Report

The action plan to implement the learning for this review was completed and signed off by the Executive sub-group in March 2022. The action plan included:

- The SSASPB is to seek assurance that Commissioners, care agencies and Hospitals agree and document their role in ensuring that there is continuance of care in circumstances where an adult with care and support needs is discharged from A&E particularly as an out of area patient (i.e. not admitted to hospital).
- The SSASPB is to reinforce the need for clear documentation and record-keeping, particularly where more than one organisation may need to respond to or act upon the comments. Decision-making is to be supported by clear rationale and acronyms explained on first use.
- The SSASPB is to seek an insertion in the West Midlands Regional Self-Neglect guidance to address the following finding 'Where adults with capacity are living at home in unsafe conditions that could put

the adult's health at significant risk, steps should be taken to explain the potential risk to support the adult in making their own decision'

- The SSASPB is to task Commissioners with ascertaining the feasibility of adults (with care and support needs who appear unkempt, are assessed as frail and are living in isolation without a package of support) having an Occupational Therapy home assessment prior to discharge
- A briefing note has been produced by the Board to give an overview of the circumstances leading to the SAR and the recommendations which is posted on the SSASPB website.

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)
- Oversaw the progress of ongoing SARs.
- The SSASPB Business Manager was a member of a national working group which acted as a reference group for the Social Care Institute for Excellence (SCIE) Quality Markers for SARs which will ensure that there is a consistent approach to SARs nationally. These were launched in March 2022. She also volunteered to represent the West Midlands Region as a SAR Champion, this entails regional representation at national meetings where SAR matters are discussed and key points widely communicated.
- Provided detailed assurance against the 29 Improvements recommended by Professor Michael Preston-Shoot in his academic analysis of SARs (2020)
- Actively raised awareness of the previously identified recurring lessons to learn from SARs, which are:
  - Better recording of the rationale for decision-making to be made in case files
  - Use of the SSASPB escalation policy to resolve professional disagreements as soon as possible
  - Appointment of a lead professional to drive multi-agency resolution in complex cases
- Promoted webinars made available nationally that are relevant to SARs
- Trialled then adopted a revised SAR 'triage' process using 3 or 4 experienced SAR members to assess the referral shortly after receipt. This was introduced to try to minimise the resource put into scoping SAR referrals that were highly unlikely to meet the criteria. The approach is regarded as helpful to the referral process.
- Produced an Independent Reviewer contract with which to commission review authors. This allowed for consistency in approach and clarity of expectations
- Promoted the finding from the National Review of SARs (Professor Michael Preston-Shoot 2020) which highlights the importance of identifying and appointing a lead practitioner in circumstances where there are several partners involved with adults having multiple needs. This was included in the SSASPB newsletter, reinforced in the Multi-agency S42 Procedures, and delivered in several learning lessons from SARS presentations

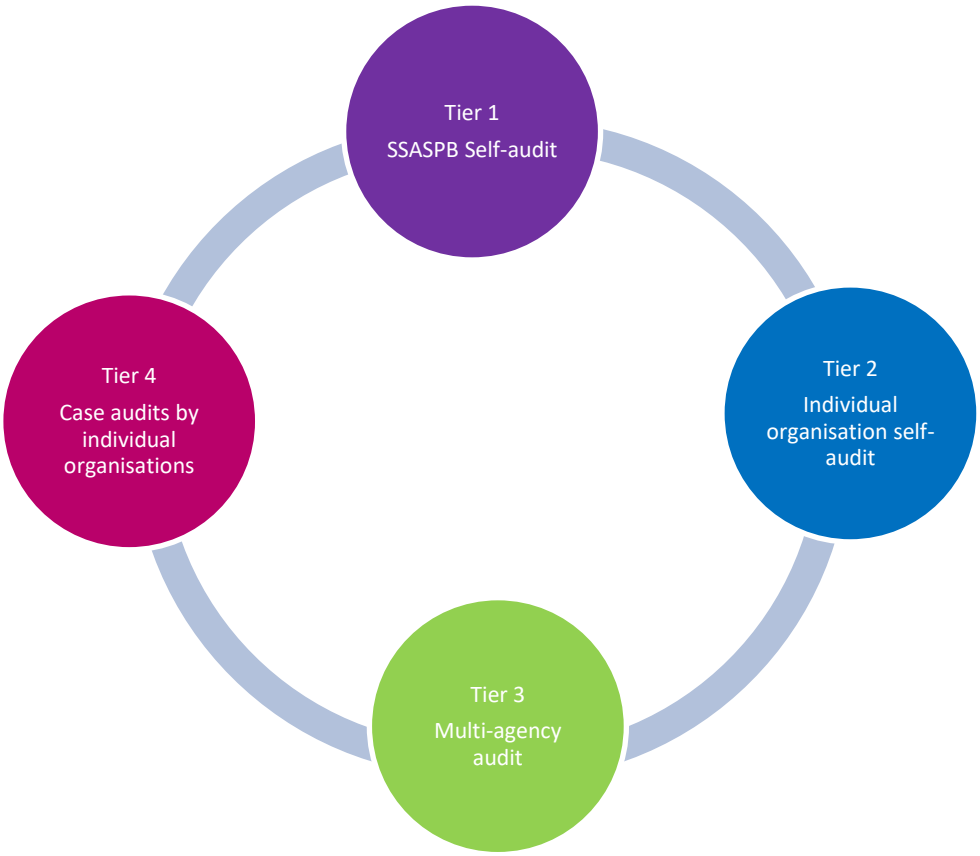
- The Board Business manager is a member of a national task to finish group which will engage with the Chief Coroner to seek the feasibility of guidance as to how Coronial and SAR processes best work together in support of their individual objectives

Audit and Assurance sub-group:

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

The SSASPB 4-tiered audit framework:

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



Tier 1 SSASPB self-audit is an annual self-assessment against the SSASPB constitution

Tier 2 Individual Organisational audit: in year 1 each organisation completes a self-assessment against a set of agreed standards, in year 2 there is a peer review of evidence put forward against specific standards

Tier 3 Multi-Agency Audits are themed multi-agency audits, the themes come from questions raised following receipt of the annual data report

Tier 4 Individual Agency audits which can be requested by the Board or one of the sub-groups with the purpose of seeking more detailed information about a trend or theme which becomes apparent

During this year the Audit and Assurance sub-group has:

- Completed the annual Tier 1 audit. This helps the Board to understand where its challenges are and where it can evidence that it is meeting the requirements set out in the Board's Constitution.
- Initiated the Tier 2 audit (year 1). All Board partners were asked to complete a comprehensive self-audit evidencing how they deliver their responsibilities both to the Care Act 2014 and as a SSASPB partner. A total of 28 responses were received and the follow up work which includes scrutiny of the evidence submitted against the self-awarded rating of Red, Amber and Green (RAG) continues at the time of this Annual Report. The outcomes will be reported on in the Annual Report for 2022/23
- Conducted a Tier 3 Multi-agency Case File Audit on the theme of Persons in a Position of Trust (PiPoT) on 11th May 2021. This audit revealed that several of the cases which were considered evidenced matters better routed through quality assurance processes this led to a Tier 4 individual agency audit where those partners who receive concerns audited what happened to referrals that did not result in a Section 42 enquiry.
- Conducted a Tier 3 Multi-agency Case File Audit on the theme of Organisational Abuse held on 1st October 2021. This audit identified that it would be helpful to raise practitioner awareness of what constitutes Organisational Abuse. The findings and learning from the audit were subsequently communicated amongst connected partners at the Practitioners Forum, through the SSASPB Newsletter, and related learning events.
- Initiated a Tier 4 audit relating to the reporting, progression and outcome of safeguarding concerns. This audit identified that often there are safeguarding concerns submitted to the local authority which would be more appropriately referred elsewhere, for example, through Quality Assurance processes. The consequence is that there are safeguarding concerns awaiting a response from 'front end' processes which are better responded to elsewhere.
- Initiated a Tier 4 audit with the question - What happens to the reported concerns which do not result in a Section 42 Care Act Enquiry? This audit arises from the findings of the 'Andrew' Safeguarding Adult Review. The audit commenced in early 2022 and is not complete at the time of this Annual Report.
- Contributed to the review of the SSASPB Strategic Plan by considering the focus for proposed strategic priorities for 2022-25. The recommendations for a focus on Self-neglect and considerations around the application of the Mental Capacity Act 2005 were accepted by the Board.
- Provided the detailed information from relevant partners to explain the data and illustrations of investigation work contained in the Annual Report.
- Completed all elements of the sub-group business cycle including the review of the Audit and Assurance Business Plan and Terms of Reference
- Sought assurances that, despite the inability to accurately determine the number of situations where Domestic Abuse is a factor the domestic abuse element is recognised and actioned including consideration for MARAC referrals. Assurances were also sought that outcomes which had been determined by the adult at the centre of the process were being met.
- Sought assurances that connected partner agencies have mechanisms to identify repeat concerns and able to have an informed picture of risk rather than consideration of immediate presenting factors.
- Revised the SSASPB Performance and Quality Framework

Policies and Procedures sub-group

Chair: Ruth Martin, Principal Social Worker and Safeguarding Lead, Staffordshire County Council

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

A contact list is held of partner agency staff who 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 has reviewed the below documents;

- Mental Capacity Act Guidance
- Financial Abuse Guidance
- Mental Capacity Act Package and Trainer Notes
- Adult Safeguarding Awareness Package and Trainer Notes
- Decision making guidance
- Adult Sexual Exploitation guidance
- Retention and destruction policy (new Policy for 2021/22)
- Board Membership Process and Guidance
- Risk Register Guidance
- Information Sharing Guidance
- Board Membership application

All public-facing documents can be found on the SSASPB website.

6. Performance against 2019/22 Strategic Priorities

Strategic Priority: Engagement

A sub-group has been formed to drive the work of the Engagement Strategic Priority. The activity around this priority is managed and co-ordinated by the Prevention and Engagement sub-group which meets bi-monthly.

Chair: Sarah Totten, Strategic Manager – Early Intervention, Contact and Hospital Adult Social Care, Health Integration and Well Being, Stoke-on-Trent City Council. Covered by Helen Jones, SSASPB Business Manager between November 2020 and April 2021.

Vice Chair: Helen Jones, SSASPB Business Manager

Engagement is a broad term, for the purposes of the work of the Board during 2021/22 engagement refers to raising awareness of adult abuse and neglect and how to respond 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

From the onset of the COVID-19 pandemic the approach to engagement changed from predominantly face to face communications through diverse networks to making extensive use of a variety of electronic methods using telecommunications and the internet. This approach has continued.

The following activities have been completed through the sub-group:

- Hosted 4 Financial and Material Abuse events via Microsoft Teams
- Held event 1 on 20th April 2021; 58 front line practitioners logged in to the first SSASPB webinar in support of the strategic priority Financial and Material Abuse. Presentations were delivered by Jackie Bloxham (SoTCC) Ruth Martin (SCC) and Claire Histead (MPFT). The topic for this presentation, the first of three, was financial and material abuse in the context of Section 42 Enquiries. This included case studies and legislative framework which were well received. The feedback following the event was extremely positive
- Held event 2 on 19th July 2021; this one was from the perspective of the Trading Standards work in both Stoke-on-Trent and Staffordshire. It was attended by 55 people, mostly from the front line within partner organisations
- Held event 3 on 15th September 2021: this one was focused on Domestic Abuse with reference to Financial and Material Abuse incorporating Coercion and Control or Psychological Abuse. A total of 28 front line practitioners or volunteers logged in to the event. The attendance was adversely affected due to competing operational demands at the time. The presenters were New Era which is commissioned to provide Domestic Abuse services in Stoke-on-Trent and Staffordshire
- Held event 4 on 29th September 2021: this was a repeat of event 3 to maximise the possibility of attendance and another 3 practitioners attended.
- Produced short video briefings on key topics including Advocacy in Financial Abuse Enquiries and Cuckooing. The videos have been placed on the SSASPB website.
- Participated in important national research projects conducted by Dr Laura Pritchard-Jones from Keele University and Research Fellow Jess Harris from Kings College London
- Refreshed the SSASPB website to make it more compliant with accessibility legislation and to refresh the content. Since the refresh there has been an increase in the use of the website.
- Commissioned Board partner Rockspur to produce a more accessible version of the 2020/21 Annual Report. This was produced by adults with autism or a learning disability and has been posted on the SSASPB website. The report was very well received and will be repeated for 2022/23.
- Supported Ann Craft Adult Safeguarding week (between 15th and 19th November 2021) with several events arranged by connected partners. Subjects covered included raising awareness of adult abuse (including specific types of abuse and neglect), how to report concerns, and an explanation and illustration of Safeguarding Adult Reviews.
- Used Twitter to support Adult Safeguarding week, raising awareness of local activity as well as retweeting relevant information produced by other SABs within the UK.
- In response to a need identified by practitioners hosted a webinar for practitioners on the subject of stalking and harassment that was delivered by members of the Prevention and Engagement sub-

group from North Staffordshire Combined Healthcare Trust (NSCHT) and Midlands Partnership Foundation Trust (MPFT), this was attended by 44 front line practitioners

- Produced two newsletters (June and November 2021) which were distributed widely and covering a variety of topics including:
  - learning from Safeguarding Adult Reviews
  -- how to make a referral to Stoke-on-Trent Multi-Agency Resolution Group (in response to SAR 'Andrew')
  - Sepsis awareness (in response to SAR 'Heather')
  - What is adult safeguarding?
- How to make a good SAR referral
  - spotlight on Rockspur – producer of the more easily accessible Annual Report
  - Lasting Powers of Attorney (link to Financial and Material Abuse)
  - links provided to both versions of the SSASPB Annual Report
- The Board has agreed to continue with Engagement as a Strategic Priority for 2022/25 and will focus in particular on how to better engage with adults with needs for care and support who have experienced abuse or neglect.

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

Case Study: Midlands Partnership Foundation Trust

The Safeguarding named nurse at Midlands Partnership Foundation Trust (MPFT) was contacted by the clinical lead of District Nursing service asking for advice regarding 'Grace' a female patient with whom the vascular team was finding difficulties in engaging and concerns about safeguarding. Grace was an intravenous drug user with a below knee amputation on one leg. Her remaining leg was in a poor state and in need of dressings.

The Tissue Viability team wanted to continue with dressings however the team were struggling with compliance – either Grace was not at home at the time of a visit, or she refuses treatment.

The District Nurses had concerns as they had not assessed the wound for some time. The consultant has been contacted and advised that nothing more could be done with the remaining leg, the options were either conservative treatment or amputation. Grace was at risk of Sepsis.

From a previous safeguarding concern an assessment concluded that the woman did not have care and support needs and she reported that she did not require any help from social care.

The clinical lead for Grace's care convened a Multi-Disciplinary Team (MDT) meeting which was attended by the named nurse for safeguarding, social work team, substance misuse worker, consultant, and Tissue Viability Lead. The consultant explained to those present the risk that Grace may lose her remaining leg and that she would not be able to walk again. The wounds are not going to heal, and it is important to ensure that they stay infection free. The risks had been explained to the patient.

It was decided at the MDT meeting that Grace's social worker and the district nurse would make a joint visit to establish if the patient met the self-neglect criteria under safeguarding. The decision was also made that Grace would only be given a script covering 7 days for her drug use and would then need to see the substance misuse worker at the clinic. As part of a coordinated approach the District Nurses would see Grace when she attended for her substance misuse appointment at the clinic.

The MDT approach to supporting and working with the patient lead to better engagement. The patient was being seen and had been doing well in self managing the necessary dressings to keep herself safe. This is a good illustration of the mutual benefits of team working with the clinical lead happy to support self- care model with supervision.

Case Study: Stoke on Trent City Council Adult Social Care

Michael and Freya had lived together as the only tenants in a Group Support Living house for several years. Both adults had diagnosed moderate learning disabilities. The accommodation was a two-storey house with each adult having their own bedroom whilst sharing the kitchen and living room areas. Individual and core support was provided twenty-four hours per day based on a strength-based approach to maximise independent living.

There was a significant age difference between the two adults - Michael was 82 years of age and Freya was 46. Their compatibility was becoming negatively affected by changes in their needs and this became more apparent during an imposed lockdown due to the pandemic. Both were forced to spend more time together in the house, at the same time, Michael was experiencing a deterioration in his mobility and mental health.

This situation led to a Section 42 Enquiry as both adults were becoming verbally and physically abusive towards each other on a regular basis and it became apparent that their living arrangements were becoming unsustainable.

Separate Social Workers were allocated to work with Michael and Freya to consider appropriate safeguards and explore solutions in the best interests of both. This involved working closely with the adults themselves, family members, the advocacy service, the Community Learning Disability Team, and the care providers, utilising a multi-disciplinary strengths-based approach.

It quickly became apparent that the relationship between both adults had broken down to the point that they were at risk of harm from each other, and it was identified that a positive solution could involve both adults moving to new accommodation with other adults of a similar age, interests, and compatibility. As part of the safeguarding and assessment process, Mental Capacity Act (2005) assessments were completed with both adults with contributions from the multi-disciplinary team. These concluded that both adults lacked the mental capacity to choose their care and support accommodation, and this would need to be done in their best interests.

The Section 42 enquiry involved working with the care provider to ensure there was sufficient staff on duty to minimise the risk of further incidents, whilst still allowing both adults to safely move freely around the house. The accommodation identified for Michael was another Group Supported Living accommodation within the same local area, with the current support team in place. It was felt that this provision would provide Michael with consistency of support, familiarity of local community services and shops. There were two other men living in this property of a similar age with similar interests and support needs. The property was a single storey bungalow which was suitable for Michael's increased mobility needs.

The accommodation identified for Freya was a tenancy-based apartment with twenty fours a day support to meet her individual needs. This provides Freya with the opportunity to increase her social and independent living skills and have more choice in her daily living and community activities.

The safeguarding enquiry was concluded with an outcome that was mutually agreed to be in the best interests of both adults in improving their quality of life and manage the risks to each other from the breakdown in their living arrangements.

Case Study: Staffordshire County Council, Adult Safeguarding Enquiry Team

'Alice' is a 31-year-old woman with learning disabilities who lives in supported accommodation.

Alice was referred to adult safeguarding by the manager of her supported living scheme following an allegation of sexual abuse by another adult with care and support needs living at the service address. The concern was graded as high risk and sent to the Adult Safeguarding Enquiry Team for further enquiry. The enquiry was joint with Staffordshire Police.

The source of risk to Alice was subsequently arrested by Police and bailed with conditions to prevent contact. This became difficult to manage when both adults lived within the same service. The source of risk breached the bail conditions on multiple occasions.

The allocated Safeguarding Practitioner and Police had gained an understanding from Alice as to how she could best be supported and the outcomes she wanted to achieve from the safeguarding process. Alice was clear that she wanted the other adult to leave the service.

The service provider had put measures in place to support Alice. Whilst the source of risk remained within the same supported living scheme the provider in conjunction with the professionals supporting Alice also considered the potential transferrable risks to other adults within the accommodation.

The source of risk presented with behaviours which were challenging for the service to manage. Due to previous concerns the provider had already given notice to the source of risk. However, the new concerns escalated the need for an alternative placement to be identified.

The Safeguarding Practitioner was in contact with professionals involved with both Alice and the source of risk. An urgent meeting was held to discuss the risks and the measures that could be put in place to mitigate these. This provided an opportunity for information to be shared in a timely way and actions set to ensure both adults received the necessary support for their assessed needs. A multi-agency approach ensured that the needs of both adults were considered and that appropriate steps were taken to manage the identified risks.

The source of risk did subsequently move to alternative accommodation which was better suited to meet his needs and the risks he presented to others. The risk of harm to Alice was removed and her anxieties reduced following his departure.

Case Study: University Hospital North Midlands Trust

'Gary' a 28 years old man was found lying outside the Accident and Emergency department of University Hospital of North Midlands, Stoke-on-Trent. He presented as unresponsive and physically unstable with respiratory and cardiac health problems. It was noted that Gary had physical injuries including facial and limb bruising and appeared malnourished and unkempt.

When Gary was transferred into the Accident and Emergency department he was reviewed and assessed. Physical health assessments determined that he was critically unwell and required admittance to the intensive care unit for life saving treatment. Gary's presentation highlighted safeguarding concerns for frontline staff as it was noted that he had a complex social history including alcohol and drug dependency with mental health and social problems. Gary explained that he had been brought to the hospital by a friend and left outside Accident and Emergency department.

Staff in the department escalated their safeguarding concerns highlighting his physical presentation, concerns for his on-going safety and welfare, as well as concerns regarding his relationship with his 'friend'.

When the patient made clinical improvement, it became apparent that there was a network of friends who were trying to obtain information about him and to contact him. Gary's friends wanted him to take his own discharge and return to a shared residence.

As Gary's condition further improved the patient began to engage with services. Social Care and the Nursing team on the ward worked together and helped the patient to talk about his personal circumstances. Gary disclosed that he had been the subject of sexual assaults. The Health and Social Care staff suspected that he may have been a victim of human trafficking. Further disclosures by the patient highlighted that his finances and accommodation were controlled by 'the friend'. The patient did not acknowledge that he had been subject to abuse or criminal activity.

The allocated social worker and ward manager worked with Gary to develop trust and offer support to mitigate on-going risk, develop safety plans and promote a safe discharge.

When further information was disclosed by the patient it became apparent that there may be wider concerns with other people at risk of human trafficking. These concerns were reported to Staffordshire Police.

When the patient was medically fit to be discharged, he was offered safe accommodation and the offer of ongoing support from Social Care, Mental Health, and Staffordshire Police. This case illustrates the prompt and positive action of the staff at University Hospital North Midlands to respond positively and sensitively to serious abuse of a patient and work with connected partners and the patient to mitigate his health risks.

Case Study: Midlands Partnership Foundation Trust

'Carol' had been experiencing domestic abuse for the duration of her 30 years of marriage which had negatively impacted her anxiety and self-esteem. In recent years Carol had been accessing mental health services to address her anxiety which, coupled with other health complaints, led to her being unable to leave her home.

As a consequence of Carol accessing more support services several professionals had raised safeguarding referrals, however Carol had not felt able to engage with immediate safeguarding measures as she did not want to leave her home.

A subsequent escalation in concern about domestic abuse led to a Multi-Agency Risk Assessment Conference (MARAC) referral. A further adult safeguarding concern led to a Section 42 enquiry. It was agreed by the professionals supporting Carol, and subsequently with Carol herself, that the only way to address this situation and remove the ongoing risk and experience of abuse was for Carol to live in her own accommodation.

Carol worked with the social worker, domestic abuse support worker and housing officer to overcome the challenges associated with moving away from her partner. Carol was required to provide medical evidence of domestic abuse to support her housing application, however, to obtain this from her GP there would be a cost of £50 that would show on her bank statement and therefore alert her abuser. Carol had also been deterred from moving home as she was not sure how to obtain the required legal advice regarding ending her tenancy.

With the support of the safeguarding social worker and domestic abuse support service, medical evidence was provided, and Carol has now been offered appropriate accommodation which she was delighted with.

A combination of joint working, appropriate sharing of information and knowledge of how to navigate agency processes and legislation helped to produce this resolution. As well as a successful outcome for Carol which was in line with her wishes there was learning for the organisations involved around domestic abuse and adult safeguarding which can be used to help others in similar situations of abuse.

Case study: Clinical Commissioning Group

'Robert' had a diagnosis of a progressive neurological disorder. The disorder progressed quickly, and he required a 24-hour care package. His care had become very complex, and he had a range of professionals involved. Robert had very little support outside of the professionals involved, he had no family to support therefore heavily relied on carers and other professionals to provide social stimulation and advocate for him as he was beginning to lose his voice due to his diagnosis.

A safeguarding referral was made, as one of the professionals involved had become increasingly concerned about the care, he was receiving from his domiciliary care provider. The concerns raised ranged from a lack of training around machinery needed to support Robert's breathing, to a lack of personal care and issues around the language barrier between the carers and Robert.

When the Clinical Commissioning Group (CCG) Adult Safeguarding Nurse became involved, it became apparent Robert was not being provided with the care he needed. A multi-agency team meeting was arranged with the professionals involved. Robert's wants and wishes were identified and discussed along with the safeguarding concerns raised, and a plan was agreed.

From the plan, to help with Robert's deteriorating communication he was provided with assistive technology. A communication book was used for his carers to readily identify Robert's basic needs. An advocate was engaged to seek Robert's wants and wishes before he lost his speech.

A pain management plan was agreed to control Robert's pain, for him to use his wheelchair comfortably and access social activities held at his home and in the community. A new domiciliary care provider was sourced on Robert's request enabling him to build new relationships, develop trust with the care company and receive the care he needed.

The collaborative work undertaken by the various agencies enabled Robert to achieve his desired outcomes, enhancing his quality of life and ensuring that he was in receipt of safe and appropriate care.

Case Study: Stoke on Trent City Council Adult Social Care

'Amy' lives alone in a local authority property and is supported by a domiciliary care agency. Amy requires support with tasks of daily living to manage risks due to visual impairment and deterioration in physical health, she also relies on family support with practical tasks and management of finances. There are no concerns in relation to Amy's capacity in any of these decisions.

The care agency raised concerns with Adult Social Care as they were concerned regarding Amy's home environment, the lack of food in the property and that she had no money in her purse to buy items that were important to her such as cigarettes, which was leaving her in distress. The Social Worker gained further information from the referrer and visited Amy to discuss her views and wishes on the concerns raised.

The visit identified that Amy's distress came from not having access (as and when she needed) to cigarettes, relying on carers to purchase food and toiletries out of their own money and from Amy having her meal

delivered by family members too late at night when she was sleeping. Amy explained that her relationship with her family was important to her but did not want to continue to be reliant on them for support. Amy was aware that her family may have been using her finances for their own purposes, but she did not wish for the concerns to be considered within the safeguarding process nor did she want any police involvement. In line with Making Safeguarding Personal, options were explored outside of a formal safeguarding enquiry.

Amy decided to inform her family of her decisions and did not want Social Care to be part of this discussion. A Care Act review was commenced and from that Amy requested that the Local Authority manage her finances via an appointeeship arrangement. Locality Connectors provided support and made links with Amy into her local community and the housing team supported via tenancy support, to ensure that the home environment was safe.

Amy maintains a positive relationship with her family, however, is not reliant upon them to meet any care and support needs.

Case Study: Queens Hospital Burton

'Michelle' name anonymised is a middle-aged lady, who resided on her own and self-funded a package of care for her physical health for which she was nursed in bed. As well as her physical health needs Michelle has a psychiatric history. Michelle has a son who is her next of kin.

The Trust Safeguarding Team received an email from the District Nurse to advise of Michelle's admission to the Queen's Hospital Burton and concerns of self-neglect, being generally unwell, and having multiple pressure ulcers. Previous hospital admissions identified presenting concerns of anaemia, being malnourished and concerns around self-neglect.

In the follow up discussions it was discovered that

- Historical safeguarding referrals had been raised in relation to concerns of self-neglect, and there was an open safeguarding enquiry.
- Michelle's GP had referred Michelle to the District Nurse due to pressure ulcers. However, the District Nurses had difficulty attending to Michelle as she had declined their services.
- Two nurses had visited Michelle and found her to be cold and in pain. The ambulance service was contacted, and she was conveyed to hospital. At hospital Michelle presented with dehydration, she was emaciated, and had numerous pressure ulcers.

Arising from the discussion of the safeguarding concerns at the Emergency Department a request was made for a Tissue Viability Team review, and for medical photography to be undertaken. The Trust Safeguarding Team supported completion of the safeguarding adult referral. Michell did not give her consent to the safeguarding adult referral because she was deemed to lack capacity to make the decision taken in her best interests.

The safeguarding referral described the nature of the pressure ulcers of concern to inform the ongoing safeguarding enquiry. The safeguarding referral detailed the measures implemented to minimise the risks of further harm and deterioration of the pressure ulcers, including the use of relevant equipment, wound management, and repositioning. A referral was made to the Dietitian.

Arising from the multi-agency discussions involving professionals from various agencies Michelle's historical care issues and responses to those were identified and used to inform the options for a plan for her safe discharge from hospital.

When Michelle was medically stable for discharge, she was deemed to lack capacity for her care and treatment, and it was not safe for her to return home. A Deprivation of Liberty Safeguards (DoLS) referral was submitted to the Local Authority.

Michelle was subsequently transferred to Samuel Johnson Community Hospital, for further social care assessments, as it was deemed unsafe for her to return home.

There was regular liaison with Michelle's son whilst she was in hospital. It was agreed that an Independent Mental Capacity Advocate was appointed to represent her views and wishes. Following a Continuing Healthcare Assessment Michelle was subsequently discharged to a nursing home to provide her with the safe care to meet her needs.

Strategic priority: Financial and Material abuse

Lead: Ruth Martin, Principal Social Worker and Safeguarding Lead for Staffordshire County Council

Strategic Priority: Financial and Material Abuse

Financial and Material Abuse has been a strategic priority for the SSASPB between April 2019 and March 2022. It is strongly suspected that the number of victims of financial or material abuse who have care and support needs is likely to be enormously under reported. Nationally it is estimated that between 10 – 20% of incidents are ever reported but this is not widely recognised. Coupled with this, perpetrators exploit the vulnerabilities of the victims and perceive that the risk of detection is low which contributes to this offending being a significant problem.

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.

A task to finish group was formed, attended by a broad range of partners, which took responsibility for managing the actions to be taken through strategic priority. A total of 8 meetings were held, the number and frequency of the meetings were severely impacted by the COVID 19 pandemic.

What we did:

- Created a Financial and Material Abuse guidance document which has been added to the SSASPB website. This will continue to be reviewed annually to ensure that it remains up to date.
- Produced a questionnaire that was completed by connected partners that provided the Board with an overview of the actions taken by partners to raise awareness of financial and material abuse, the actions taken when financial and material abuse occurs and to gain assurances as to how partners assess the effectiveness of those actions.
- Awareness raising of Financial and Material Abuse at the SSASPB conference attended by around 200 people at Yarnfield in November 2019.
- Planned for learning events in April and June 2020 that had to be cancelled due to the COVID 19 pandemic. These were converted to webinar events consisting of three separate presentations. On 20th April 2021 presentations were given by Ruth Martin (Staffordshire County Council), Jackie Bloxham (Stoke-on-Trent City Council) and Claire Histead (Midlands Partnership Foundation Trust). On 19th July 2021 there was a presentation by Trading Standards. The final presentation was given twice, on 15th and 29th September 2021 by New Era which specifically referenced Financial Abuse as a type of Domestic Abuse. A total of 232 practitioners attended these events.

- Conducted two multi-agency case file audits on 28 January 2020 and 15 September 2020. (Findings previously reported in Annual Report 2020/21)
- In April 2020 there was a focus on raising awareness of Financial and Material Abuse and practical actions for practitioners in the SSASPB newsletter.
- Through the links with the Prevention and Engagement sub-group the ASIST and Voiceability advocacy agencies produced a short video which was widely distributed and posted on the SSASPB website in November 2021

The SSASPB has excellent links with the universities in our area. Staffordshire University (School of Law, Policing and Forensics) was invited to assist with research into doorstep crime. Five BSc Hons final year students produced dissertations connected to Financial and Material Abuse. The projects entailed the researchers' examining data from Staffordshire County Council and Stoke-on-Trent City Council safeguarding teams, Trading Standards for both local authorities and Staffordshire Police.

The projects highlighted that age was a significant factor in likelihood of being a victim of this type of crime, with the propensity increasing for people over the age of 50 years. The research indicated some geographical areas where there appeared to be a higher risk but, it was recognised, this could be related to better reporting. The reports highlighted that women were more likely to be targeted than men.

The research also highlighted the different ways that organisations categorise types of financial abuse and suggested that responses may be improved if there was collaboration and consistency between agencies particularly in recording arrangements.

The projects identified examples of good practice and awareness raising and that wider engagement in these would benefit communities. These practices included visibility of groups such as Neighbourhood Watch and local Police Community Support Officers. It was recommended that proactive awareness raising could be done in those areas that have been identified as having a greater prevalence of repeat victims.

Conclusions

Much of the work undertaken through the SSASPB has involved raising awareness about the potential for and impact of Financial and Material abuse.

It would be difficult and overly optimistic to rely upon data to identify the effectiveness of the actions taken as recording methods have to be considered. Raised awareness could increase reports of abuse which was a key focus of the priority and accordingly a good outcome.

The final report of the task and finish group was considered at the meeting of the Board on 21st July 2022 when it was agreed that the work of the task group has helped to ensure a focus on a category of abuse that is under reported. The work of the task group is complete and oversight by the Board will continue through business as usual.

Staffordshire and Stoke-on-Trent 2021/22 performance report overview

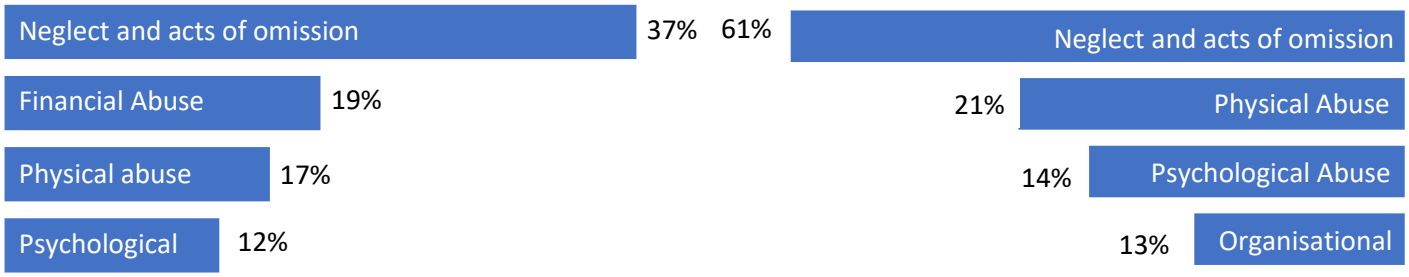
Number of safeguarding concerns received by the Local Authorities in 2021/22

13,227	4,590
Staffordshire	Stoke-on-Trent

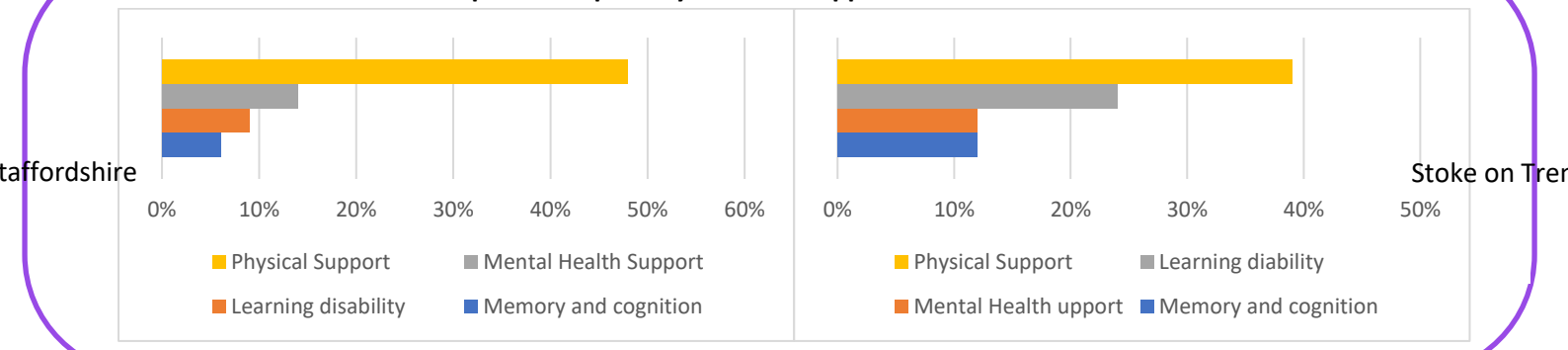
Staffordshire	Stoke-on-Trent
59%	54%

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

Most prevalent types of abuse 2021/22



Most prevalent primary care and support need for the adult



Location of Abuse

	Own Home	Residential Home	Nursing Home	Hospital
Staffordshire	**62%**	**11%**	**16%**	**1%**
Stoke-on-Trent	**26%**	**35%**	**12%**	**2%**

8. ANALYSIS OF ADULT SAFEGUARDING PERFORMANCE DATA

This section provides commentary and analysis of safeguarding data from Stoke on Trent and Staffordshire. Please note that in many sections the percentage has been rounded to the nearest whole number and therefore not all percentages will add up to 100%.

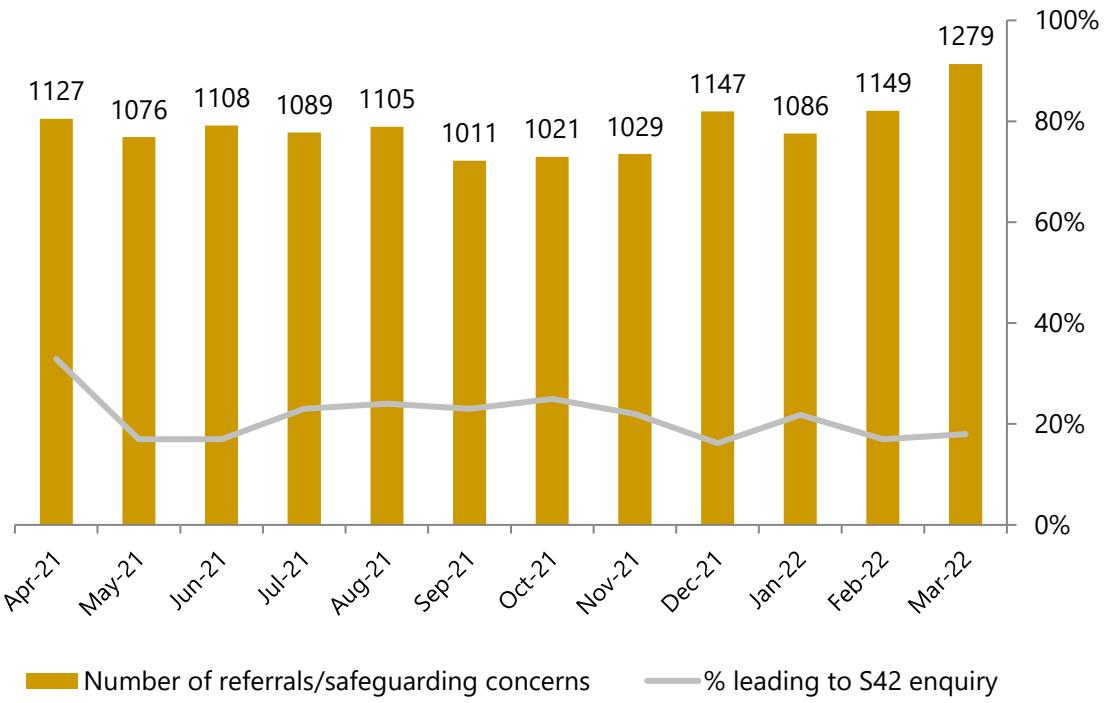
Number and proportion of referrals/safeguarding concerns

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.

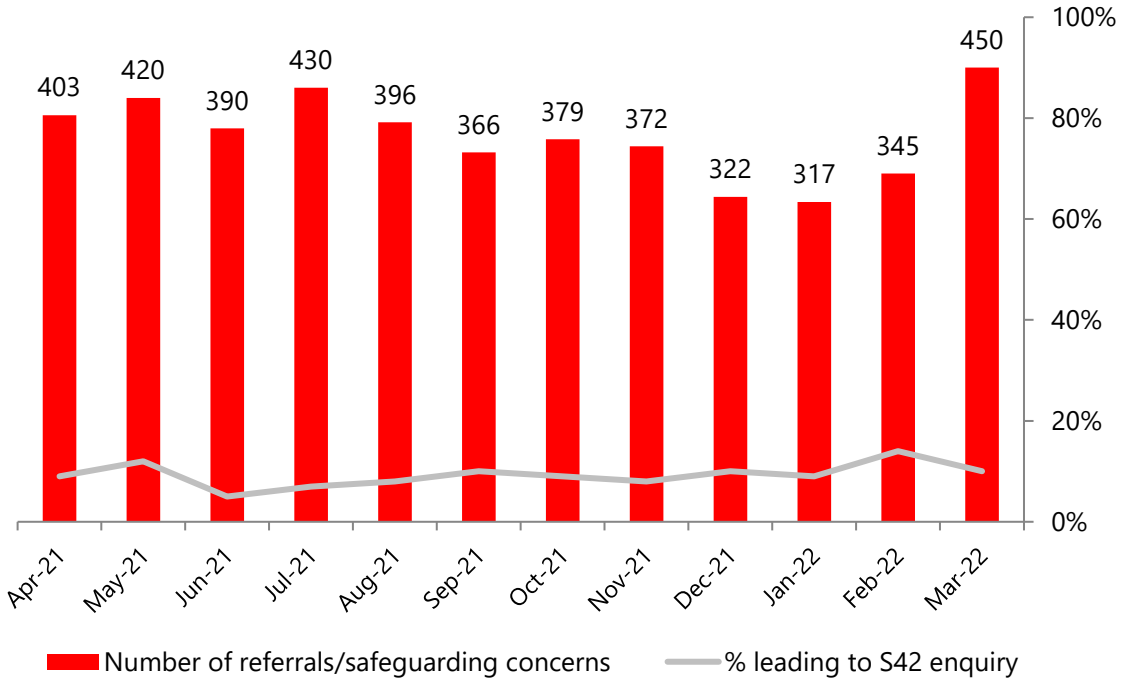
Fig.1 - Staffordshire: number and proportion of referrals/safeguarding concerns



During the course of the year 2021/22 in Staffordshire there have been 13,227 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 1,051 occasions from 12,176 in 2020/21 which is an increase of 8.6%. This year the duty of enquiry requirement was met in 21% of reported concerns a decrease of 4% from 2020/21.

The reasons for the percentage decrease in concerns meeting the duty of enquiry threshold have been explored. The information gathered from audits, indicates that this could be related to the type of concerns raised, for example, there are more concerns relevant to quality issues and or requests for assessments. Monitoring of those concerns that do not meet threshold will continue over the next year to better understand this.

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



In Stoke on Trent there were 4590 reported safeguarding concerns in relation to adults with care and support needs during 2021/22. This is an increase of 395 from 4195 compared to 2020/21 which is an increase of 9.4%.

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 albeit a telephone call or further discussions with the provider and or adult at risk in accordance with Making Safeguarding Personal. Following initial assessment, it was determined that the duty of enquiry requirement was met in 9% of occasions when a concern was raised.

The Board has requested an audit by both local authorities regarding what is done with concerns that do not meet the criteria for a section 42 enquiry. This will be reported on in the 2022/23 Annual Report.

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 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 and 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.

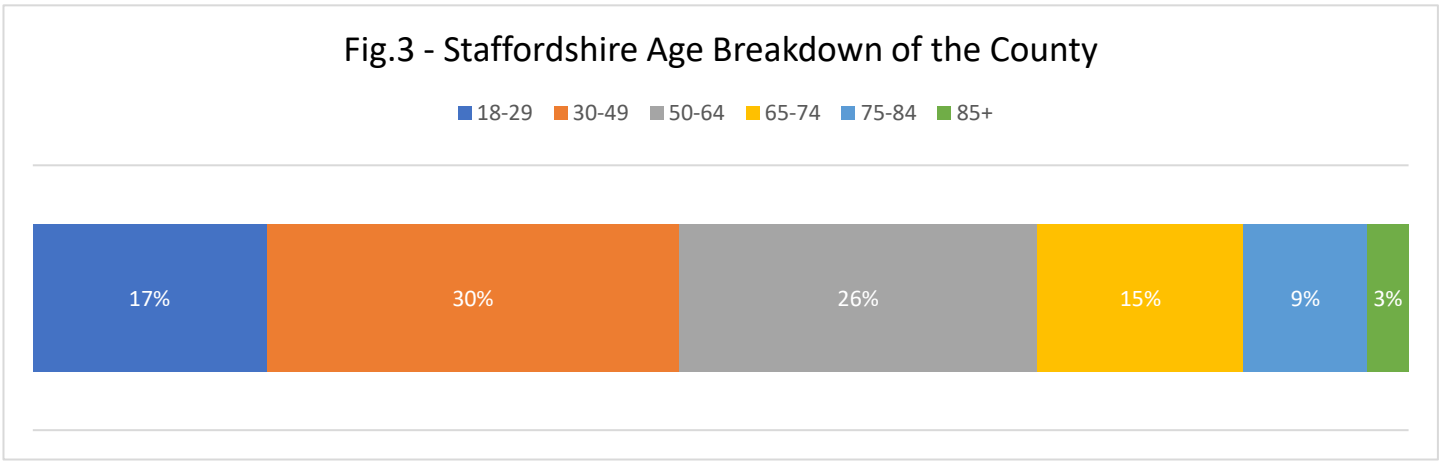
- If the decision is for no further enquiries, it is at this stage that Staffordshire and Stoke on Trent make a different recording decision –
- Stoke on Trent record this decision as – No Section 42 required (but also record what other actions either care assessment request, review etc. as a non-statutory Section 42)
- Staffordshire record this decision as – Section 42 enquiry completed (either no ongoing risk, closed at adult's request, concerns substantiated or unsubstantiated)

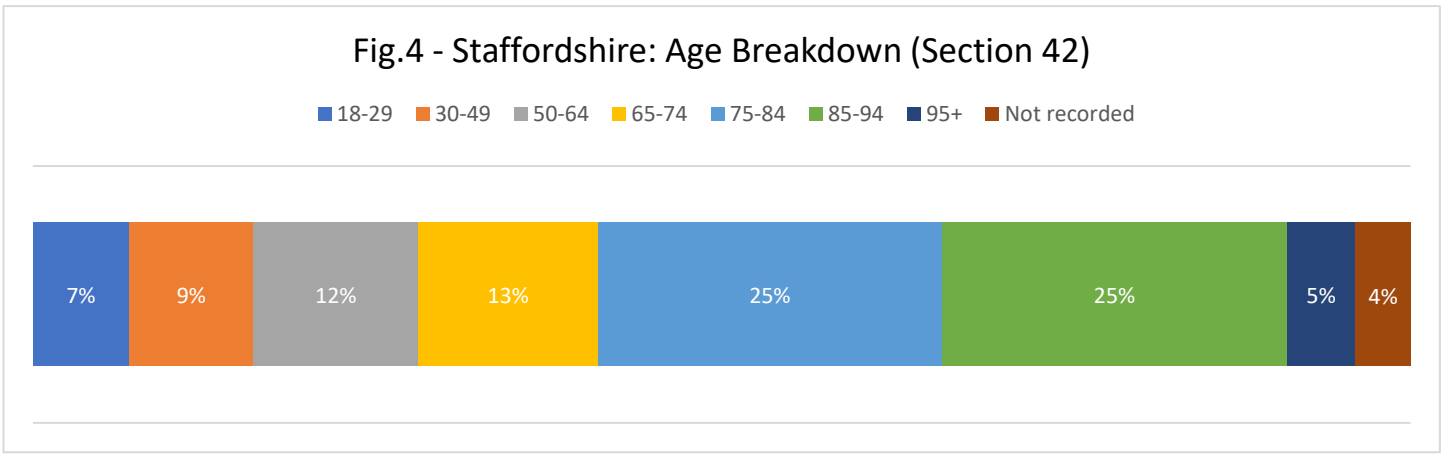
In essence Staffordshire and Stoke on Trent Local Authorities follow the same procedures but the recording on systems is an internal decision for each authority. This review has illustrated that both authorities are taking the same steps to ensure adults are safe and risks minimised. Both authorities have undertaken to re-examine their approaches to seek better alignment in recording practices and conversion to Section 42 enquiry rates.

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 care and support and this information is provided below.





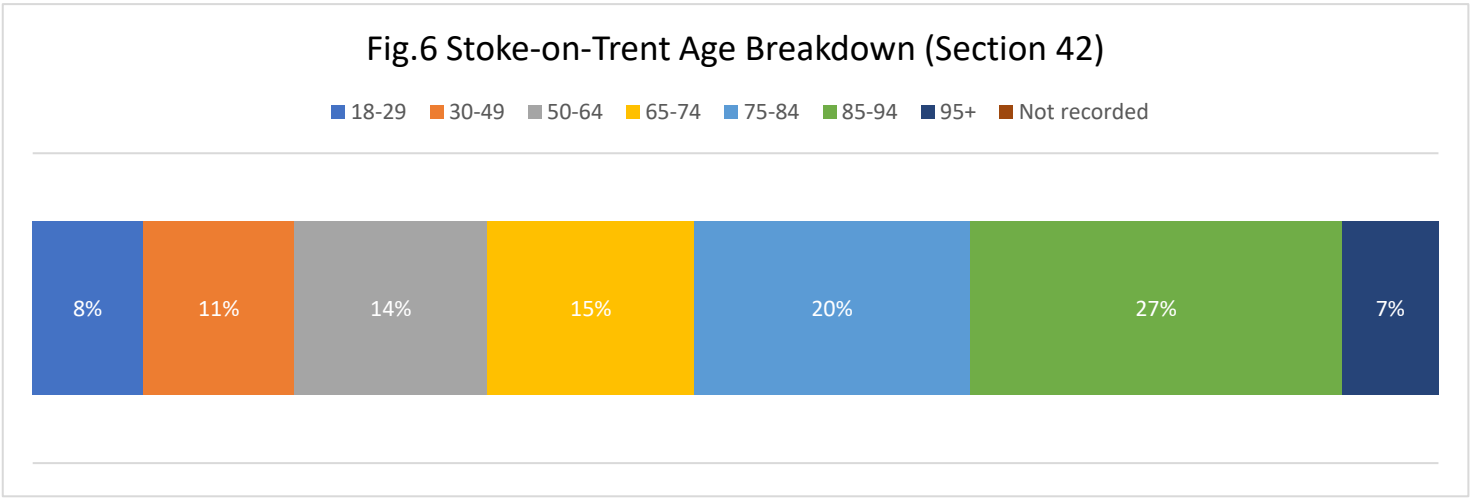
Staffordshire

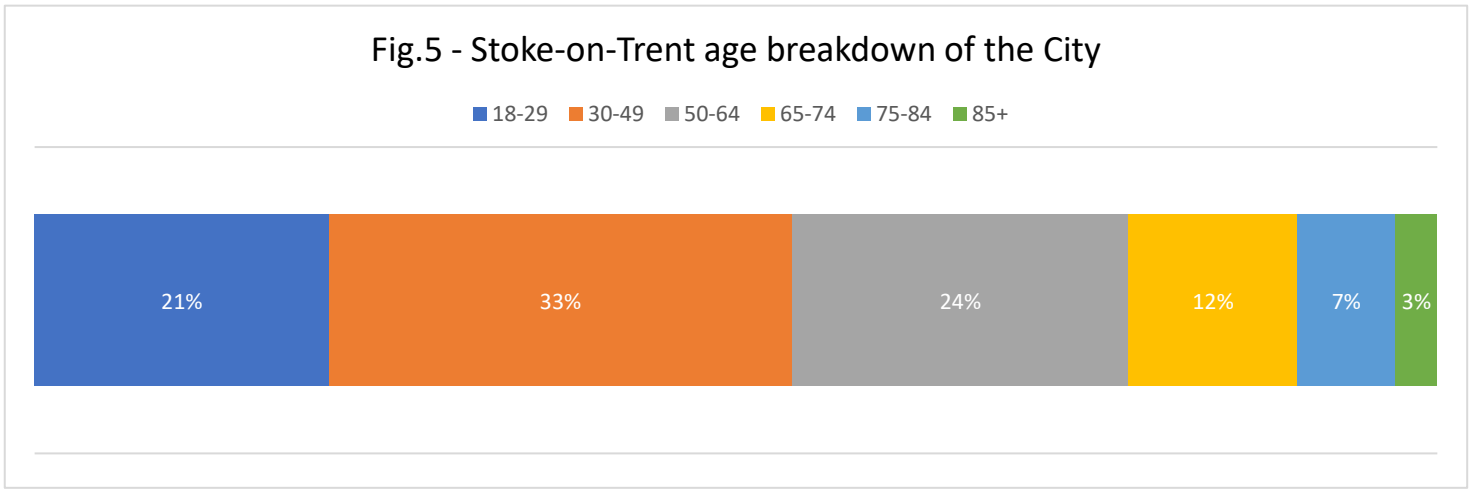
Of the adults who have been the subject of a Section 42 enquiry, those aged 85-94 (25.2%) represent the largest cohort followed closely by 75-84 (24.9%), there has been very little change in age percentages this year compared to last year.

When comparing the age breakdown with general Staffordshire population statistics, it is evident that people in the 75+ age groupings are disproportionally overrepresented for Section 42 enquiries. Around 3% of the adult population in Staffordshire are aged 85 or over, however, 30% of safeguarding enquiries relate to this age group.

The average life expectancy for a man living in Staffordshire is 79.7 years and for a woman 83.5 which may explain why there are more enquiries for women than for men as there is an increased need as a population grows older for care and support. This seems consistent with the national picture over the last few years.

Note: the age bands given by the Office of National Statistics conclude at 85+ and do not match the age-related Section 42 enquiries above.





Stoke-on-Trent

For Stoke-on-Trent, the largest cohort is adults aged 85-94 years (27%) an increase of 7% from last year and 75-84 (20%) a decrease of 5% from last year. There has been a 5% increase on average for all adults over 75 who have been subject of a Section 42 enquiry.

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 and that 34% of referrals are regarding 3% of the adult population in Stoke-on-Trent, those 85 or over.

Men in Stoke on Trent have a life expectancy of 76.5 years and for women 80.2 years, there are also more concerns raised for women this year which may be because there are more women who are older and the older the population the greater the need they may have for care and support.

Due to the relative low numbers that go to Section 42 Enquiry small changes in numbers can significantly change these percentages. The number of Section 42 enquiries for adults aged 85-94 increased by 10 in 2021-22 from 2020-21, whereas number of Section 42 Enquiries for adults 75-84 decreased by 13 in same period.

Gender

Fig.7 - Staffordshire: Gender breakdown (Section 42)

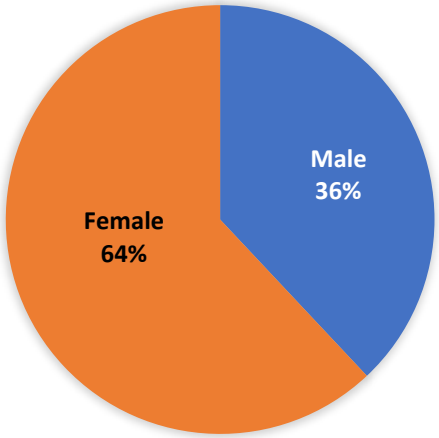
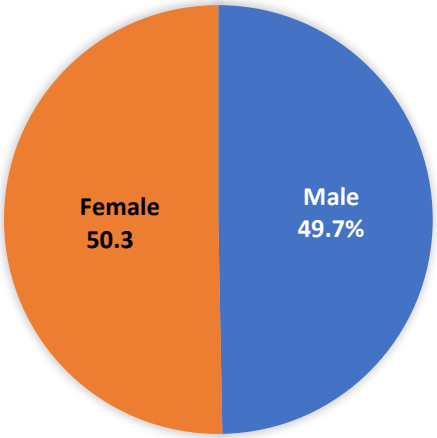


Fig.8 - Staffordshire: Gender breakdown of the County



Staffordshire

Females represent the majority of adults subject of a Section 42 enquiry with 64% over the year an increase of 2% with males having a corresponding decrease. Females are overrepresented (by 14%) when compared to the overall Staffordshire gender breakdown. This may be partially due to the fact that women have a higher life expectancy 4.8% (3.8 years) more than men and as a population is more elderly, they may have more needs for care and support.

Fig.9 - Stoke-on-Trent: Gender breakdown (Section 42)

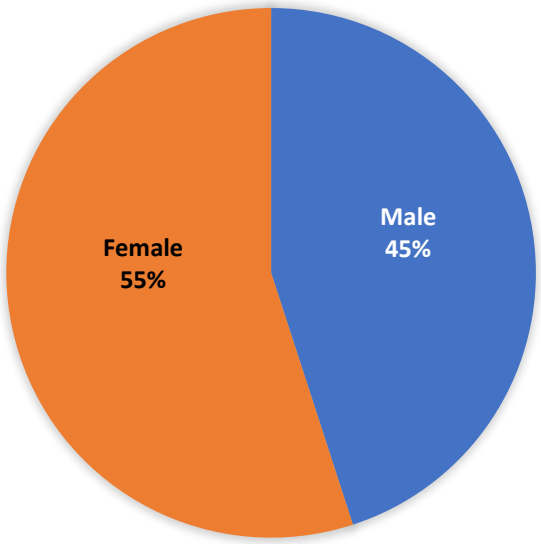
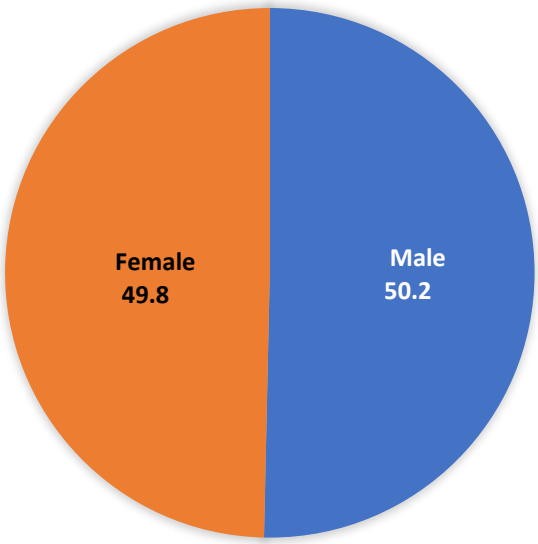


Fig.10 - Stoke-on-Trent: Gender breakdown of the City



Stoke on Trent

Stoke on Trent has remained the same for the number of males and female who were part of the Section 42 enquiry process. This may be partially due to the fact that women have a higher life expectancy by 4.8% (3.7 years) more than men and as a population is more elderly, they may have more needs for care and support.

Note: Recording systems are currently unable to break down data further to reflect broader gender categories to be fully inclusive. This has been raised with the Local Authorities with regards to their recording systems with requests that there be a greater range of gender options to reflect the local communities.

Ethnicity

Ethnicity	Stoke on Trent section 42 enquiries	Stoke on Trent overall population		Staffordshire S42 enquiries	Staffordshire overall population
White British	83.1	86.4		87.8	93.6
Not Known	9.8	-		6.2	-
Pakistani	1.3	4.2		0.5	0.8
Black Caribbean	1.3	0.3		0.4	0.3
Other White British	0.9	1.9		1.1	1.6
White Irish	0.9	0.3		0.3	0.5
Any other ethnic group	0.9	0.5		0.2	0.1
Indian	0.4	0.9		0.5	0.8
Not Stated	0.4	-		2.3	-
Any other mixed background	0.4	0.5		-	-
Mixed White/Caribbean	0.4	0.3		0.3	0.5
Any other Asian Background	0.4	1.4		0.2	0.4
Bangladeshi	0.0	0.4		0.0	0.1
Black African	0.0	1.0		0.1	0.2
Arabic	0.0	0.2		0.0	0.1
Gypsy /Roma	0.0	0.1		0.0	0.1
Any other Black Background	0.0	0.1		0.1	0.1

Note: 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' 87.8%, a very slight decrease from last year (87.9%), followed by 'Other White British at (1.1%). The Not Known category has decreased by 2.2% (from 8.4%) since a Not Stated category has been introduced this year. Following the upgrade to the Care Director recording system Staffordshire County Council has held practitioners' forums to raise staff awareness and understanding of the increased functionality.

Stoke-on-Trent

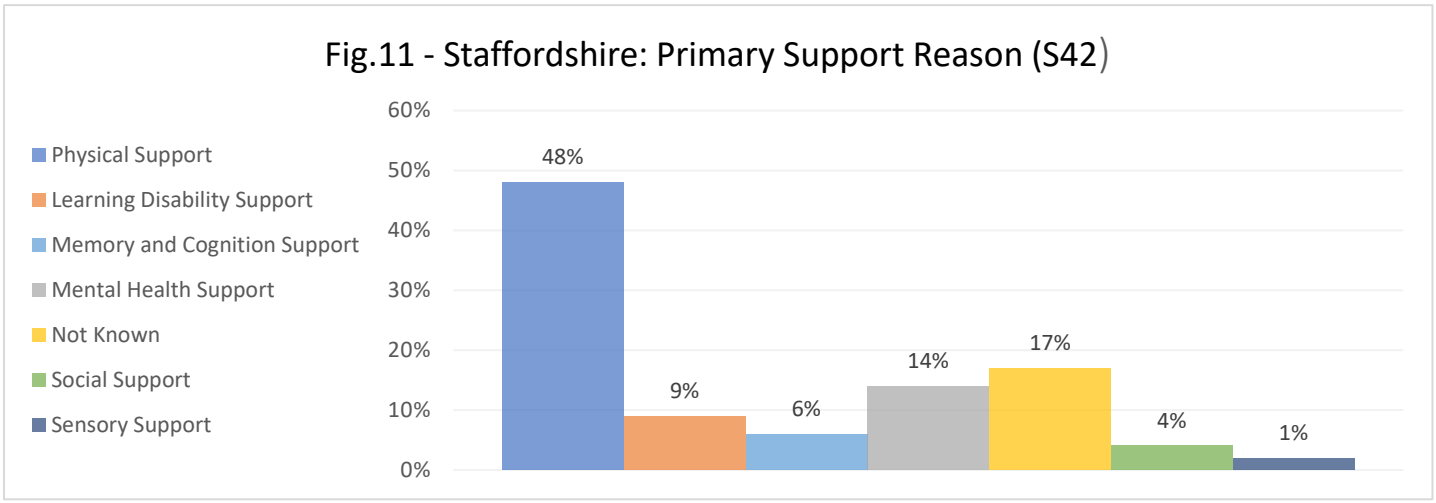
The pattern is similar in Stoke-on-Trent, the majority of declared ethnicities are 'White British' 83.1%, a decrease from 88.2% last year.

It is known that people from ethnic minority populations are disproportionally under-represented in Section 42 enquiries, however, for both local authorities Staffordshire 8.5% and Stoke on Trent 10.2%, there are

records where the adults do not have their ethnic background captured which limits the usefulness of any comparison to the wider population.

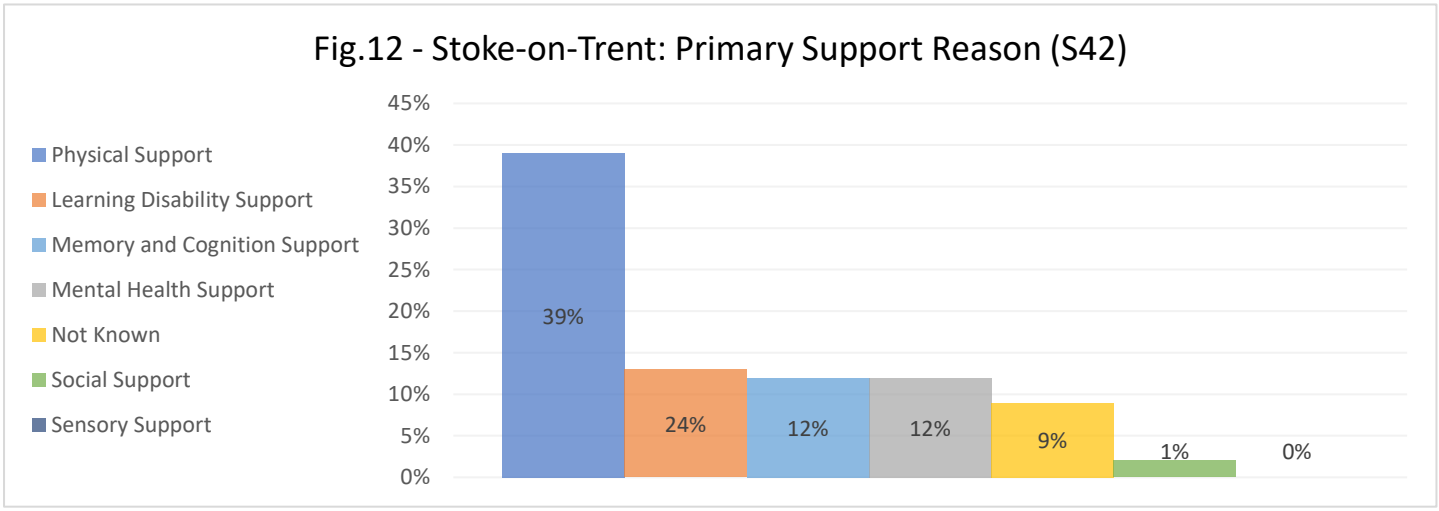
Primary Support Reason

The bar charts below illustrate the type of care and support need of the adult subject of abuse or neglect.



Staffordshire

Physical support continues to be the most common primary support reason in Staffordshire in 2021/22 (48%) an increase from 40% last year. This is followed by 'Not knowns' (17%) that is a decrease from 29% last year.



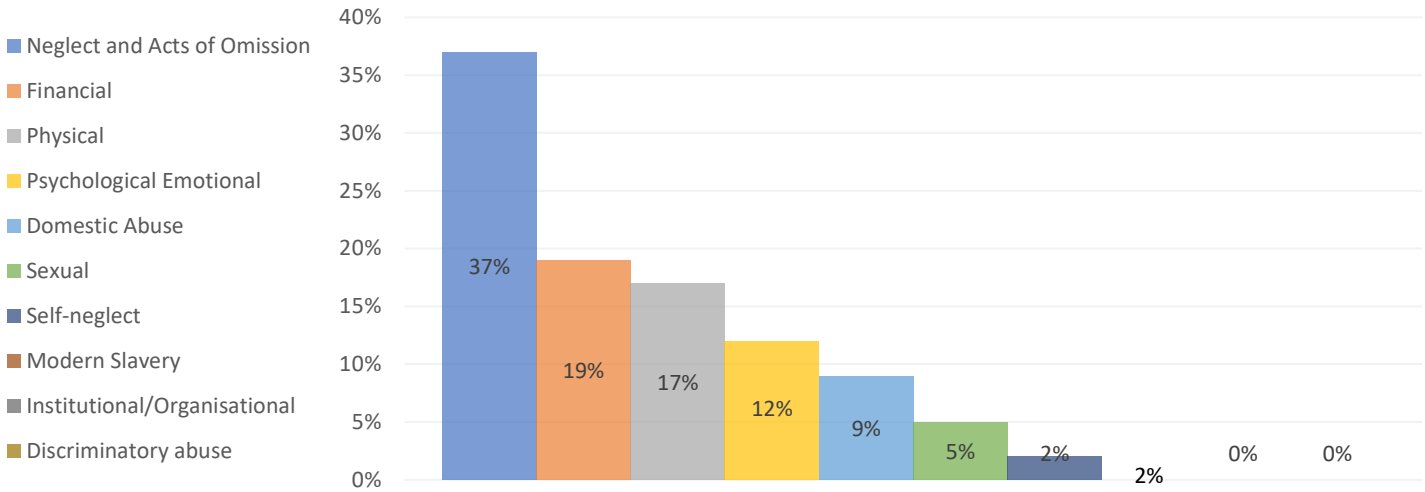
Stoke on Trent

Physical support similarly represents the largest proportion of primary support reasons recorded in Stoke on Trent at 39%, followed by learning disability support with 24%, which remains at the same percentage as last year. Mental health support accounts for 12% which remains at a similar level to last year.

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:

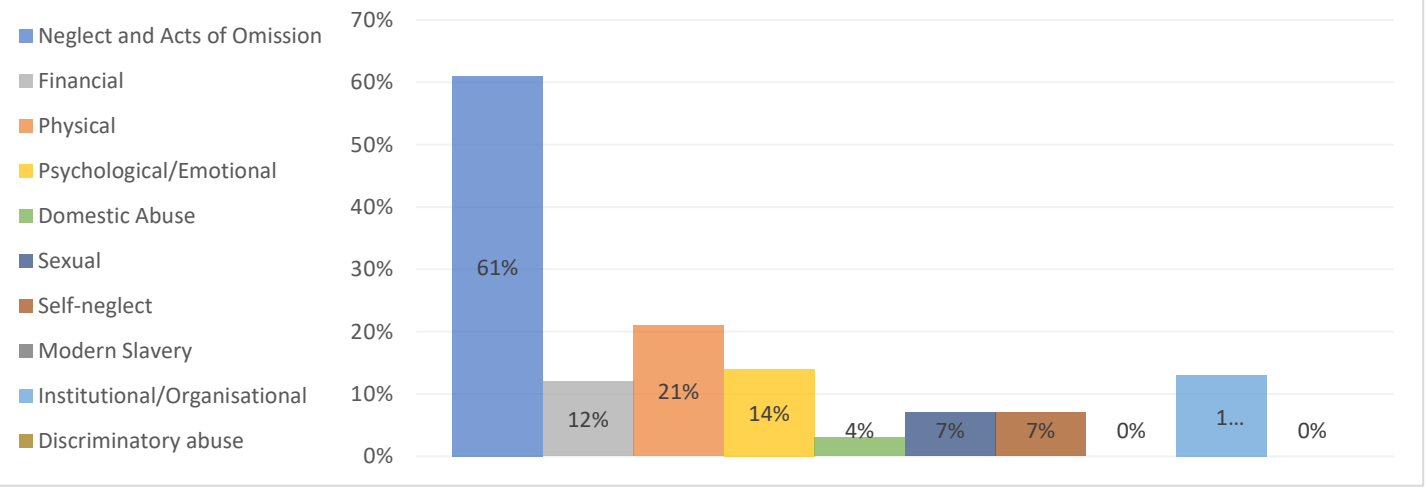
Fig. 13 -Staffordshire: Types of abuse or neglect identified at Section 42 safeguarding enquiry



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 73% of all harm/abuse recorded. Neglect and acts of omission show a slight increase from last year; whilst financial abuse has increased (by 4%) in 2021/22. There has been a significant decrease in recognition of Organisational abuse which has decreased from 7% to 0%. This may be related to the fact that there is only one type of abuse that can be recorded. Organisational abuse has been the subject of an audit by the Audit and Assurance subgroup. The Board has been given assurances that practitioners in contact centres know and recognise organisational abuse and are able to record this appropriately. The contact centre record what type of abuse the referrer believes the abuse to be. Practitioners have access to guidance as to what constitutes organisational abuse and this is confirmed at the decision making stage.

Fig. 14 - Stoke-on-Trent: Types of abuse or neglect identified at Section 42 safeguarding enquiry

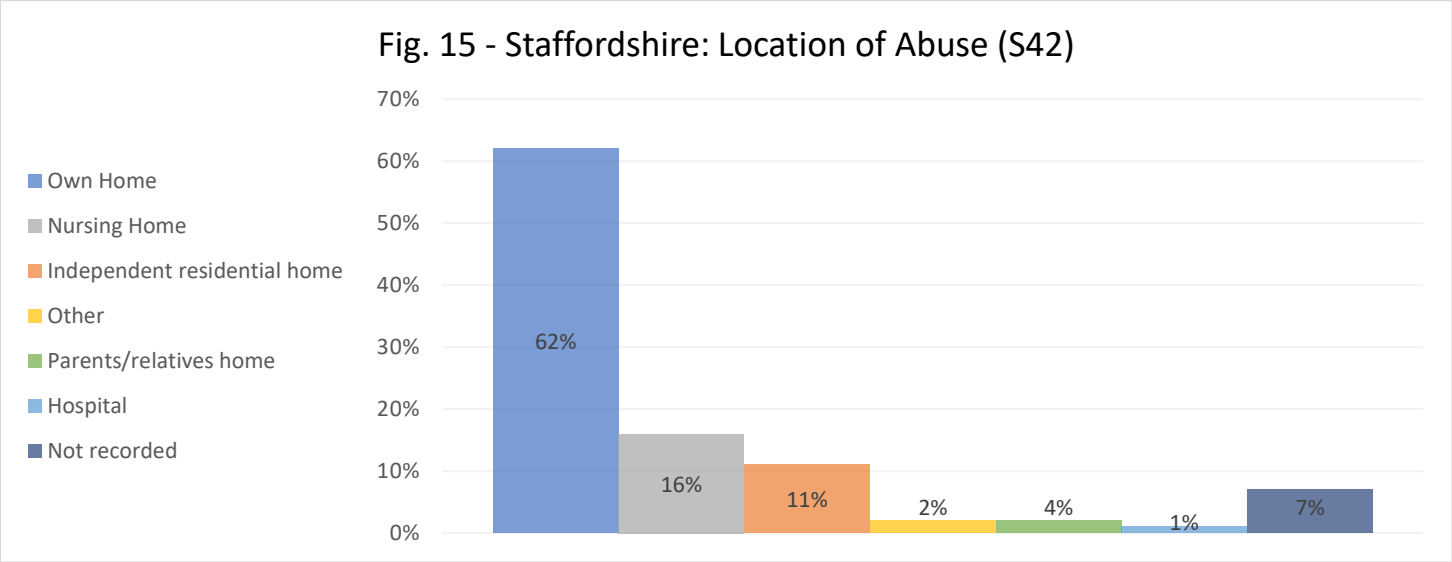


Stoke-on-Trent

The percentage of neglect and acts of omission cases has increased from 58% in 2020/21 to 61%. Physical abuse has increased by 7% (from 14% last year) and financial abuse has decreased by 14% (from 26% last year). Self-neglect has increased from 2% to 7% reflecting in part an increased awareness amongst practitioners arising from the learning from the 'Andrew' SAR.

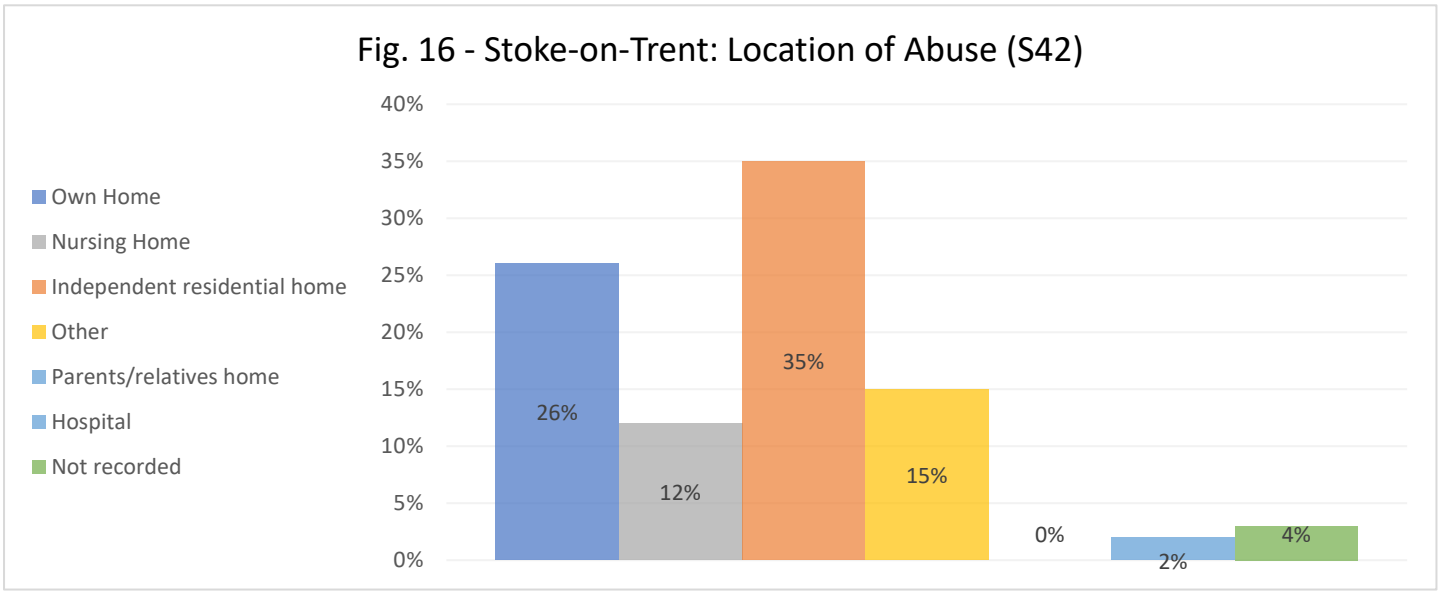
It should be noted that there can be relatively small numbers of adults in types of abuse which can cause a percentage change to appear more pronounced. In Stoke on Trent more than one type of abuse may be reported for a single case. The total cases are therefore more than 100%.

Location of abuse



Staffordshire

Of those people subject of Section 42 enquiries, the most common location of abuse or neglect was the person's own home (62%). The next most common locations in Staffordshire were nursing homes (16%) an increase of 5% from 2020/21 and independent residential homes (11%) which is similar to last year.



Stoke on Trent

The most prevalent location of abuse in Stoke on Trent is in an independent residential home (35%) followed by the person's own home (26%) and Nursing Home (12%). There has been a decrease in Abuse in the person's own home by 11% from last year and an increase of abuse reported in Independent Residential homes by 11%.

Through audit it has been identified that some practitioners record a care home as a person's own home

Findings of Concern Enquiries

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

Staffordshire: Repeat referrals have remained the same from last year at 19% and remained relatively stable for the past three years.

Stoke-on-Trent: The percentage of repeat referrals has decreased from 7% to 4% with similar rates for the past three years.

Note: There is an explanation for the reasons for variation in repeat referral recording between Staffordshire and Stoke on Trent on page 26.

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

Fig.17 - Staffordshire: Outcomes

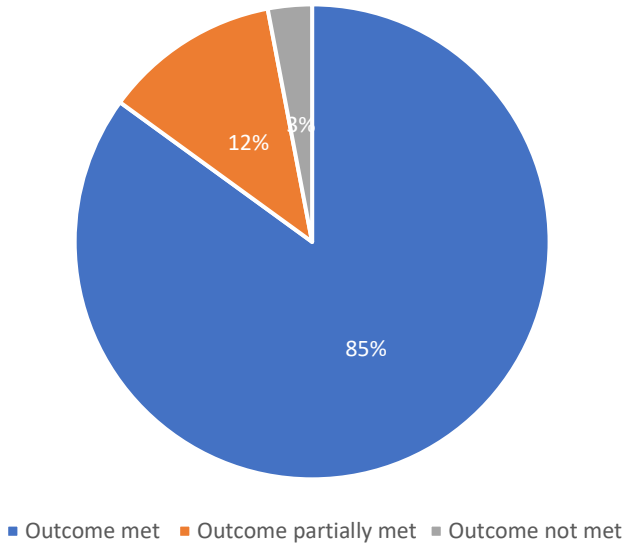
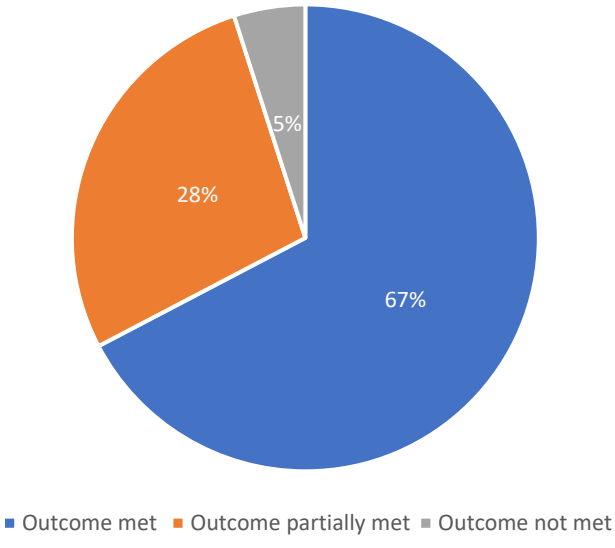


Fig.18 - Stoke-on-Trent: Outcomes



Staffordshire

The data is collected by the enquiry worker at the close of the case who will discuss with the adult or their representative their opinion on if the case has met, partially met, or not met their preferred outcome.

In Staffordshire 67% of adults subject of a Section 42 enquiry provided a response to the question of whether their desired outcomes from the enquiry were either met in full, partially met or were not met. A total of

97% of adults responding stated that their desired outcomes were fully met or partially met. This is a slight reduction from 98% last year.

Stoke on Trent

The data is collected by a social worker who has been working with the adult and able to obtain the adults opinion.

In Stoke on Trent 44% of adults subject of a Section 42 enquiry provided a response. A total of 96% responding stated that their desired outcomes were fully met or partially met. This is a slight decrease from 98% last year.

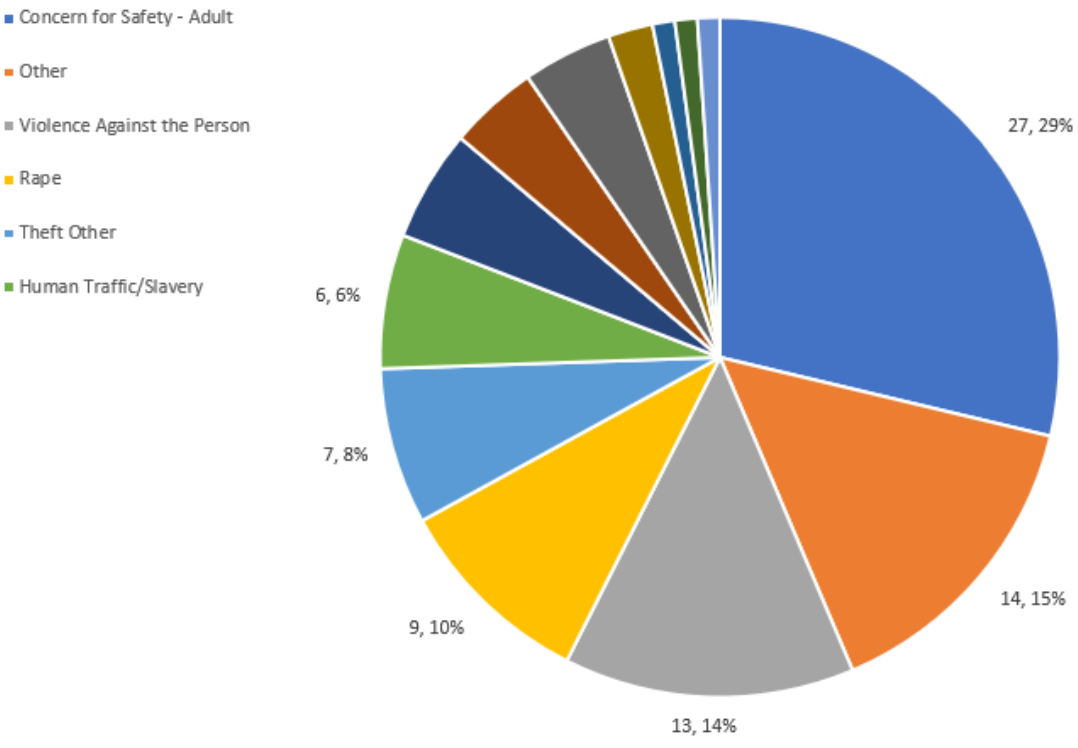
Report from Staffordshire Police and Adult Safeguarding Enquiry Team

The Adult Safeguarding Enquiry Team (ASET) is a multi-agency team comprising Police detectives and Adult Social Care with a remit to undertake investigations into reports of abuse and neglect of adults with care and support needs and associated investigations into persons in positions of trust. The team has wider links to safeguarding partners, the Care Quality Commission (CQC) and Her Majesty's Coroner.

Whilst a number of investigations involve a potential criminal act the team is also engaged in multi-agency investigations and early intervention in care settings that do not reach criminal thresholds, for the purpose of preventing harm to vulnerable adults. This approach can achieve better outcomes for adults than a response after harm has occurred.

The below table and chart indicate the types of incidents that the ASET investigate (1st April 2021 to 31st March 2022)

Fig. 19 - Incident types



Incident Type	
Concern for safety - Adult	27
Other	14
Violence against the person	13
Rape	9
Theft other	7
Human Trafficking /Slavery	6
Administration	5
Fraud - Action Fraud	4
Sexual offences - Not Rape	4
Sudden Death	2
Concern for safety - Child	1
Fraud - Other/Forgery	1
Harass/Stalking	1
Total	94

In the last 12 months ASET has dealt with a lower proportion of non- recordable crime compared to the previous year. The proportion of violent offences such as common assaults have reduced. Sexual offences make up a higher proportion of the identified crimes.

Examples of investigations include: -

A 97-year-old female who was moved to a care home due to her granddaughter spending her money under Power of Attorney. Following an investigation, the granddaughter was charged with offences of Fraud. During the granddaughter's trial at the Crown Court special measures were put in place to enable the grandmother to attend court via Video link from the care home where she was living. Despite their being a 5-year time gap in the matters being heard by the Crown Court and the grandmother having dementia, the grand daughter was found guilty of Fraud whilst being in a Position of Trust and was sentenced to imprisonment.

An investigation was conducted into a taxi driver and assistant following reported concerns of ill treatment of young adults with significant health and learning difficulties. The victims were not verbal and could not give any evidence for the offending. The main witness has severe learning difficulties but gave evidence by video interview. Special measures contained within Section 28 of the Youth Justice and Criminal Evidence Act 1999 enabled the witness to give evidence in the best possible way without the ordeal to attend court. The taxi driver and assistant pleaded guilty to the charges at court and await sentence.

Fig. 20 - Adult Safeguarding by Crime type

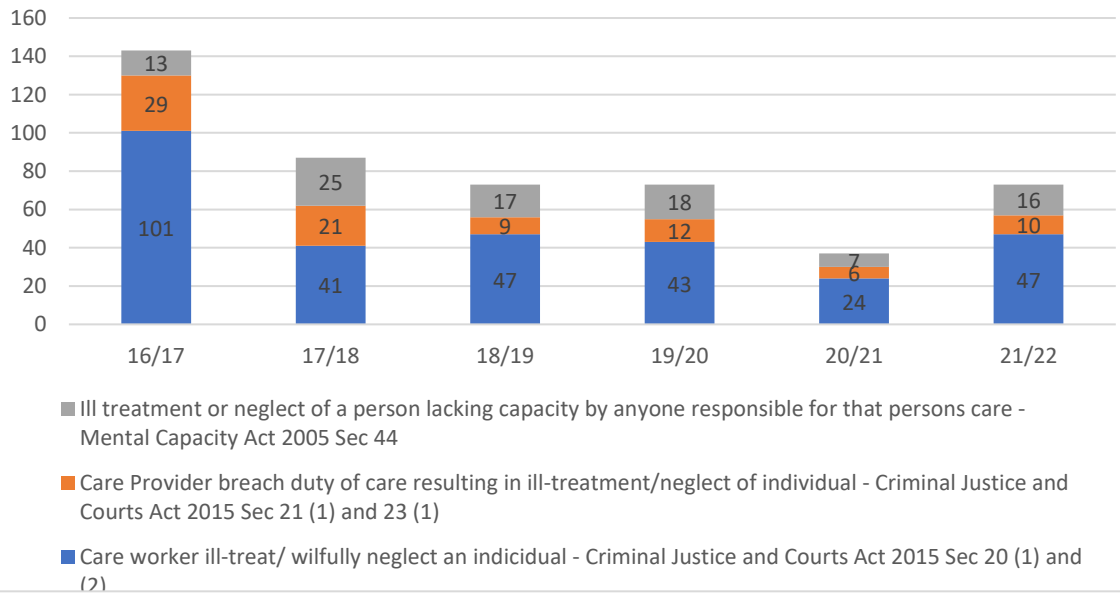


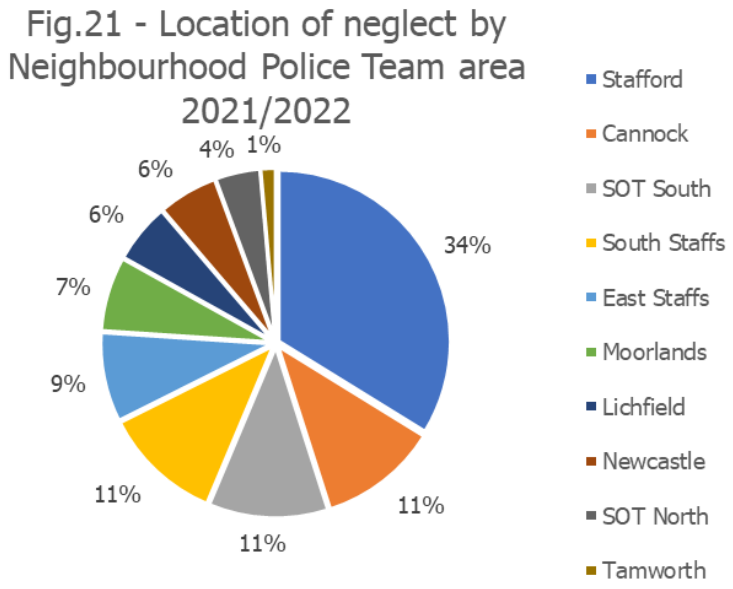
Figure 22 illustrates that there were a total of 73 offences reported for criminal investigation in the 12 months to 31 March 2022. The year is contrasted with previous years to indicate reporting rates over time.

From analysis of 2021/22 reports:

- Of the Neglect offences, there are 5 repeat victims in the last 12-months period; neither had been a victim in the previous 5 years.
- 4 out of the 5 offences against the repeat victims were committed at the same location.
- 2 repeat offenders are linked to the same 3 crimes.
- There are 5 repeat locations in the last 12-month period. These are at 4 care homes; 1 residential address.
- There are 9 locations that had 1 offence in the last 12-month period as well as other Adult Safeguarding offences in the previous 5 financial years.

The analysis is used operationally in conjunction with safeguarding partners to target preventative actions.

The below pie chart demonstrates the geographical locations of Neglect offences based on Neighbourhood Police Team (NPT) areas.



8. 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 offered to provide 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 2 of a 3-year budget agreement which was approved by the statutory partners in July 2019.

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/Employee costs	£120,034 *note (i)*
	Consultant fees	£5,750
	Training resources	£4,500
	Website costs	£2,500
	Insurance	£2,368
	TOTAL:	**£135,152**

Note (i) All staffing costs including employment costs, mobile phone, printing and travelling

9. APPENDICES

APPENDIX 1: BOARD PARTNERS

Statutory Partners as of 1st April 2021

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

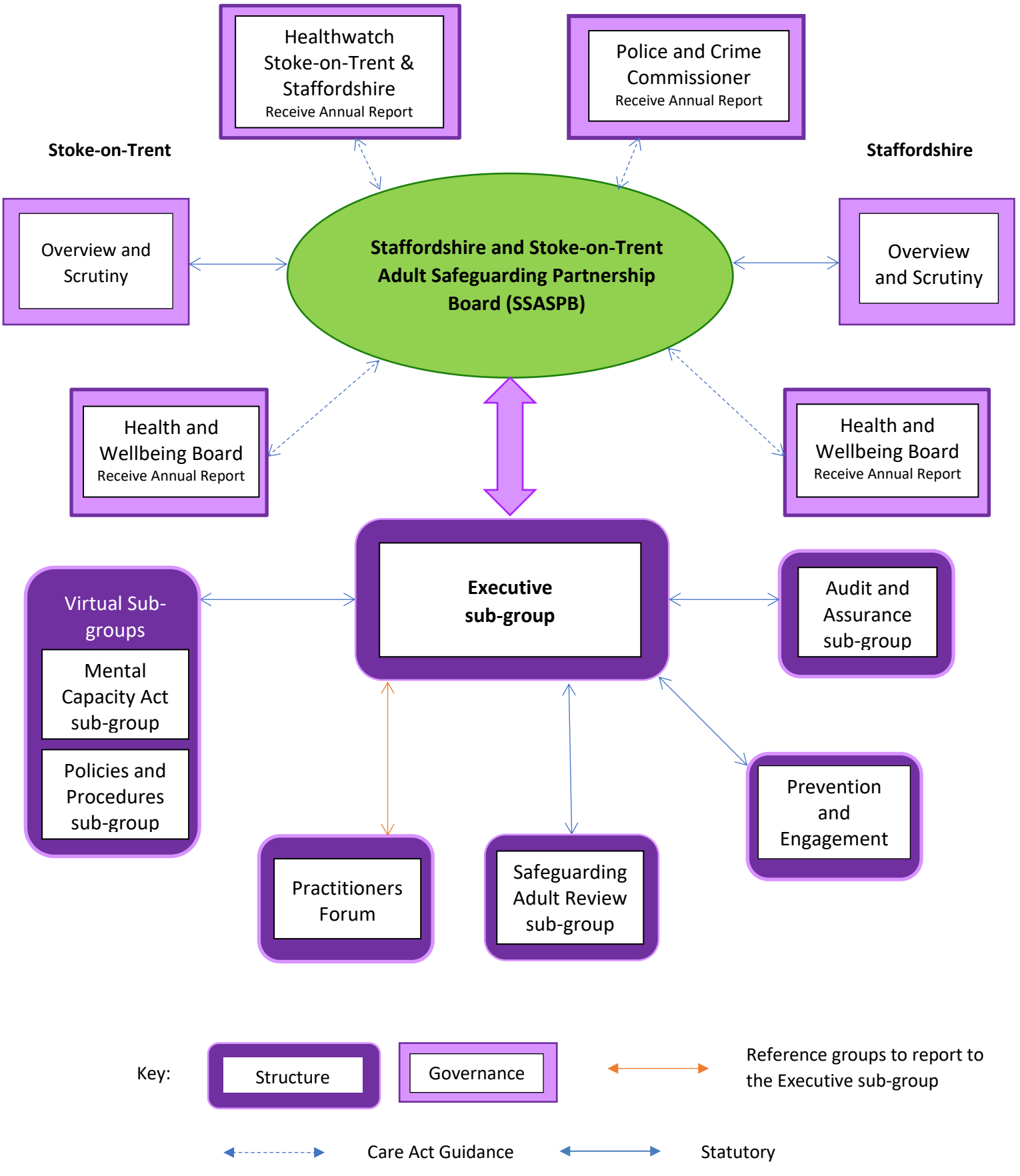
Extended Partnership as of 1st April 2021

- ASIST advocacy
- Brighter Futures
- Community Rehabilitation Company (CRCs) (Staffordshire and Stoke-on-Trent)
- Domestic Abuse Forum
- Domestic Abuse Providers Network (GLOW, Staffordshire Women's Aid)
- Healthwatch (Staffordshire and Stoke-on-Trent)
- Her Majesty's Prison Service (HMPS)
- Housing Plus
- Local Authority Lead members
- Midlands Partnership Foundation Trust (MPFT)
- Middleport Matters Community Trust
- 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)
- Your Housing Group
- West Midlands Ambulance Service (WMAS)

APPENDIX 2: GOVERNANCE STRUCTURE

From 1st April 2021

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.

10. 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
DoLS	Deprivation of Liberty Safeguards
GDPR	General Data Protection Regulation
HMIC	Her Majesty's Inspectorate of Constabulary
HMIP	Her Majesty's Inspectorate of Prisons
ICB	Integrated Care Board
LD	Learning Disabilities
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
PiPoT	Persons in a 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
SFARS	Staffordshire Fire and Rescue Service
SSASPB	Staffordshire and Stoke on Trent Adult Safeguarding Partnership Board
SSSCB	Stoke on Trent and Staffordshire Safeguarding Children's Board
SoTCC	Stoke on Trent City Council
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

‘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

Staffordshire County Council

Safeguarding Overview and Scrutiny Committee – 5 January 2023

Staffordshire Safeguarding Annual Report (SSCB) 2021-2022

Recommendation

I recommend that the Committee:

a. Members are asked to receive the report to understand what the safeguarding partners of the Staffordshire Safeguarding Children Board (hereafter referred to as the SSCB) have done as a result of the arrangements, including on child safeguarding practice reviews, and how effective these arrangements have been in practice. Members are asked to consider or comment on the progress that the Board has made since the last annual report was presented to the committee in December 2020. This SSCB Annual Report sets out the progress made by the partnership during 1st April 2021 and 31st March 2022.

Local Member Interest: N/A

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

Summary

What is the Overview and Scrutiny Committee being asked to do and why?

1. The SSCB are required to report annually on the progress made by the 3 statutory safeguarding partners to the Overview and Scrutiny Committee to enable robust Member scrutiny of its statutory functions. SSCB Annual Reports provide a transparent, public account of the work of the partnership during 2021-2022.

Report

2. The SSCB works together in partnership to safeguard and promote the welfare of children across areas of safeguarding activity that consider the need to promote equality of opportunity and to meet the diverse needs of all children living in our communities. Specifically:

   a. Engage partner agencies to set the strategic direction for safeguarding all children;

b. Identify and prevent harm and impairment of health or development and help ensure that all children are provided with safe and effective care as they are growing up;
c. Lead and coordinate on proactive work to target vulnerable groups;
d. Lead and coordinate on responsive work to protect children suffering, or at risk of suffering, significant harm;
e. Lead and coordinate statutory rapid reviews and child safeguarding practice reviews; and
f. Lead and coordinate the development and delivery of multi-agency safeguarding training.

3. The objectives of the Board are pursued through core statutory functions which are set out within the Children Act 2004 and the statutory guidance Working Together to Safeguard Children 2018. These core functions are achieved through the work of the Board's revised subgroup structure. Each subgroup is responsible for measuring its performance against an annual work plan, which is derived from the SSCB Business Plan. Members of the Board and Scrutiny and Assurance group monitor the effectiveness of the work completed.

4. Membership of the SSCB is set out in Working Together to Safeguard Children 2018 and the published SSCB new arrangements document. Organisations that include local authority, police, and health (specifically the ICB) are required to cooperate with the local authority in the establishment and operation of the Board and have shared responsibility for the effective discharge of its functions. The Staffordshire County Council Cabinet Member for Children and Young People also attends the Board as a participating observer.

5. The governance arrangements of the SSCB have been the subject of significant review since 2019 and are in line with the statutory guidance Working Together to Safeguard Children 2018. The Board is confident that it is fully compliant with the statutory function requirements for local safeguarding children partnerships.

6. Since the last report to the Committee the SSCB continues to make steady progress on a wide range of objectives through effective local partnership working, despite the challenges presented by the Covid-19 pandemic, the economic climate, and agency restructures. This includes engaging in activity which is targeted at groups of children and young people who have been identified as being vulnerable due to criminal exploitation, and neglect. The information provided in the annual report highlights some of the most noticeable achievements in respect of the priority areas and work undertaken with partner agencies.

Link to Strategic Plan

7. The work of the SSCB contributes to and supports the values and principles detailed in the Staffordshire County Council's Strategic plan.

Link to Other Overview and Scrutiny Activity

8. The work of the SSCB links to Committee's overview of the local authority's Children's Social Care arrangements.

Community Impact

9. Not required, as there is no changes to be made to policy, decision or function that would substantially impact staff, service users, the economy, the environment, climate change, health and care or a community.

List of Background Documents/Appendices:

Appendix 1 - Staffordshire Safeguarding Children Board Annual Report 2021/22

Contact Details

Director for Children and Families: Neelam Bhardwaja (LA Statutory Safeguarding Partner)

Report Author: Lynne Milligan (on behalf of the SSCB)
Job Title: Children and Families Partnership Boards manager
Telephone No.: 01785 854572
E-Mail Address: lynne.milligan@staffordshire.gov.uk

Staffordshire Safeguarding Children Board

Annual Report (FINAL DRAFT)

Staffordshire Safeguarding Children Board 2021/22

Contents

Foreword

Neelam Bhardwaja, Director of Children and Families, Staffordshire County Council

The safeguarding partnership has continued to build on its strengths to be ready for the challenging agenda arising from local inspections, self-assessment reviews and audits as well as the national agenda arising from the well-publicised deaths of two young children in particular. The stronger partnerships forged during the coronavirus (COVID-19) pandemic continues to assist us to navigate our way through organisational changes and future direction, for example, the review of the Multi-Agency Safeguarding Hub (MASH) and contributions of all agencies to progressing the partnership agenda which will help ensure that we all play our part in keeping children safe and can evidence it through a robust performance management system.

Heather Johnstone, Chief Nursing and Therapies Officer, Staffordshire and Stoke-on-Trent Integrated Care Board

The past year has been another significant one for the NHS and partners with the continued challenge of managing the response to the COVID-19 pandemic and we have continued to keep a strong focus on safeguarding children whilst strengthening the partnership arrangements we have in place. This culminated with the appointment of a new Independent Chair who is now in post and bringing fresh eyes and new challenge to the membership.

Alongside this, the NHS has completed the extensive work required to close down Clinical Commissioning Groups (CCGs) and launch the Integrated Care System (ICS) and Integrated Care Board (ICB). Learning from previous NHS reforms, the CCGs gave a commitment that during this transition the arrangements for safeguarding children would not change in order to ensure continued progress of the work across the partnership and this has continued in line with that commitment.

The strength of the Safeguarding Partnership has continued to grow and I am confident that we will work together going forward, as we have in previous years, to maintain a high standard in all aspects of the Safeguarding Children agenda.

Jennie Mattinson, Temporary Assistant Chief Constable, Staffordshire Police

This year safeguarding partners have continued to recovery, adapt and improve services following the COVID-19 pandemic. Progress has been made against the safeguarding board priorities and the partnership is clear about where further improvements are needed. Operation Encompass has been successfully implemented resulting in thousands of referrals to schools to ensure teachers and staff are aware when a child has been exposed to domestic abuse, there is greater recognition of neglect and increased awareness and understanding of the importance of capturing, and acting on, the voice of children across all partners. The work in these areas will continue this year along with work to improve the effectiveness of our MASH arrangements.

Staffordshire Police also have a specific Child Protection Improvement Programme in place following the police specific inspection in September 2021. This has delivered some early improvements and will continue to be a focus throughout 2022/23 with joint working with safeguarding partners in key areas.

1 Our priorities

Neglect (focus on under ones)

Neglect continued to be a priority for the Board with a particular focus on infants under one. As part of our **strategic approach** to addressing underlying issues of abuse and neglect, we initiated the development of a local protocol to start strengthening our relationship with other key Strategic Partnerships in Staffordshire, i.e., the Staffordshire Health and Wellbeing Board (HWBB), Staffordshire and Stoke-on Trent Adult Safeguarding Partnership Board (SSASPB) and Staffordshire Strategic Community Safety Partnership (CSP). The protocol, which has now been endorsed by all Boards, demonstrates our joint commitment to working together to keeping children and adults safe from harm and improving their health and wellbeing. The protocol will improve our links with each other to maximise effectiveness and minimise duplication. Going forward the Chairs and lead managers will meet on a regular basis to share, align and agree priorities across the various Partnerships.

As part of our commitment to ensuring that infants receive help at the earliest opportunity we have continued with our early help/place-based approach work. Some examples include:

- commencing design work on the Family Hub model to ensure access is integrated
- broadening criteria for Supporting Families (Building Resilient Families and Communities (BRFC)) to ensure that low level neglect is identified and worked with under the programme with analysis of audits demonstrating impact
- recommissioning Tier 2 services across Staffordshire to better match need
- commencing the review of our early help strategy

Impact of early help interventions (BRFC)

"….by addressing the financial difficulties this has reduced mother's stress and impacted positively on mother's reduction in alcohol"

"[Young person] also engaged with Early Help completing the Bump to Baby and virtual doll programme. He has engaged with the parenting assessment and is on the waiting list for New Era. [Young person] has done very well to abstain from using cannabis in the past three months and is engaging positively with support in this regard…."

"The plan has led to positive change for [young person], she continues to be supported by health and receiving therapeutic support from CAMHS. Education provision is in place from September and [young person] has also started to make friendships through InterHigh and sharing her love of music"

"It is a positive that there was a clear safety plan in place for parents to follow when mum struggled with her mental health. Mum was engaging well with mental health professionals and taking her medication appropriately at the time of closure"

"Keyworker addressed education supporting with College applications with [young person] which has led to [young person] attending College to complete a public services course"

Audits from early help demonstrate that parents were being engaged and there was a good understanding of the risks children were exposed to enabling informed decisions to reduce or mitigate them. In line with the strength-based approach of restorative practice the majority of assessments and reviews also identified positives within families. However, findings from the audit also identified a significant fall in the number demonstrating whole family working from the previous year. Consent and restrictions were identified as contributors to practitioners not always being able to gain a whole family approach. Think Family is an issue that has also been identified within learning from reviews and further assurance will be sought next year through a Peer Review.

We have also had conversations with parents to understand the challenges that they face. We sought feedback from four parents and the findings were shared with Partners engaged with the family as well as Safeguarding Partners through the Scrutiny and Assurance Group. The findings highlighted little acknowledgement of the views of parents with some practitioners content they had delivered in line with the standard operating procedures (SOPs). These findings have been fed back through commissioners to service providers as part of the contract management process and we will seek assurance from commissioners that improvements are being made through our performance management framework.

Early identification of neglect though improved skills and knowledge in the workforce through the commissioning of evidence-based Graded Care Profile (GCP2) assessment tool

Last year we reported we had commissioned the use of Graded Care Profile (GCP2) to improve our response to neglect at the earliest opportunity and how a multi-agency steering group (with our neighbours Stoke-on-Trent Safeguarding Children Partnership) was set up to oversee implementation across the area.

During March 2021 we trained 30 professionals from across a range of agencies to become GCP2 champions. These champions have now delivered awareness sessions to over 900 leaders and practitioners across Staffordshire and Stoke-on-Trent and have also trained 940 practitioners to become licensed to use the GCP2 tool across a range of settings including education, health and children social care. Two Police colleagues have also been trained with a view to consider how GCP2 can be implemented, if at all, into the policing landscape; similar to the work being done across policing nationally.

We reported last year on the peer support programme which was set up to support our champions. Our GCP2 champions are instrumental in the development and delivery of the training packages ensuring fit for purpose, tailored training to each audience. GCP2 is referenced in regular communications through the Board's website, social media and monthly newsletter. In 2021 the Board hosted a successful joint neglect conference capturing the voice of the child and showcasing GCP2. The conference was opened by a young person from the Voice Project who called upon delegates to pledge their commitment to the child's voice, a selection are shown in Figure 1.

Figure 1: Selection of pledges from the neglect/GCP2 conference, 2021

Discussion held with our delegates a year later showed the messages and pledges had stayed in their working practice to this day.

"I would say that the sentiment has certainly stayed with me. When attending strategy meetings the voice and the lived experience is something I keep centre of my practice and decision making in regards to threshold."

Social Worker

"The voice of the child is fully embedded within our daily practices and is at the centre of all of our policies. We firmly believe that our nursery belongs to our children and their voices shape how our nursery functions on a day-to-day basis. We work on active listening, and we always encourage children to use their voices and words at every opportunity – but this is also equally as important with our non-verbal children and our youngest babies. We discuss daily looking out for those 'little things' that require us to stand back and absorb how children are making choices and voicing their opinions either verbally or through gestures. Sitting back, observing, watching and listening is important for us to piece together children's ideas and opinions about their experiences in nursery"

Nursery manager

Data from the training evaluation evidences an increase in both knowledge and confidence in using the GCP2 assessment tool. Post-training evaluation also demonstrates a commitment from attendees to use their acquired skills and knowledge to improve outcomes for children and families. However, the number of assessments that were recorded as being completed during the year was still relatively low (70) and further work continues to address the barriers.

The introduction of GCP2 has meant that trained practitioners within the workforce have a clear understanding of neglect in terms of the impact on the child and wider family outcomes. This is also supported by a restorative approach which is evidenced in the audit activity and observations of practice by Children Social Care.

Where the tool was well embedded, practitioners felt it improved their practice and that families had benefited from its use:

- Practitioners felt that referrals were clearer and more likely to lead to actions that would support the child
- Some families were reported to make positive health and lifestyle changes as a result of the use of the tool

Case study

An early-years setting had concerns about a three-year-old child in their care. The child was seen crossing the road unattended, being left alone at the gate for 20 minutes and their sibling attending with a mark on their face. Each concern was raised with parents, but concerns remained although didn't meet threshold. The designated safeguarding lead conducted a GCP2 with the parents around safety in the home and road. Despite being reluctant to engage, the parents then agreed to worked with the family support worker and manager.

Contact was made with mum weekly through the family support worker or nursery manager. The older child continued to attend nurture groups for his emotional health and improvements were seen both in the nurture group and in the classroom. The younger sibling has had no existing injuries since the meetings and is progressing in all areas of his development. Parent and school communication continues to be good.

"The GCP2 toolkit was self-explanatory and provided us with the necessary statements and questions to aid our conversation with mum, and to get her the help she needs. We liked the visual aspect of the numbers and found it is encouraging that we could use the toolkit to help mum improve the areas of concern, by suggesting next steps. GCP2 provided a good foundation to start a conversation and to broach difficult questions. Along with very helpful statements the tool provides, we also felt that we could refer to it through each concern and it help guide us through the difficult conversations with the family."

Whilst it is difficult to attribute impact directly to the work we have done around neglect and GCP2, during 2021/22 we did see a reduced number of re-referrals and children subject to a Child Protection Plan (CPP) for a second or subsequent time where neglect is the main category of concern from the previous year.

In terms of reducing the impact of the underlying causes of neglect we have had assurance that we have set conditions which should see improvements over the next 12-18 months which we will be able to evidence through the Early Year Advisory Board's performance framework.

Our focus next year will be on:

- Implementation of our local protocol with key Strategic Partnerships
- Seeking assurance on how we know every practitioner "gets it" and understands the impact of parental neglect on children outcomes
- Ensuring GCP2 is consistently embedded across the whole system and routinely used
- Continuing to seek assurance on the ongoing impacts of Covid-19, such as reduced face-to-face opportunities for identifying neglect early, and in particular for babies, due to some of our contacts/services still operating as 'digital-first'
- Seeking assurance that professionals acknowledge all new parents' opinions are significant
- Implementing the revised Early Help Strategy and accompanying delivery plan which includes the delivery of Family Hubs
- Improving information sharing - given that most children are known to single-agencies - to proactively help children and families. This was an issue that we were unable to resolve during 2021/22 and discussions between the local authority and health are ongoing
- Improve the recognition and identification of neglect within Staffordshire Police and understanding why we have a disproportional low crime recording of neglect within performance data in comparison to the significant number of safeguarding referrals where it is referenced as a significant cause
- Improving how we triangulate what we do with impact and outcomes

Child exploitation

The Stoke-on-Trent and Staffordshire Child Exploitation Joint Task Group, continue to lead on this priority for the Board with the key objectives being to review the child exploitation strategy which is due for renewal in 2022 and to develop a partnership performance framework to monitor its impact.

Our approach to child exploitation has meant we have seen a reduction of criminalisation of children with reductions seen in both child victims and offenders.

During the last 12 months children have continued to be identified and the latest data from our Multi Agency Child Exploitation (MACE) panels demonstrates that child exploitation is being identified by a range of partners and children are being appropriately referred into services using the Risk Factor Matrix (RFM). The latest data tells us that for 90% of the children the risks are reduced through disruption of those causing them harm and co-ordination of partnership safeguarding measures.

Case study

Child A was thought to be unhappy with her home life which was pushing her towards a group of peers linked to gang culture. There were indications that she was being sexually exploited by a local group of males and then groomed into facilitating the involvement and possible exploitation of additional young girls. Child A was known to Partners through previous receipt of statutory intervention. Child A expressed changeable daily lived experiences of life associated to these peers, undoubtedly linked to fear and anxiety. There were reports that these associates routinely carried knives and an intimidating environment with the group appearing to be widening. Due to long-term absence from school, her parents raised concerns as they were unsure where she was going during school time and reported her missing.

She was referred to the MACE panel which resulted in her receiving services from the commissioned child exploitation service, Catch22. She received a high level of responsive, trauma-informed support and direct work around increasing her understanding and knowledge of child exploitation from Catch-22 as well as access to support services within school. Her parents also received support, education and awareness to help them support their daughter.

Following positive interventions, risk levels for Child A gradually reduced with some feedback around how this has impacted her in a positive way. Child A now has an improved relationship with her parents. She has indicated that she feels safe and is no longer connected to the group. She is now 16 and has applied for a college placement and is also exploring potential employment opportunities.

Through information gathered through the MACE panel, the multi-agency team were also able to understand, map and put in interventions to disrupt the group from exploiting other children.

Partners are continuing to embed the Vulnerability Assessment Tool (VAT) which will provide a multi-agency product that delivers a comprehensive understanding of child exploitation throughout Staffordshire. It will also provide analytical opportunities to better influence all agencies to drive a partnership approach improving our understanding and approach in tackling this area of vulnerability/criminality.

During 2021/22 the Child Exploitation Task Group undertook a number of reviews and consulted with children and practitioners. Based on these reviews they found that there were some common themes which included:

- Fear and intimidation for children who are being actively exploited
- Experiences of trauma and witnessing violence
- Engaged in criminal activity because of the exploitation

As a result of the reviews, a programme of work has been agreed by the Board which will ensure a whole system review and approach:

- Ensuring the development of flexible service offers which meet the individual needs of children and their families whilst also providing clarity in respect of the delivery between the Pan-Staffordshire Child Exploitation and Missing Children Service; Youth Justice Prevention and Intervention; Early Help Services (provided and commissioned) and Children's Social Care

- Ensuring youth violence is acknowledged as a potential symptom of child exploitation, with clearly defined pathways for children who are not yet known within the system (which includes those children and their families where there are no known associated exploitation concerns)

- Ensuring the independence of Staffordshire County Council and Stoke-on-Trent City Council remains whilst sharing a shared commitment to striving towards a Pan-Staffordshire approach to safeguarding children at risk of child exploitation

This work began in 2021/22 and will continue into 2022/23.

2 Ensuring effective multi-agency safeguarding practice

As part of our core business, the focus of this overarching priority is to demonstrate that there is a multi-agency approach to our safeguarding practice which is effective. We will ensure that learning is identified, its improvements embedded at both individual and multi-agency level, be alert to emerging risks and understand systemic issues which policy and practice changes will address. These continue to be implemented and/or monitored through our structure and sub-groups.

Our workforce

Similar to the national picture, many of our Partners are facing challenges in staff recruitment and retention. We will continue to monitor any adverse impact this may have on maintaining a consistent and trained multi-agency workforce in the area of abuse and neglect and also how this may impact on us embedding learning and improving outcomes for children and young people.

Listening to children and families

One of the Board's objectives was to seek assurance that the voices of children, young people and families were heard and considered when developing safeguarding practice and priority areas. The voice of the child has also been a recurrent theme in local and national child safeguarding practice reviews and also featured in some of our independent inspections.

Having trialled agenda slots for partners to share examples of where the voices of children, young people and families had been instrumental in shaping the support provided, partners still feel further assurance is required to understand how embedded and effective this practice was across the partnership system.

Innovatively seeking a better solution, Staffordshire Council of Voluntary Youth Services (SCVYS) shared a quality assurance tool they had developed and trialled to self-assess or peer-assess an organisation's engagement against nine key standards: accessible, meaningful, ethical, efficient, clear, coordinated, timely, quality and partnership. The tool can be used equally as well with a single engagement activity or to assess engagement delivery across a whole organisation. Safeguarding Partners have agreed that the self-assessment tool will be used next year as a follow-up to the planned Section 11 peer assessment in July 2022 to provide assurance that the voice of children, young people and families is being heard and considered by all Partners.

Some of the recurring issues identified by children and young people are shown in Figure 2.

Figure 2: Top 10 recurring issues for Staffordshire children and young people, May 2022

Source: Compiled by SCVYS on behalf of the Families Strategic Partnership Board based on various consultations including Make Your Mark, #TheBigAsk, DCMS Youth Review, The Big Vote (Children and Young People in Care) and insight from local youth engagement practitioners

Some examples of how these are being addressed include:

- Opportunities to contribute - Local Holiday Activity and Food Programme providers have supported older young people as volunteers to deliver the programme. This has engaged the older cohort who are less attracted to participating in the programme, and in some cases has led to sports leader qualifications.
- Climate change - Staffordshire County Council were due to hold a climate conference which included young speakers in June 2022 (unfortunately this was postponed with a new date to be announced).
- Voice and Influence - SCVYS are working with the SEND and Inclusion Partnership on a Co-Production Charter over the next 12 months. This will be co-produced with young people and partners, and should help embed key principles across the partnership that keep young people central and ensure they are heard.
- Mental health - SCVYS have worked with young people to co-design the Wellbeing Health Action Map (WHAM) Plan with CAMHS practitioners. Children's Voice is embedded as part of their plans to ensure that they have the opportunities to participate and contribute in a way that is meaningful for them.
- Staying safe - our 'with or without words' e-learning which supports practitioners on how to use the voice of non-verbal children linked to our neglect priority continues to be promoted within the early years sector.
- Extra help at the right time - the voice of children and young people's has contributed to the development of a revised early help strategy.
- Opportunities to contribute - the Police Cadets scheme has grown post COVID-19 restrictions to ensure more young people have the opportunity to contribute.
- Things to do; place to go - the Space Programme helps ensure children and young people have places to go and things to do during the holidays.

Our transformational programme

This year has been one of significant change in the health and social care landscape. Further details are highlighted below.

- **Local Authority transformational programme** - during the year Children Social Care have made transformational changes which has included improvements to the front door (Staffordshire Children's Advice and Support). This now means that a discussion takes place between practitioners who have concerns and dedicated social workers. Anecdotal evidence suggests that there are improved conversations at the front door and that restorative practice is becoming well embedded with better signposting. They have also developed district-based duty hubs with dedicated social workers which means there is a timelier response and improved quality in assessment of need at the right time, Family Group Conferences (FGCs) and family meetings.

  Following a successful pilot in Cannock Chase, adult specialist workers with domestic abuse, substance misuse, mental health, and financial inclusion expertise have been introduced into the new district operating model to work alongside children's social workers. This will enable dedicated support to the whole family unit, with a focus on helping and supporting parents and their children at the earliest opportunity.

- **NHS reform** - During 2022/23 we will also see the NHS undergo significant change with the abolition of Clinical Commissioning Groups (CCGs) and the development of launch of an Integrated Care Board (ICB) and wider Integrated Care System (ICS) as the local NHS body. The CCGs gave a commitment to maintain current safeguarding arrangements throughout the transition to ICS and ICB and this commitment was met and has continued. As the ICB and ICS mature the arrangements for safeguarding will be further strengthened with additional posts and plans to review how health partners contribute to this vital work whilst ensuring best use of the available resource across all ICS health partners. (NB: The new arrangements commenced on 1st July 2022).

  The ICS are in the process of developing and launching a new approach to key work programmes which will be known as portfolios. One of these portfolios will be children, young people and maternity. This will support further development and strengthening of joint work but will also support further progress on the safeguarding agenda and executive leadership for this will be provided by the Chief Nursing and Therapies Officer who is also the ICB lead for Safeguarding thus further enhancing the opportunities to continue to improve joint working whilst maintaining a clear focus on the safeguarding agenda.

- **Staffordshire Police** - Staffordshire Police have reviewed and agreed a new local policing operating model which will go live in Summer 2022. This will see increases in the number of staff and officers working in district-based harm reduction hubs. This allows for closer working with many partners and families to ensure the correct support is available at the right time.

In 2022 there will also be a full review of the police operating model across the areas of public protection. This will improve the quality of criminal investigations and ensure departments are suitably staffed in terms of the numbers of people working within them and also that staff have the correct skills and training.

Multi-Agency Safeguarding Hub (MASH)

As well as delivering value around decision making where concerns are considered with reference to a continuum of need and an understanding of thresholds, which is its core purpose, the MASH delivers additional value as it:

- Enables more effective and efficient downstream work within agencies by providing information (particularly about involved agencies)

- Provides awareness raising by informing agencies already working with a family/individual (for a different purpose) of concerns that have been identified

- Provides benefits simply because agencies are co-located or virtually, which enables sharing of information to support downstream agency core business and general multi-agency working

During the year and as part of the MASH review, Partners have had more honest conversations about the areas for improvement. We have:

- initiated a review of the governance and working of the MASH to capture strengths and weaknesses
- reviewed the staffing structure and appointed new staff with renewed focus on the areas of weakness in the MASH, namely performance and operational effectiveness including investment in sergeants to improve child protection strategy discussion and outcomes
- launched a new governance structure which includes regular reporting to the Board on delivery under the new arrangements

We are also looking at replacing our current Information Sharing Log (ISL) and have held workshops with operational colleagues to understand the requirements as well as what works well and areas of improvement in order to improve our assessment of risk and decision-making. We are linking this work with our multi-agency performance and audit requirements. Unfortunately, the impact of Covid-19, major transformational changes by both Children Social Care partners and recruitment gaps have delayed the pace of improvement. However, we do have plans in place to undertake a self-assessment during 2022/23 which will help us further understand our strengths and weaknesses.

Working with educational settings

- **Operation Encompass** - this national initiative went live in Staffordshire in February 2021 and was a significant step towards better partnership working to protect children living in households where domestic abuse occurs. Operation Encompass ensures that information is shared between the police and the child's school so that effective support and safeguarding can be provided. This has seen in excess of 4,000 children whose schools have been notified that they are living with domestic abuse (meaning that they are a victim of domestic abuse by their presence in the household). Operation Encompass is currently being evaluated for effectiveness by Staffordshire Police with findings due in November 2022.

- **Support and training** - GCP2 training has been delivered to a large number of schools and many have now completed assessments within their settings. Colleagues from schools have also attended two Synergy events with Counter Terrorism colleagues. This is a table-top exercise where they talk through a real case study and it is regarding far right ideology. The Education Safeguarding Advice Service (ESAS) deliver half-termly briefings to Designated Safeguarding Leads (DSLs). These briefings have a specific focus and always now contain a section covering learning from reviews such as domestic abuse and sexual abuse. DSL drop-in sessions have also been trialled to deliver additional support and guidance on a variety of current topics. Over 120 schools have attended these weekly drop-ins run by which are subject specific including: sexual violence and sexual harassment (including consent/coercion/control), Ofsted inspections for safeguarding, Operation Encompass and bullying. These are also recorded and are now included via YouTube clips on the Education Safeguarding page of the Staffordshire Learning Net (SLN) and are sent out in the weekly school bag.

- **Access to information** - ESAS have reviewed and updated the Education Safeguarding section on the SLN which now contains a wealth of resources for schools including recordings of our new focussed drop-in sessions so that schools can access them as required. We have been informed that more schools are accessing the ESAS SLN pages and those pages are having an increased number of hits. Schools are directed to this as well as the SSCB website for advice, support, guidance and a wealth of tools for them.

- **Section 175/157 audit** - following a comprehensive review of the Section 175/157 safeguarding audit a new online audit was procured by ESAS. This new tool will allow both school settings and ESAS richer qualitative information to inform practice and action planning. The survey includes sections on neglect, peer on peer abuse, Prevent and a section focussing on the Virtual School. The findings, due in Autumn 2022, will enable ESAS to tailor training, newsletters and briefings to reflect the safeguarding needs of schools.

Inspections

Staffordshire Police underwent a National Child Protection Inspection during September 2021. This examined how effective the police's decisions were at each stage of their interactions with or for children. This was from initial contact through to the investigation of offences against them. The inspection also scrutinised how the force treated children in custody and assessed how the force is structured, led and governed, in relation to its child protection services.

In preparation of the force inspection, force audits were undertaken and highlighted several areas of focus:

- Safeguarding assessments, both their use and grading
- Quality of referral
- Lack of supervisory oversight in investigations
- The Voice of the Child not being present

Following the inspection, whilst pockets of good practice were identified, significant areas for improvement were apparent. As a result, the force adopted a Child Protection Improvement Programme and Chief Officer oversight is provided by ACC Jennie Mattinson who chairs a Strategic Child Protection Board.

The programme focuses on delivery of improvements against 15 areas identified by the inspectorate. Key areas include:

- A review of training for all officers and staff which seeks to improve risk assessments, raise awareness of the voice of the child and ensure specialist investigators are appropriately trained and accredited.
- Improvements in the risk assessment process and management of missing children.
- An introduction of new and improved risk assessment processes within the Contact Centre where telephone and digital contact is received from the public.
- Improving practices and partnership working when children are taken into emergency police protection.
- A review of how the force use Public Protection Notices (PPNs) to understand risk and threshold and make referrals to partners.
- Training for all custody staff to ensure full understanding of safeguarding responsibilities to children in police detention. Appropriate and adequate arrangements will be made through multi-agency partners including the swift identification and use of appropriate adults, healthcare provision and information sharing with Children Social care for every detained child.
- A review of the staffing levels within specialist child protection teams.
- Improved governance and oversight of performance for all areas of child protection.

Making policies and procedures more accessible

In 2021, the Board initiated a project to deliver essential policies and procedures to its front-line practitioners in a more efficient and effective way. Over 400 front line practitioners were surveyed online and in person to discuss the availability of policies on the website and the value of them whilst also establishing what was needed from policies to enable confidence and competence when faced with concerns. This consultation along with analytical evidence of the website demonstrated that many policies were in need of review or not accessed by users due to their format and content.

The Board have now identified a suite of 12 policies to be held on a more assessable format on the Board's website along with a suite of further guidance in the form of seven-minute briefings, video and animation to meet the needs of practitioners who wanted easy to access and concise information at the touch of a button.

This project is ongoing and will continue to provide improved access to policies and procedures.

Section 11 assurance: learning and development

During 2021/22 we focused our Section 11 audit on learning and development. Our findings were positive with most Partners able to evidence how they were providing staff with training and support and the impact of this. Most Partners also evidenced how they had aligned training plans to the Board's priorities as well as learning from the system, for example intra-familial sexual abuse and Think Family. Further assurance will be sought next year on the impact of staff training and development through a peer assessment.

Multi-agency performance

We are continuing to develop our performance data frameworks in several forums as a partnership approach to deliver sustainable change and identify emerging threats. This will help provide a connected view of partnership data which will be supported by further work by the data analytics group through Staffordshire County Council. It will also provide a clearer safeguarding picture compared to the singular view that single-agency data currently gives.

Child safeguarding practice reviews

The CSPR sub-group is a multi-agency group, comprising of the statutory partners as well as education, probation, youth offending service, voluntary sector services and representatives from other agencies on a case-by-case basis, that has delegated responsibility from the Board to oversee reviews and to report to the national Child Safeguarding Practice Review Panel on learning and progress made in line with Working Together 2018.

During 2021/22 there were four Rapid Reviews and in contrast to last year were all related to adolescents. Two young people died from suicide, one young person was significantly harmed as a result of child sexual abuse and one Rapid Review considered the potential harm caused to two young people subject to forced marriage and removed from the UK.

Two of the Rapid Reviews have led to newly commissioned child safeguarding practice reviews (CSPRs) involving child sexual abuse and forced marriage. There are also three unpublished CSPRs, one review which is in the final draft format and two reviews completed and awaiting the finalisation of parallel legal proceedings.

The themes identified during the Rapid Reviews and CSPRs involved issues related to failure to capture the voice of the child; lack of information sharing and dilution of information that was shared; parental bereavement and subsequent neglect; lack of professional curiosity, and challenge; ineffective risk assessment; professional confusion related to the terms sex offender status and person posing risk to children (PPRC) and what this means for managing risk; lack of critical thinking leading to over optimism; missed opportunities for intervention and protection; interpreting allegations of domestic abuse; the management of special guardianship orders; children subject to legal care orders, child in need plans and child protection plans, impact of Covid 19 on accessing children face-to-face, child mental ill health and violent suicide.

The findings and learning demonstrate similarities with the national findings identified in the Child Safeguarding Practice Review Panel Annual Report 2020 and some of these are recurrent themes locally:

1. Understanding what the child's daily life is like
2. Working with families where their engagement is reluctant and sporadic
3. Critical thinking and challenge
4. Responding to changing risk and need
5. Sharing information in a timely and appropriate way
6. Organisational leadership and culture for good outcomes

They also highlight the potential impact of Covid-19 as this cannot be avoided as being a significant factor in the lives of families across Staffordshire.

Findings have been identified using a system-focussed approach and there have been some positive outcomes achieved over the past year where agencies have worked well in partnership to improve systems and processes and ultimately improving safeguarding practice and outcomes.

We have started to include a broader range of partners on learning reviews such as commissioners so that learning can be embedded into performance and quality assurance conversations. Commissioners have embedded lessons learned into contract review mechanisms where required. Learning has also been shared with other Partnership Boards such as the Early Year Advisory Board (EYAB) and Early Help/Place Based Approach Operations Group to help shape the development of their delivery plans.

The focus for next year remains on being able to evidence the 'so what' factor and demonstrating that things are improving for children and young people in Staffordshire. During 2022/23 we also plan to commence discussions with our academic partners to understand why we are seeing recurrent learning.

Learning form child deaths

The Child Death Overview Panel (CDOP) reviews deaths of all children and young people under 18 years resident in a specified area to learn what happened and why, whether there were any modifiable factors whereby local activity could prevent or reduce similar child deaths in the future. The local CDOP is made up from a range of partner agencies across Staffordshire and Stoke-on-Trent and an update is distributed to partners giving an overview of recent notifications and reviews with recommendations, learning points and any emerging themes. The CDOP also sends data to the National Child Mortality Database (NCMD) so that learning can be identified and shared at a national level.

During 2021/22 we saw an increase in the number of notifications of child deaths (93 compared with 69 notified the previous year) with neonatal deaths (deaths within 28 days of life) continuing to account for the largest proportion (47%). 14% of our child deaths occurred in teenagers aged 15-17. Of these, 24 (26%) were categorised as unexpected requiring a joint agency response (JAR).

During the year 67 child deaths were reviewed in Staffordshire and Stoke-on-Trent. Of these 17 were considered to have modifiable factors with the most frequent themes being:

- Smoking
- Poor mental health of either parent/carer or child
- Alcohol / drug use by parents/carers
- Access to appropriate services or gaps in service
- Unsafe sleeping environment
- Living in chaotic environments

We continue to implement improvement activity against our recurring modifiable factors. As one of the most prevalent modifiable factors, the smoking in pregnancy service has been recommissioned with a revised process to ensure better take-up of the service and support. We have also rolled out ICON (Infant crying is normal; Comforting methods can help; it's Ok to walk away; Never, ever shake a baby) programme to partner agencies and continue to seek to improve services by engaging child and families in the process. We also have continued our work through campaigns, support and multi-agency training such as promoting Safer Sleep and sharing information around unintentional injuries and hazards such as button battery awareness.

Deaths from suicide (six) continue to be a concern and were the highest since the panel formed in 2008. (Note: fluctuating figures due to the very small numbers involved). As a result, we conducted a thematic review during the year and also participated in a region-wide review. The key findings from the review identified some emerging learning in relation to local pathways and processes.

The common themes were: understanding and accessing the mental health support; communication and support following discharge from mental health services; support for young people aged 16-18 (this cohort of children were managing their own mental health support and many parents expressed frustration of being unaware of treatment plans to support their vulnerable children in this age group); and multi-agency working. The lives of young people were not triangulated by agencies involved in their support and therefore a full picture of the young person's life. Some support services were also working in isolation to support young people.

The findings from the review have been accepted by the ICS Children and Young People's Mental Health Improvement Board through focus on: outcomes; prevention; capacity and demand; service delivery/i-thrive; access; workforce; and care experienced children and young people. In recent months there have been significant developments around the support offered to children and young people in crisis or at risk of crisis. Progress against the findings is being monitored by the Board's Scrutiny and Assurance Group and in particular in terms of the impact on children and young people.

Review of restraint

The Review of Restraint Group is established under the safeguarding board arrangements to ensure compliance with Working Together 2018 in providing scrutiny of restraint. The group reviews whether staff in Werrington Young Offenders Institute (YOI) are trained in behaviour and de-escalation techniques and ensure that appropriate monitoring arrangements are in place to oversee restraints of children. During 2021/22 the group continued to meet despite the challenges of Covid-19 restrictions.

The use of restraint in Werrington YOI is higher than in all other YOIs and has risen in 2021/22. Most incidents of restraint are in a response to violence. All incidents of restraint are reviewed by the social work staff seconded from the local authority into the establishment and a selection are chosen for review by the Review of Restraint Group. Over the last 12 months the Review of Restraint Group has selected 24 incidents of restraint for scrutiny. All of those incidents demonstrated a sound knowledge of applying restraint appropriately and within the expected standards. During 2021/22 the Restraint Co-ordinators introduced a mentoring scheme and early indications are that this is supporting safe application of restraint.

During 2021/22 children within Werrington have attended the Review of Restraint meeting and they have told us the following things:

- They understand why they need to be restrained
- They know where to go for help and support

Given that restraints are more often than not driven by violence our improvement plan for 2022/23 will be focused on driving down violence within HMYOI Werrington to ensure children feel and remain safe.

The Chair of the Review of Restraint Group has also escalated concerns to the Board who are now seeking assurance on a monthly basis and ensuring there is partnership support to the establishment in reducing the levels of violence. To support this area of work Staffordshire's Director of Children and Families is also attending the Youth Custody Service (YCS) Safeguarding Continuous Improvement Board and the Safeguarding Lead from the YCS has attended the Scrutiny and Assurance sub-group to discuss how we can work together to address the issues of violence.

WORK PROGRAMME
Safeguarding Overview and Scrutiny Committee – 2022/2023

This document sets out the work programme for the Safeguarding Overview and Scrutiny Committee for 2022/2023.

The Safeguarding Overview and Scrutiny 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 Bob Spencer
Chairman of the Safeguarding Overview and Scrutiny Committee

If you would like to know more about our Work Programme or how to raise issues for potential inclusion on a Work Programme, then please contact Helen Phillips, Scrutiny and Support Officer (helen.phillips@staffordshire.gov.uk)

Staffordshire County Council

Work Programme 2022/2023			
Date of Meeting	**Item**	**Details (Background)**	**Action / Outcome**
16 June 2022 10.00am	**Community Safety & the Outcome of the Fishmonger Hall Investigation** Cabinet Member: Victoria Wilson Lead Officer: Trish Caldwell	Findings from the Fishmonger Hall incident showed there had been inadequate management of Usman Khan. Members want to satisfy themselves that changes have been made to prevent further such incidents. This also impacts on the Committee's role as the designated crime and disorder panel.	The PFCC (the Commissioner) has arranged a meeting with colleagues and partners to discuss learning from the Inquiry on 28 June 2022. The Chairman has been invited as the O&S Committee's representative. Consequently the report has been put back to allow outcomes from the 28 June to further inform Members scrutiny.
	Low Level Neglect Cabinet Member: Mark Sutton Lead Officer: Nisha Gupta	Suggested by the Cabinet Member at 17 June meeting to look at impact of long-term low-level neglect, the current changes to ways of working and challenges that remain.	The Committee were reassured at the work undertaken following the 2019 Serious Case Review in identifying the early signs of neglect. They were pleased to see the introduction of the GCP2 tool and the manner in which this has been introduced, noting the further work needed to measure the gains from its use.
	Work programme Planning Lead Officer: Helen Phillips	Within the remit of the Overview & Scrutiny Committee, begin planning the work programme for 2022-23.	The proposed amendments and additions suggested at the 23 may informal work programme planning meeting were agreed
19 July 2022 10.00 am	**Customer Feedback & Complaints Annual report – Children's Social Care**	Report brought annually	The Committee congratulated Officers on the report, noting the expectation that once the District Hub model was embedded

Staffordshire County Council

Work Programme 2022/2023			
Date of Meeting	**Item**	**Details (Background)**	**Action / Outcome**
	Cabinet Member: Mark Sutton Lead Officer: Kate Bullivant		complaints around SEND were likely to level off.
	Customer Feedback & Complaints Annual report – Adults Social Care Cabinet Member: Julia Jessel Lead Officer: Kate Bullivant	Report brought annually	Members welcomed the report and, in particular, commended the proactive work to identify and address future challenges from the new Social Care Act.
	Draft Early Help Strategy Cabinet Member: Mark Sutton Lead Officer: Natasha Moody	Draft Early Help Strategy for pre-decision scrutiny	The comments and concerns raised by the Committee inform the further development of the Early Help Strategy.
1 September 2022 10.00 am	**Family Hub** Cabinet Member: Mark Sutton Lead Officer: Ruth Blunn-Jennings	Pre-decision scrutiny	This initiative was supported and because of the importance of the proposed changes Members suggested a whole council briefing would be beneficial.
	Children's Services Transformation Cabinet Member: Mark Sutton Lead Officer: Neelam Bhardwaja/Natasha Moody	The new Children's Transformation went live on 1 October 2021. More than six months on this is an opportunity for Members to seek reassurance that it is delivering as intended, including on SEND.	The candid assessment and feedback of the Transformation process was welcomed. A mechanism for regular feedback on the action plan progress will be established, with a full review in 12 months.

Staffordshire County Council

Work Programme 2022/2023			
Date of Meeting	**Item**	**Details (Background)**	**Action / Outcome**
	MacAlister Report Cabinet Member: Mark Sutton Lead Officer: Nisha Gupta	Suggested at 17 June meeting – looking at the report's proposals and how they impact on Staffordshire's Children's Services November date for this suggested at 3 Aug Triangulation Originally scheduled for 4 November meeting but moved back awaiting publication of the final report. Final report published on 23 May 2022	The Committee were pleased that much of the direction of travel proposed in the Report was reflected in the Staffordshire approach. Members now await details from central Government on the areas for implementation.
	Ofsted Focused Visit – improvement action plan Cabinet Member: Mark Sutton Lead Officer: Nisha Gupta	The Chairman attends the Children's Improvement Board (CIB) meetings on behalf of the Committee. At the June CIB details of the Ofsted Focused Visit were discussed, including the development of an improvement action plan. The Chairman requested this plan be brought to the O&S Committee.	Members welcomed the improvement action plan and will look to receive details of progress with its implementation.
	Domestic Abuse recommissioning arrangements Cabinet Member: Victoria Wilson Lead Officer: Trish Caldwell	Pre-decision scrutiny item	The Committee raised a number of issues for Cabinet to consider before taking a decision on the Contract renewal.

Staffordshire County Council

Work Programme 2022/2023			
Date of Meeting	**Item**	**Details (Background)**	**Action / Outcome**
24 October 2022 10.00 am	**Community Safety & the Outcome of the Fishmonger Hall Investigation** Cabinet Member: Victoria Wilson Lead Officer: Trish Caldwell	Findings from the Fishmonger Hall incident showed there had been inadequate management of the assailant. Members want to satisfy themselves that changes have been made to prevent further such incidents. This also impacts on the Committee's role as the designated crime and disorder panel. This will include outcomes from the Commissioner's 28 June meeting considering Inquiry findings.	Concerns were shared around the naming of the assailant and his heritage in the report. These details will be removed from future reporting. The detailed changes made within Police, CTU and Probation were welcomed.
	The LAs role in the Prevent Partnership & Feedback from the Commissioner's 28 June meeting Cabinet Member: Victoria Wilson Lead Officer: Trish Caldwell	As part of their Crime and Disorder role the Committee wish to scrutinise the methods the LA has in addressing community safety. They also requested feedback from the Commissioner's meeting with partners around learning from the Fishmonger Hall inquest.	Overall Members recognised the importance of the Prevent work and the LA's role in this. Concerns remain around internet access, particularly outside of education settings, and how to educate individuals to ensure they can stay safe whilst using these services.
24 Nov 2022 10.00 am	**Regional Permanency Partnership** Cabinet Member: Mark Sutton Lead Officer: Scott Crawford & Jo Sullivan	Previously considered at 6 July 2021 O&S Committee where Members requested details of how the partnership progresses and specifically the two pilot projects TESSA and Mockingbird.	Members welcomed the progress made and congratulated Officers for the work done.

Staffordshire County Council

Work Programme 2022/2023			
Date of Meeting	**Item**	**Details (Background)**	**Action / Outcome**
	Young Carers Report of the O&S sub-group	Report of the O&S sub-group that met with young carers to consider the support they receive and the levels of care they provide	All recommendations to be action. The Committee agreed that the Chairman would discuss with the Cabinet Member for Education ways in which the profile of the Young Carers Service can be raised in schools and how to extend the Member advocate initiative.
5 January 2023 10.00am	**Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board (SSASPB) – Annual Report** Independent Chair: John Wood Lead Officer: Helen Jones	Report brought annually.	
	Adult Social Care Transformation – update Cabinet Member – Julia Jessel Lead Officer: Jo Cowcher, Ruth Martin	Suggested at the 1 September Triangulation to update the Committee on developments and progress with the Transformation programme, including performance against KPI.	
	Staffordshire Safeguarding Children's Board Annual Report	Report brought annually	

Staffordshire County Council

Work Programme 2022/2023			
Date of Meeting	**Item**	**Details (Background)**	**Action / Outcome**
	Independent Chair: Ian Vinall Lead Officer: Lynn Milligan		
16 Feb 2023 10.00 am	**Whole Life Disabilities Strategy 2023** Cabinet Member: Julia Jessel Lead Officer: Andy Marriot & Nicola Day	Pre-decision scrutiny	
	House Project Cabinet Member: Mark Sutton Lead Officer: Nisha Gupta	Pre-decision scrutiny	
	Children's Transformation - briefing Cabinet Member: Mark Sutton Lead Officer: Neelam Bhardwaja/Natasha Moody	At the Triangulation meeting of 1 September 2022 it was agreed that the Committee receive a progress briefing approximately every 4 months, with a full progress report at 12 months (September 2023)	
	Sexual Harassment in Education – Executive Response Cabinet Members: Mark Sutton & Jonathan Price		
20 April 2023 10.00 am	**Safeguarding of Permanently Excluded Pupils**	Looking at the safeguarding issues of those pupils who have been permanently excluded from school. Particularly in connection with the high	

Staffordshire County Council

Work Programme 2022/2023			
Date of Meeting	**Item**	**Details (Background)**	**Action / Outcome**
	Cabinet Members: Mark Sutton & Jonathan Price Lead Officer: Tim Moss & Nisha Gupta	level of exclusions in Staffordshire. Suggested by the Chairman at the 24 November O&S meeting and agreed for the April meeting at the 7 December Triangulation meeting.	
	Safeguarding Assessment Cabinet Member: Julia Jessel Lead Officer: Ruth Martin	Suggested at the 7 December Triangulation	
	DoLs Cabinet Member: Julia Jessel Lead Officer: Pete Hampson	Suggested at the 7 December Triangulation	
	Placement Sufficiency Strategy Cabinet Member: Mark Sutton Lead Officer: Natasha Moody	Suggested at the Triangulation meeting of 7 December.	
tbc	**Early Intervention & prevention** Cabinet Member: Mark Sutton Lead Officer: Neelam Bhardwaja	Suggested by the Cabinet Member at 17 June meeting.	

Staffordshire County Council

Work Programme 2022/2023			
Date of Meeting	**Item**	**Details (Background)**	**Action / Outcome**
tbc	**Governance Model** Cabinet Member: Mark Sutton Lead Officer: Neelam Bhardwaja	Suggested by the Cabinet Member at 17 June meeting. Considering how to work better together. Trying to develop a better and more effective governance model.	

Items for Consideration – Work Programme 2022/2023		
Suggested Item	**Details (Background)**	**Proposed Date of Meeting**

Standing Items 2022/2023		
Item	**Details (Background)**	**Action / Outcome**
Crime & Disorder Cabinet Member: Victoria Wilson Lead Officer: Catherine Mann/Trish Caldwell	This O&S Committee is the LAs designated Crime and Disorder Panel. Following discussions with the Chairman and Officers from the PFCC and the Cabinet Member and Officers responsible for community safety, it was agreed that the Chairman and Vice Chairmen will meet with the Cabinet Member and Officers after each Safer and Stronger Communities Strategy Group (SSCSG) to gain an overview of community safety within the County and identify areas for further scrutiny as appropriate.	Chairman and Vice-Chairman briefings on: • Thursday 19 May (at the conclusion of Full Council) to brief on performance discussed at the 18 May 2022 SSCSG NB the May SSCSG was moved to 16 June and consequently the briefing was moved to 20 June • Tuesday 13 September to brief on performance discussed at the 12 September 2022 SSCSG

Staffordshire County Council

Standing Items 2022/2023		
Item	**Details (Background)**	**Action / Outcome**
Children Improvement Board (CIB) Cabinet Member: Mark Sutton Lead Officer: Neelam Bhardwaja	The Chairman attends the CIB on behalf of the O&S Committee and feeds back developments to Members at each meeting as part of the work programme agenda item. CIB scheduled dates: 28.04.22; 25.05.22; 30.06.22; 20.07.22; 25.08.22; 29.09.22; 27.10.22; 24.11.22; 22.12.22	
Themes emerging from Serious Case Reviews Cabinet Member: Mark Sutton Lead Officer: Neelam Bhardwaja	Where Serious Case Reviews have taken place the Overview & Scrutiny Committee will consider any learning that can be taken from the Review	Some areas picked up by the DHR review process

Briefing Notes / Updates / Visits 2022/2023			
Date	**Item**	**Details (Background)**	**Action / Outcome**

Working Groups / Inquiry Days 2022/2023			
Date	**Item**	**Details (Background)**	**Action / Outcome**
21 September 2022	Young Carer Visits	Following scrutiny of the Young Carers Service in April, Members requested the opportunity to speak first hand with young carers to consider the service they receive.	

Staffordshire County Council

Membership – County Councillors 2022-2023	Calendar of Committee Meetings - 2022-2023
Bob Spencer (Chairman) Gill Burnett (Vice Chairman - Overview) Richard Ford (Vice Chairman – Scrutiny) Janet Eagland Derrick Huckfield Johnny McMahon Gillian Pardesi Kath Perry Mike Wilcox Conor Wileman	16 June 2022 at 10.00 am
	19 July 2022 at 10.00 am
	1 September 2022 at 10.00 am
	24 October 2022 at 10.00 am
	24 November 2022 at 10.00 am
	5 January 2023 at 10.00 am
	16 February 2023 at 10.00 am
	20 April 2023 at 10.00 am
	Meetings usually take place in the Oak rm, County Buildings