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Safeguarding Overview and Scrutiny Committee

Thursday 4 January 2024
10:00
Oak Room, County Buildings, Stafford

The meeting will be webcast live and archived for 12 months. It can be viewed at the following link: https://staffordshire.public-i.tv/core/portal/home

John Tradewell
Deputy Chief Executive and Director for Corporate Services
27 December 2023

Agenda

1. **Apologies**

2. **Declarations of Interest**

3. **Minutes of the meeting held on 23 November 2023** (Pages 5 - 12)

4. **Homes for Children in Our Care** (To Follow)

   Report of the Cabinet Member for Children and Young People

5. **Family Help Model** (Pages 13 - 18)

   Report of the Cabinet Member for Children and Young People

6. **Staffordshire Safeguarding Children's Board (SSCB) Annual Report 2022-2023** (Pages 19 - 62)

   Report of the SSCB

7. **Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board (SSASPB) Annual Report 2022/2023** (Pages 63 - 118)

Report of the SSASPB

8. **Work Programme** (Pages 119 - 130)

9. **Exclusion of the Public**

The Chairman to move:

"That the public be excluded from the meeting for the following items of business which involve the likely disclosure of exempt information as defined in the paragraphs of 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-Faulkner (Vice-Chair (Overview))	Kath Perry, MBE
Janet Eagland	Paul Snape (Vice-Chair (Scrutiny))
Ann Edgeller	Bob Spencer (Chair)
Johnny McMahon	Mike Wilcox
Gillian Pardesi	Conor Wileman

Notes for Members of the Press and Public

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Minutes of the Safeguarding Overview and Scrutiny Committee Meeting held on 23 November 2023

Present: Bob Spencer (Chair)

Attendance	
Gill Burnett-Faulkner (Vice-Chair (Overview))	Kath Perry, MBE
Janet Eagland	Paul Snape (Vice-Chair (Scrutiny))
Ann Edgeller	Mike Wilcox
Johnny McMahon	Conor Wileman
Gillian Pardesi	

Also in attendance: Paul Northcott, Mark Sutton and Victoria Wilson

Part One

1. Declarations of Interest

There were none on this occasion.

2. Minutes of the meeting held on 24 October 2023

That the minutes of the Safeguarding Overview and Scrutiny Committee held on 24 October 2023 be confirmed and signed by the Chairman.

3. Family Hubs in Staffordshire

[Natasha Moody, Assistant Director for Wellbeing and Partnerships, Sarah Edgerton, Family Hub Operational Lead, and Debbie Nash, Cannock Family Hub Manager, in attendance for this item.]

The Scrutiny Committee heard from the Cabinet Member for Children and Young People and considered a presentation outlining developments within the Family Hub initiative.

The Family Hub model had evolved in Staffordshire and Members considered details of progress made to date regarding this model and the support it provided to families with children 0-19 (25 for those with SEND), including current staffing structures and the integration of priorities with the Early Help Strategy.

Whilst Staffordshire had not been one of the 75 local authorities allocated funding for the Family Hubs, they remained committed to delivering

integrated services and support through a local Family Hub approach. In March 2022, Ofsted, The Care Quality Commission (CQC) and His Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS), announced the restart of their programme of Joint Targeted Area Inspections (JTAIs). Family Hubs will contribute to the inspection under this framework, particularly regarding the integrated Early Help Offer.

The Committee heard that since their last report on this topic a diverse workforce had been recruited within the Family Hubs, with a skill set that matched all aspects of the core delivery model. Governance structures had been aligned to contribute to those of the Health and Wellbeing Board, particularly around the Early Years Advisory Board and central Early Help Partnership Board. Eight multidisciplinary Family Improvement Boards had been established. These provided challenge, scrutiny and direction in each district to support priority achievement.

A consultation had been undertaken to rebrand the Children's Centres as Family Hubs, including Basin Lane (Tamworth) and Faraday Road (Stafford) in the network of Children's Centre assets. The Early Help Strategy had been launched in each district. A performance management framework was being developed to capture how success would be measured. A core virtual help service offer was also being produced through Staffordshire Connects and the County Council's website to enable ease of accessibility.

Within Staffordshire's Early Help Delivery Plan six "Priority Pillars" had been established, these being: access; family voice and experience; leadership and governance; communities; workforce development; and, data and delivering outcomes. Detail on work within each of these priority areas was shared with the Committee. This included:

a) work with Staffordshire Council of Voluntary Youth Services (SCVYS) towards a Staffordshire Co-production Promise and agreed way of working around hearing the voice of the family and the family experience. This was launched in October 2023 and Members were urged to become advocates for this and to pledge their support;
b) development and publication of the first virtual Bump to Toddler Pathway;
c) the first version of the Family Hub logo/brand created and shared for feedback.

In the next twelve months it was anticipated that:

a) the one brand for Staffordshire's Family Hubs would be used by the wider Family Hub Network and be recognised by families;
b) there would be one referral form to access Staffordshire County Council Services with a view to expand on this for the wider partnership;

c) a multi-agency triage in place within each of the eight districts;
d) Family Hub Quality Standards in place that partners would sign up to, becoming part of the wider minimum offer for Family Hubs;
e) a multi-agency workforce development offer for partner access;
f) a comprehensive, easy access local offer that had been co-produced;
g) a performance framework in each district and for the county that helped to evidence the effectiveness of work undertaken.

Members requested details of Family Hub locations and emphasised the importance of accessibility. They were pleased to note that they were most often located in areas of highest deprivation and with accessibility being a key consideration. The wider Family Hub Network was also used bringing opportunities for greater community access.

The Committee acknowledged the hugely ambitious nature of this project, congratulating the Cabinet Member and Officers on developments to date. The significant impact of effective triage was highlighted by Members, having concern over the potential impact on the initiative if this process was not accurate, and seeking reassurance around the process, training and expertise of those involved. There was a need to consider the triage process from a whole family perspective, bringing together learning from the Early Years Team, the MACE Panel and Vulnerability Hubs. The success of the SEND Inclusion Hub model had influenced this approach. Initially the new triage process would begin in Stafford, with learning from this supporting the process roll out across the county.

The Committee were pleased to note that communication was effective and partner attendance and engagement at meetings was excellent. They welcomed the work to overcome fragmentation of systems and services. The extent of the task was not underestimated, however the success of this approach helped all partners and the current strength of relationships between partners was excellent.

Whilst acknowledging the successful work to date, Members asked whether there had been any of areas of delay or concern with the process and were informed that co-production had taken longer than initially expected. There was also a need to ensure that the essential early years 0-5 work was not watered down within the 0-19 Family Hub agenda. Members heard of the proactive work with the Family Identification Operation (FIDO) system which helped to identify those families likely to need support at the very earliest point, enabling proactive early help. This system could also be used to help identify patterns and trends within an area and therefore enable targeting of resources.

Members discussed the differences in the work of the Early Years Forum and the Family Improvement Boards. They heard that performance data

would help identify priorities to drive future improvement. Managing expectations of what Staffordshire County Council delivered was also a part of this work.

Resolved: That,

a) the emerging Family Hub model be supported;
b) Officers and the Cabinet Member be congratulated on the progress to date;
c) Members become advocates and pledge their support for the Staffordshire Co-Production Promise;
d) details of: the Bump to Toddler Pathway; the Risk register; and the location of the Family Hubs forwarded to the Committee; and
e) progress against the performance framework be shared with the Committee at either 6 or 12 months (at the discretion of the Chairman in consultation with the Cabinet Members).

4. Trading Standards including Vaping Safeguarding Concerns

[Catherine Mann, Interim Assistant Director for Culture, Rural and Safer Communities and Trish Caldwell, County Commissioner for Regulatory Services and Community Safety in attendance for this item]

The Cabinet Member for Communities and Culture introduced a presentation on the work of Trading Standards, explaining the varied nature of their work. Specific issues being considered at this meeting were around their work safeguarding vulnerable adults and safeguarding concerns of vaping when targeted at children.

Vulnerable adults were targeted through a range of scams, with the impact of these being much broader than financial loss, effecting health, wellbeing, family, loss of confidence and increased anxiety. Scams were any uninvited contact and could be via letter, telephone, cybercrime, and doorstep crimes. One in four of those who fell victim to a scam were likely to be repeat victims and studies showed that victims' names were shared with other scammers. Older scam victims were shown to be 2.4 times more likely to move to assisted or supported living arrangements as a result.

Only between 10-20% of incidents were reported according to the Crime Survey. In the first 5 months of 2021, 36 million people had been targeted by a scam, with those over 55 most likely to be targeted via the telephone.

The City London Police managed Action Fraud, which was the Government funded body responsible for handling reports of fraud nationally. Action Fraud figures reported 342,000 scams in the last 13 months with £2billion

worth of losses. The average age of victims had been 75years. In the same period to October 2023 Staffordshire Action Fraud data showed 5910 incidents of fraud or cybercrime, resulting in approximately £20million lost.

Local Trading Standards dealt with criminal activity and calculated that the amount they saved for Staffordshire consumers from scam frauds was £4.7 million. Members were urged to sign up to become scam champions to support this work.

Part of Trading Standards work to support vulnerable adults was through the installation of call blockers, which blocked recorded telephone messages and any numbers that were not pre-identified. Evidence showed that they were successful in blocking up to 95% of nuisance calls. Referrals for these products were made by GPs, voluntary agencies, social care and other partners. Trading Standards installed the blockers on a free loan basis. 208 call blocker installations had been made so far, with an estimated potential £118,000 fraud prevention as a result. Members heard details of a case study which highlighted the incredibly positive impact a call blocker installation could have.

Members asked how prevention work against scams could more effectively be shared. Partner organisations and community groups such as neighbourhood watch schemes should already be aware of this work. The Friends against scams initiative, becoming a scam Champion or scam Marshall, were all ways for individuals to highlight the issue in their locality. Links to a website detailing these initiatives, which also included helpful information around avoiding and identifying scams, could be found on the County Council website.

With regard to vaping the Committee heard that Trading Standards used intelligence to prioritise their work, targeting illicit tobacco products including counterfeiting. Members heard there were clear links to organised crime gangs and Trading Standards worked closely with the Police and HMRC on these issues, including non-compliance and selling to children.

Where an individual was trying to stop smoking, vaping was an effective tool. However, for individuals who had never smoked, and particularly for children, vaping was dangerous, resulting from their nicotine content and other unknown potential long-term impacts. The number of children using vapes had tripled in last 3 years and evidence showed that 20% of children had tried vaping in 2023.

Encouraging children to use a product designed for adults was unacceptable. There had been an increase in the number of products that

were clearly designed to attract children through their colour, flavour and use of language.

It was important to have a strong enforcement approach and Members heard that in 2022-23 National Trading Standards evidenced that 27% of 1000 test purchases resulted in illegal sales. Within Staffordshire, of 76 test purchases there had been a 9% failure where vaping illicit products were sold to children.

In Staffordshire 52000 illicit cigarettes had been seized to date, with a value of almost £50,000. 115,000 illicit vapes had also been seized this year to date. The impact of seized products on a premises was significant in lost sales.

The Government had made £3million investment to National Trading Standards to manage this issue. The Government investment in enforcement funding would go to the Boarder Force & HMRC, however some of this funding may indirectly support work within Staffordshire through joint projects with HMRC. New track and trace systems run by HMRC were being introduced and these would enable local trading standards to report concerns through an app where illicit vapes and tobacco were found. HMRC then take enforcement action, which could include the loss of a shops licence to sell tobacco products. Once operational this will provide an alternative enforcement route for trading standards teams.

Members queried why shops remained open where offences had taken place. In some instances, court delays created difficulties. Work was also being explored with district and borough councils on closure orders for persistent offenders.

A confidential hotline existed where concerns around non-compliance could be reported. Members asked how this resource could be made more widely known. Work was ongoing to improve this, including through local libraries.

Members asked whether work was undertaken to target the suppliers of these illicit products. This work was undertaken and led by the Police at a local and regional level. Once the level of the criminality was identified, the investigation would be undertaken by HMRC and/or the Police as appropriate.

Members asked for further enforcement data on the work of Trading Standards, including per year the:

a) number of test purchases
b) number of enforcements
c) number of prosecutions

d) the percentage of successful prosecutions

Members also queried whether the enforcement policy on the County's website was current. The policy would be checked and updated if necessary. The requested enforcement data was available and could be forwarded to Members after the meeting.

The Committee raised concerns over vaping shops being positioned near schools and colleges. Planning legislation allowed for constraints to be placed on fast food premises and Members felt this approach should be mirrored for premises selling vapes. The Cabinet Support Member for Public Health and Integrated Care suggested that district and borough planning considerations could address this through their Health in all Policies, embedding these restrictions in their local plans. The Committee suggested that a letter should be sent to all planning committee chairs in Staffordshire highlighting the impact of vaping and seeking their support for these restrictions. They further suggested that the letter should be sent jointly from the Chairman and the Portfolio Holder.

Resolved: That the work of Staffordshire Trading Standards be supported and that:

a) enforcement data for Staffordshire Trading Standards be forwarded to the Committee;
b) the Chairman and Portfolio Holder write to the chairs of the eight district and borough planning committees raising the issue of vaping, and seeking their consideration to include planning restrictions through their Health in all Policies to prevent Vaping premises being positioned near schools and colleges; and
c) members consider becoming scam champions.

5. Work Programme

Two pre-decision scrutiny items had been requested for inclusion on 4 January 2024 meeting agenda:

- The Family Help Pilot, and
- Provision of Services for Children and Young People

As a consequence, the MASH Children's One Front Door item had been moved back to the February meeting.

Following the informal meeting with the Police, Fire and Crime Commissioners in October the Committee's work on Right Care Right Person had included gathering information from those local authorities within the Humberside Policing area, looking at how this initiative worked from a local authority perspective. Detail had already been shared with Members from East Riding Council and the Chairman was contacting Paul Johnson, the Clinical Director for the Humber Teaching NHS Foundation Trust, as the contact for Hull Council. It was anticipated that a report

summarising this work would come to the Committee in the New Year.

The Health and Care Overview and Scrutiny Committee 's Social Care Assurance Working Group would be meeting on 4 December looking at ensuring safety within the adult social care system. The Chairman had been invited to attend this meeting but was unavailable. Mrs Edgeller agreed to represent the Safeguarding Overview and Scrutiny Committee in his absence.

Members requested an additional item to their work programme on the outcome of the recent Ofsted inspection of Children's Services as soon as this was available.

Members also requested a further report on developments with the Family Hub Programme. The Chairman agreed to undertake discussions with the Cabinet Member for Children and Young People on the most appropriate timing for this, possibly in 6 or 12 months.

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

Chair

Staffordshire County Council

Safeguarding Overview and Scrutiny Committee – 4th January 2024

Family Help Model

Recommendation

I recommend that the Committee:

a. To scrutinise the implementation of pilot, trialling the Family Help Model in two districts (Stafford and Lichfield).

Local Member Interest:

N/A

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

Summary

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

1. It's recommended that the committee scrutinises the implementation of the Family Help Pilot, trialling the Family Help Model in two districts (Stafford and Lichfield).

Report

Background

2. This report is to provide the committee with an overview of the pilot, including the rationale for its implementation, the engagement undertaken with staff to date and the pilot's next steps.

3. The pilot was approved by the Children and Families Senior Leadership Team in October 2023. It forms part of the change and transformation activity that is happening within Children and Families.

4. Family Help is an approach suggested by the government in their consultation proposal "Stable Homes, Built on Love", a response to "The Independent Review of Children's Social Care".

5. The pilot has been formed in line with the government's vision for "a non-stigmatising, welcoming family help service based in local

communities". The intention is to use a skilled, multi-disciplinary workforce so that the needs of children and families can be met in one place".

6. The government has introduced a 'Twelve Families First for Children Pathfinder' initiative. Local authorities have been identified to test the operationalisation of the family help vision. They will be supported by £45 million of investment. The first wave of pathfinding authorities were identified in July 23: Lincolnshire, Wolverhampton, and Dorset.

7. Although Staffordshire are unable to bid to be a pathfinder in wave 2 due to being part of Family Network Pilot, we are aspirational for our children, supporting the current government proposals which are based upon the same principles that we adhere to, they are:

   a. prioritising relationships at the heart of the care system,

   b. reducing the need for crisis response and providing more early support to families including local early help and intervention with issues such as addiction, domestic abuse, and mental health to keep families together,

   c. using family networks at an early stage to support parents and minimise risks to children by using family group decision-making, such as family group conferences. Staffordshire has pathfinder status (Wave 2) for the Family Network Pilot which compliments this model.

Staffordshire's Family Help Offer

8. To achieve the vision identified above and respond to the operational and structural issues that we are facing; we are piloting a reconfiguration of our Children's Social Care and Family Practitioner Teams to deliver a Family Help offer.

9. Following SMT approval, the new operating model will be implemented in the Stafford & Lichfield Districts from February 2024. The aim of the pilot is to test the implementation of an integrated, localised operating model. The pilot will consist of Child in Need (CiN) work being undertaken within Family Help Teams, whilst Assessment and Staying together Teams (AST) and Children in Care (CiC) Teams will continue to deliver the functions as described in the District Operating Model. The exclusion of Child in Need work means more reasonable and manageable workloads within AST (only Child Protection and Court work) and CiC with a focus upon an improved and more timely response to our most high-risk children being supported at this level.

10. The core principle of Family Help will be supportive, non-stigmatising relationships, alongside skilled and well attuned support that responds to family's needs.

11. The Family Help model will aim to not only reduce handovers between practitioners, but it can also help to reduce the stigma of having a social worker and help families in need of support by maintaining the family practitioner as the lead professional and coopting in the specialist support and supervision of an experienced social worker.

12. To enable the Early Help Teams to respond to the additional CiN work, additional capacity will be created in the pilot districts, by:

    a. Stafford: several vacant social work posts that we have not been able to recruit to will be changed to family practitioner posts for the duration of the pilot.

    b. Lichfield: the Early Help Teams have carried a significant number of vacancies for almost a year. All posts have now been recruited to creating an opportunity to allocate CiN work. They will also change vacant social work posts to family practitioner posts for the duration of the pilot.

    c. Both Districts will also create additional capacity by not allocating work for co-working between Assessment and Staying Together teams and Early Help.

    d. There will also be some additional SW resource due to The Frontline Units being in both districts and Newly Qualified Social Workers (NQSWs) starting their first year in practice within Family Help.

    e. The cabinet investment which has enabled social work progression plans has supported the planning of the Family Help Pilot. An opportunity has been created to implement Social Work Practice Leads who are experienced social workers with expert knowledge to support the early help teams to manage the child in need work through additional supervision and expertise.

    f. We will also be strengthening the Early Help offer by co-locating one IPS worker and one Family Group Conference (FGC) Convenor within each pilot district. It is anticipated that by offering targeted support and family solutions much earlier in the system, families will not escalate to a point where more statutory services are required. The recent Ofsted visit confirms the need for us to provide FGC at the earliest opportunity.

g. It is considered that this model will complement the family hubs and we are engaged in discussions with them to ensure a seamless early help offer across Tier 1, 2 and into our Family Help service.

Developing the Model

13. The project has identified an initial five workstreams. This has been done in conjunction with our staff engagement group. Each staff group has developed a workstream scoping document which outlines the objectives of the workstreams, stakeholders, risks, assumptions, and deliverables.

    a. Workstream 1 - Operating Model
    b. Workstream 2 - Form and Process Updates
    c. Workstream 3 - Partnership Working
    d. Workstream 4 - Roles & Responsibilities
    e. Workstream 5 - Internal Communications

Governance

14. The governance for the project is being established. A Strategic Project Board will have oversight of the pilot and will include representatives from Children and Families, Peoples Services, Legal and the Change Team.

15. An Operational Project Group has been set up and includes managers from both districts. This group will be responsible for the day to day running of the pilot.

16. The two District Leads will also attend the Children in Care Programme Board to provide updates, alongside a monthly status report. The right help at the right time is key to us ensuring in the long term we are providing children the opportunity to remain living in their family units. By strengthening our Early Help and child in need offer we are providing this opportunity to families, and this is part of the wider vision to reduce children in care numbers within Staffordshire as we will be providing preventative support to reduce the need for crisis intervention.

Link to Strategic Plan

17. As part of the council's Strategic plan, we will:

    a. deliver effective early help that is focused on helping families to get back on track,
    b. work with partners, parents, and carers to keep the most vulnerable

children and young people safe, and support them to achieve their potential

18. The pilot will help us test the family help concept and should reduce the need for crisis response by providing more early support to families.

Link to Other Overview and Scrutiny Activity

19. The Family Help Pilot is linked to the investment from cabinet provided to CSC earlier in 2023. This pilot also has co-dependencies over our Children in Care Programme.

Community Impact

20. It is not anticipated that the pilot will have any negative community impact. Providing services to families at the earliest possible opportunity is likely to ensure that children are having their needs met quicker.

List of Background Documents/Appendices:

Contact Details

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Staffordshire County Council

Safeguarding Overview and Scrutiny Committee - Thursday 04 January 2024

Staffordshire Safeguarding Annual Report (SSCB) 2022-2023

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 2021. This SSCB Annual Report sets out the progress made by the partnership during 1st April 2022 and 31st March 2023.

Local Member Interest:

N/A

Report of: Mr Ian Vinall, Staffordshire Safeguarding Children Board Independent Chair and Scrutineer.

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 2022-2023.

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 (soon to be revised). These core functions are achieved through the work of the Board's 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 SSCB published arrangements document. Organisations that include local authority, police, and health (specifically the Integrated Care Board) 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 current 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. The statutory guidance is under review following publication of the government's plans, outlined in Stable Homes, built on love with a commitment to transform children's social care. This will bring about significant changes to the local arrangements and the safeguarding partners will be afforded greater clarity about what is required of them individually and how they need to work in partnership with each other to deliver effective services. It is anticipated that Working Together 2023 will be published in the autumn of 2023.

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 legacy 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 2022/23

Contact Details

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

Report Author: Lynne Milligan (on behalf of the SSCB)
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Annual Report
(FINAL DRAFT)

Staffordshire Safeguarding Children Board
2022/23

Contents

Foreword

This year has seen our safeguarding partnership achieve an incredible amount. We are proud of our renewed emphasis being placed on our children and their families. We want them to be at the centre of our system and working with us, having developed our co-production promise we want this to redefine our relationship so that we recognise, respond and realise better outcomes for our children.

We have seen first-hand the impact of doing this through the development of the Early Help Strategy. As we now develop our approach to performance this will illustrate how this approach leads to better outcomes. As a partnership we know that we still have challenges to face, but we continue to do this together in the best interests of children and remain persistent in seeking to continue to improve and develop.

Our commitment to prioritise the safeguarding of children within Staffordshire and Stoke-on-Trent, has remained a top priority for the NHS and its partners throughout 2022 and 2023. Following the closing down of the Clinical Commissioning Groups on July 1, 2022, Integrated Care Systems (ICS) were legally established through the Health and Care Act 2022. The core principles of the ICS are to strengthen collaboration and integration of services to deliver high-quality care.

Our partnerships and Boards have continued to focus upon safeguarding and promoting the welfare of our most vulnerable children through continuous improvement and learning. Within the Integrated Care Board, we have taken significant steps to strengthen safeguarding through the appointment of an Associate Director of Safeguarding and Deputy Designated Nurse for Safeguarding Children. Plans are also underway to develop a Provider Collaborative approach to safeguarding, further enhancing and strengthening our commitment to deliver a system that protects children, especially the most vulnerable.

In March 2023 His Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) re-inspected Staffordshire Police and found that the force had improved the service to children and commented that: *"the force has made several positive changes to improve the ways it protects vulnerable children, including better clarity in its senior leadership and governance arrangements."*

The force understands that further improvements are required. The quality of investigations and the response to missing children needs to improve further and the risk assessment and allocation of response by the force Contact Centre also needs to be better.

The force continues to build both capacity and capability within the Public Protection Teams and works closely with safeguarding partners to improve multi-agency working. The force has also introduced enhanced vulnerability training days to frontline staff. To date, over 1,200 frontline officers and staff have been trained to capture the voice of the child, recognise, and respond to child protection concerns.

The force is investing £5 million into a new Public Protection Unit (PPU), ensuring an extra 100 officers to work in public protection. Recruitment is underway to bring in experienced Detectives as well as to train new officers to be able to work in this vital area of policing. Extra resources will ensure dedicated child protection specialists for criminal investigations and safeguarding for missing exploited children.

Neelam Bhardwaja, Director for Children and Families Staffordshire County Council

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

Becky Riggs, Assistant Chief Constable, Staffordshire Police

Ian Vinall, Independent Chair and Scrutineer, SSCB

1 Introduction

Welcome to the 2022/23 annual report for Staffordshire Children Safeguarding Board (SSCB). Our Board is made up of the three statutory partners: health (Integrated Care Board, ICB), local authority and police and headed up by an Independent Chair and Scrutineer. We work with other relevant partners such as the Children and Family Court Advisory Service (CAFCASS), education (represented by the Local Authority Education Safeguarding Advice Service, ESAS), health providers, His Majesty's Young Offenders Institution (HMYOI) Werrington, Probation, Staffordshire Council of Voluntary Youth Services and Youth Offending Services who sit on our various sub-groups.

In order to bring transparency for children, families and all practitioners about the activity undertaken, Working Together 2018 requires the three safeguarding partners to publish a yearly report at least once in every 12-month period which sets out what they have done as result of the arrangements including on child safeguarding practice reviews and how effective these arrangements have been in practice.

The report should include evidence of the impact of the work of the safeguarding partners and relevant agencies, including training, on outcomes for children and families from early help to looked after children and care leavers as well as ways in which partners have sought and utilised feedback from children and families to inform their work and influence service provision. Yearly reports should also include observations from independent scrutiny.

During 2022/23 we developed a three-year business plan in response to feedback from partners about having a longer-term plan. The areas chosen were related to evidence from performance information, learning from the system as well as feedback from relevant partners and key stakeholders. Our main priority is to focus on neglect as well as four quality assurance priorities; child exploitation; domestic abuse; early help and the legacy impact of coronavirus (COVID-19) with the voice of children, families and practitioners running throughout as cross-cutting themes.

This report provides a level of assurance and accountability about the progress we have started to make against some of these objectives.

2 Observations from the independent chair and scrutineer

This is my first opportunity to contribute to the annual report and having been in role now for 18 months, I have had the privilege to meet with many safeguarding professionals from across Staffordshire. Children and young people's stories have helped me focus on the current and future areas of scrutiny and then to provide feedback and assurance to the safeguarding partners (Staffordshire Police, Staffordshire and Stoke on Trent ICB and Staffordshire County Council). We need to continue to hear more of children's stories which reflect their experiences of the safeguarding system, both positive and negative. I did have the opportunity to meet with the young people from HMYOI Werrington in September 2022 and this provided an opportunity to plan for a future Board meeting to be held at the YOI and for safeguarding partners to meet the young people.

True engagement with children and young people remains a challenge for the partnership. Whilst there is effective engagement activity being undertaken in each agency, there remain more opportunities to consider this through a safeguarding partnership lens. The Board's Team is busy making plans for meetings in 2024 to be held in partnership organisations where safeguarding leads can interact with children and families.

Section 11 of the Children Act 2004 places duties on a range of organisations, agencies, and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children. The Section 11 Peer Audit held in July 2022, highlighted the challenges of maintaining a consistent and trained workforce owing to the ongoing challenges of staff recruitment and retention and the ability to evidence the collective impact of multi-agency safeguarding practice on outcomes for children and young people. The Scrutiny and Assurance Group is tasked with developing more focused assurance on the frontline of multi-agency safeguarding practice and will go some way to consider this.

The safeguarding partners have a developing group of leaders working alongside each other at the Scrutiny and Assurance Group. This group is working to refocus on the emerging issues in keeping children and young people safe in Staffordshire and following a joint session with the safeguarding partners in November 2022, set out on developing the Scrutiny and Assurance Group into focusing on frontline safeguarding practice. This has included the development of the Learning Hub, mirroring practice in the London Borough of Bexley which will really focus the safeguarding partnership on practice issues that require additional scrutiny. This is a very positive development if all partners commit to it.

The Safeguarding Board continues to meet monthly, and dates set for the meetings are set a year in advance and full attendance allows for decisions to be made and positive reflection to take place. Delegated authority by the safeguarding leads requires ongoing clarity as decisions made at the Board level need to have a level of seniority. I have highlighted to the safeguarding partners that they need the opportunity to develop their own priorities rather than inheriting the priorities of previous senior leaders and work in the new year should go some way to address this.

The safeguarding partners are all struggling with a challenging financial envelope and there needs to be clear and open discussion of how the safeguarding partners want the arrangements to look in the future within the context of a challenging financial picture. Working Together 2023 may not address the issue of equity and equality of partnership contributions.

It is positive to report that the chairs of the safeguarding children board, the adult safeguarding board, the community safety partnership, the ICB and the health and wellbeing board are now meeting quarterly to ensure alignment and identify opportunities to enhance shared priorities. This has been particularly relevant for concerns around domestic abuse.

In December 2022, I had the opportunity to scrutinise the work of the Multi-Agency Safeguarding Hub (MASH) and am pleased to note that my recommendations were incorporated into the ongoing MASH strategic plan. I have asked safeguarding partners to provide a clear timeline for the implementation of any new MASH arrangements as it is key to ensure this key multi-agency partnership continues to keep children and young people safe and is designed with the child's journey in mind. I was also clear that the safeguarding partners need clear assurance regarding the developments in the MASH.

I have continued to ask the question of safeguarding partners how they evidence the impact the safeguarding arrangements are having on children and young people. Whilst we can assess training effectiveness for example, which has received very positive feedback from colleagues, we need to develop mechanisms to ensure we measure impact and effectiveness of the arrangements. I have been encouraging more multi-agency audit work, a greater understanding of how learning from local child safeguarding practice reviews is being embedded into practice and how we seek feedback from children and young people and professionals. The partnership continues to focus on its key priorities and now it is developing the multi-agency dataset needed to refocus on frontline safeguarding practice so assurance can be given that practice is effective. This must be progressed more quickly, but I am encouraged by the willingness of the safeguarding partners data officers meeting together to consider this.

Neglect remains the Board's priority and over 1,500 practitioners have been trained in the GCP2 assessment tool. Whilst this has not reflected in the number of assessments undertaken, there is no doubt that the training has raised awareness and there is some evidence to indicate practice has shifted. The partnership does need to review the effectiveness of GCP2 and how it is impacting on children and young people's outcomes.

My engagement with local early years, schools, pupil referral units (PRUs), colleges and local authority education colleagues has reinforced the need to engage school leaders and designated safeguarding leads in a regular working group that could support my scrutiny function. These establishments play a key role in safeguarding children and young people, and they have significant knowledge of children's needs and the communities they serve. There is a real opportunity to develop this relationship between the safeguarding partners and educational establishments, particularly considering the refreshed statutory guidance: Working Together to Safeguard Children, due for publication in late 2023.

Colleagues from health continue to be engaged in the arrangements and the development of a safeguarding provider collaborative is an excellent development. I am keen to engage health providers in the safeguarding arrangements and have had the chance to meet with health visitors and school nurses and understand safeguarding practice from their perspective. Health colleagues continue to update and assure the safeguarding partners of specific areas of concern.

Staffordshire Police were reinspected by His Majesty's Inspectorate of Constabulary and Fire and Rescue and there were some positive developments highlighted. The safeguarding leads are regularly updated on the development of the Public Protection Unit and the response to the inspection.

I will be providing the safeguarding partners with a draft report on the effectiveness of the safeguarding arrangements with a series of recommendations in late 2023. One of those is recommendations is ensuring future engagement and accountability considerations with the chief executive of the county council, the chief constable of Staffordshire Police and the chief executive of the ICB.

Learning from reviews has highlighted the challenges of embedding learning across the workforce and there have been some consistent themes arising from reviews that require safeguarding partners to analyse why they become recurring themes. There are methods of communicating the learning, yet each agency needs to identify how this learning is being embedded and more importantly how this is impacting on children and young people.

The subgroups continue to progress the priorities of the Board through their workplans and there are opportunities to enhance their role and functions refocusing on their impact on children and young people.

In my visits to safeguarding partners in this reporting period I have been impressed by the compassion, commitment and professionalism of all staff working with children and young people in Staffordshire. There are some fabulous examples of how children's lives have been impacted by multi-agency practice. I am keen to ensure the safeguarding partners hear these stories. I am equally keen to develop a practitioners' forum which will build on the opportunities to understand how practitioners are experiencing the safeguarding system.

Finally, I must mention the skill, professionalism and commitment of the Staffordshire Safeguarding Children Board Team led by Lynne Milligan. The team behind the Board arrangements can often be forgotten in the maelstrom of safeguarding work, yet they go about their work with compassion and focus. Their support to the safeguarding arrangements should be congratulated and recognised and I cannot thank them enough for the support they provide across the system.

3 Neglect

National research indicates that around 10% of children suffer from neglect.[1] Neglect featured in almost 65% of child protection plans in Staffordshire during 2022/23 and remains higher than both statistical comparators and the national average (circa. 50%). Neglect continues to be a priority for the Board with a particular focus on infants under one based on local and national intelligence and learning from reviews including a local thematic review of under ones undertaken in 2020/21.[2]

3.1 Our strategic approach

One of the key objectives in the Board's business plan is to ensure we have a clear strategic approach in reducing the impact of parental risk factors by working with Strategic Partnerships who play a key role in helping us deliver our desired outcomes.

- There is a close connection between translating the learning from reviews such as perinatal mental health and more recently concerns on pre-birth plans feeding directly into the **Maternity Transformation Programme** (MTP) through the ICB's statutory partner on the Board. The long-term improvement plan for perinatal mental health provides assurance to the Board on the early diagnosis and response to poor mental health of parents, including maternal and paternal wellbeing pre and postnatally.

- As part of our strategic approach to tacking neglect in under ones, the **Early Years Advisory Board** (EYAB) have worked as a multi-agency group to develop a delivery plan which was developed using the evidence-base including the Early Intervention Foundation (EIF) and What Works Centre for Children and Families as well as feedback from practitioners. This plan has three sub-group leads to drive forward the three priority areas: happy and healthy; enjoy and achieve; and safe and belong. Although the safe and belong strand is more focused on the Board's priority area, all aspects of the delivery plan will have a positive impact on neglect under ones. The EYAB has reflected on the learning from local Child Safeguarding Practice Review's (CSPRs) they have determined that the actions being taken will ensure that learning is embedded throughout the partnership. The partnership has generally been well attended, but there has recently been some loss of traction due to changes in personnel across the system resulting in lack of regular attendance which has impacted on the pace and continued impact of the work. The long-term delivery plan therefore requires continued support to achieve the outcomes identified including through better intelligence, attendance, and contribution from key partners.

[1] https://learning.nspcc.org.uk/media/2621/statistics-briefing-neglect.pdf

[2] Note: this thematic review was undertaken by the former Staffordshire and Stoke-on-Trent Safeguarding Children Board

- Development and implementation of a **local protocol** to strengthen our relationship with other key strategic partnerships and organisations in Staffordshire. We reported that the protocol had been endorsed last year demonstrating our joint commitment to working together to keeping children and adults safe from harm and improving their health and wellbeing. A partnership chairs and operational leads group has now been established and meets on a quarterly basis to share, align and agree priorities across the various partnerships. Some of the early decisions from these meetings include agreement to:
    - support the Health and Wellbeing Board to conduct a thorough Joint Strategic Needs Assessment (JSNA). This is their statutory responsibility but often partners have conducted separate needs analysis. The JSNA will support the partnerships to determine and agree priority areas
    - continue to share good practice to facilitate better integration of the way the partnership works.

What difference have we made?

Whilst it is too early to tell if this work has led to sustained improvements in outcomes there are several key impacts which help us to know that there has been changes in the system which will reduce neglect under ones including:

- Planned improvements to community perinatal mental health (PMH) teams across the County with increased capacity for women to access a range of evidence-based psychological interventions, support and therapy. Demographic, health inequality and service data have also helped identify the changes and improvements required to address health inequities.

- Practitioners having access to help and support including through the **Early Years Safeguarding Forum** which was established in collaboration with the sector. The forum helps build positive relationships, share lessons learnt, and discusses innovation and future topics of understanding and learning as well as listening to the voice of those practitioners to co-produce solutions.

- Practitioners have accessed free training provided by the Board regarding how to hear the voice of the child, '**with or without words**' with positive feedback from those who have attended training. Feedback captured three months after training has evidenced the impact of how some practitioners who attended training have used their training to evidence concerns for referrals into Children Social Care.

'With or without words' - post training feedback

"….use information given by caregivers but make sure that you put yourself in the child's shoes - what does their lived experience of day-to-day life look like?"

"Ensure I always hear the child and put the child first and ensure the child's safety always remains precedent"

- Staffordshire County Council launched the **Early Help Strategy** (2022-2027) in October 2022 to bring together partner organisations in building a common understanding of where we are trying to get to with children and families and how we will work with them, and each other to achieve this. As a subgroup of the Health and Wellbeing Board, the Family Strategic Partnership Board will bring the strategy to life with the support of the Early Help and Placed Based Approach Partnership. Plans are in place to develop a Staffordshire Family Hub model which brings together a range of early help provision into a coherent, connected, and accessible offer to families around a local place, supporting them to achieve and maintain positive outcomes and seek to prevent needs from escalating. The Board will continue to seek assurance on the impact of early help provision.

- Themes from recent Ofsted inspections and SSCB learning has been used to inform the focus of themes for the termly County Council Funded Early Years Sector Workshops with recent topics including safeguarding themes from inspection; neglect; and learning from child safeguarding practice reviews.

- Good take-up of entitlements and health visiting services.

Barriers and challenges

- Lack of consistent engagement from key personnel: attendance trackers are in place to ensure those who consistently do not attend are held accountable or alternative members can be identified
- Overwhelming partnership governance: a session has been planned to develop a shared understanding of accountability, responsibility and improvements to create a leaner structure
- Clearer understanding of the learning from child safeguarding practice reviews so that the system can improve

Focus for 2023/24

- Our connection to the learning is not as well developed as it could be, we need more specific examples of learning from reviews so that we can start to improve practice

- Partners are still reporting a high number of under ones coming into the care of the local authority. We need better intelligence, attendance and contribution from key partners who can provide this link with the partnership work

3.2 Improved skills and knowledge in the workforce

Evidence from local learning found practitioners often failed to recognise and respond to low levels of neglect and understand the cumulative impact of neglect. As a result of a recommendation from a local review in September 2020 we commissioned the use of Graded Care Profile (GCP2)[3] to improve our response to neglect with our neighbours Stoke-on-Trent Safeguarding Children Partnership through a joint delivery group set up to oversee implementation across the two areas. The GCP2 assessment tool came into service wide operation in April 2021.

At the end of March 2023, across Staffordshire and Stoke-on-Trent we have trained over 1,500 practitioners to become licensed to use the GCP2 tool across a range of settings including education, health and children social care. The numbers of assessments that have been recorded as being completed during 2022/23 has increased significantly compared to the previous year (207 in 2022/23 compared with 71 the previous year).

We have also done work with practitioners to understand the barriers and come up with joint solutions. As a result, we have developed and launched the new 'Supporting GCP2' training package for those not working directly with children to enable them to contribute to an assessment or signpost to a licensed practitioner, having gained valuable understanding and confidence in recognising low level neglect, as well as a screening tool for practitioners to use alongside GCP2.

The NSPCC undertook a review of our GCP2 implementation in March 2023 with our score being 51% (target is 60% for full implementation). They found that we were performing particularly well in providing quality training, supporting trainers, and gathering data around attitudes, training and GCP2 use. The key challenges they identified were: senior management engagement; practitioner use of GCP2; and monitoring the quality and impact of GCP2.

What difference have we made?

Data from the training evaluation continues to evidence 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. This data also shows that trained practitioners have a better understanding of neglect in terms of the impact on the child outcomes. We have also had positive feedback from practitioners on how they have used GCP2 to improve outcomes for children and families.

[3] Graded Care Profile 2 - Staffordshire Safeguarding Children Board (staffsscb.org.uk)

Feedback from practitioners

"Worked in partnership with the Home-School-Links Worker to discuss parental supervision and safety around use of on-line devices and what children are being exposed to in the home. Parents have now put strategies in place and are managing access to devices more securely"

"The training which is being implemented with my families has worked well and had a positive impact on the children because concerns have been addressed and improvements have been made"

"I have been able to help some young girls whose mom struggled anyway. She has now had twin boys, so I have been supporting that family and helping get some help in place as there were already concerns about neglect"

Whilst it is difficult to attribute impact directly to the work we have done around neglect and GCP2, during 2022/23 we continued to 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 previous years.

Barriers and challenges

The progress made by the joint implementation group stalled during the year leading to significant drift and delay. Therefore, a decision has been made to split our arrangements for implementation from Stoke-on-Trent from next year. There has also been a noted lack of commitment and buy-in from senior managers in understanding the benefits of using GCP2 with anecdotal evidence suggesting some feel that GCP2 has been a barrier to working with children with neglect. Further work needs to be done to reinvigorate the commitment from senior and middle management as well as practitioner engagement through feedback and mentoring through the existing NSPCC evidence base and network.

Focus for 2023/24

- Review the GCP2 programme with a focus on demonstrating whether GCP2 has had an impact on our desired outcomes

4 Quality assurance priorities

This section reports on the quality assurance priority areas that were identified in the Business Plan for 2022-25.

4.1 Child exploitation

Between May 2022 and April 2023, a total of 610 children were discussed at Multi-Agency Child Exploitation Panels (MACE) panels equating to a 20% increase from the previous year. There is an even split between criminal and sexual exploitation. The data also highlights children with multiple risks with the most common being missing episodes, exclusion from school; being open to youth offending services and/or having an education health and care plan (EHCP).

During 2022/23 the Board agreed to split governance arrangements from our neighbouring Stoke-on-Trent Safeguarding Children Partnership to enable singular focus on the needs of Staffordshire's children and communities which can be delivered in a more bespoke localised response. The revised structure supports the amalgamation of the child exploitation and missing responsibilities through a single strategic group jointly chaired between the local authority and Police.

Key deliverables during the year included:

- An in-depth needs analysis of the current need and demand to support the development of a revised draft strategy and the commissioning of services
- The appointment of additional child exploitation coordinators by the local authority to act as a single point of contact for professionals across the eight districts within the County. The coordinators will support the management of risks inclusive of the MACE panels and wider response to children who are at risk of or are exposed to exploitation.
- Improvements to the strategic monitoring and understanding of missing children in Staffordshire cementing further links with our exploitation response.

What difference have we made?

A good individual example is a child who has been supported by a lived experience mentor through the commissioned service, Catch-22; they were supported into training and community activities and the adults have been disrupted. This has led to a reduction in the risk of exploitation and the child feeling safe and supported.

- Our MACE panels are well attended by partners and continue to deliver risk reduction interventions to victims of child exploitation. Data demonstrates that child exploitation continues to be identified by a range of partners and children are being appropriately referred into services. In terms of outcomes, the data evidences that for the majority of children the risks are reducing, they are engaging with partners when referred and supporting disruption of those causing them harm. Only around 7% of children show no reduction in risk over three consecutive panels.

- There is a more localised footprint and specialist support and advice within a district model which means that the MACE objectives and principles including disruption can be embedded in communities.

- There is evidence that safety plans are being developed with children and parents but further assurance is required to ensure that we are truly capturing their voices.

- The introduction of weekly missing meetings has helped make necessary connections for children at risk of exploitation, identifying further disruption opportunities at an earlier stage.

- Utilising audits and feedback have helped to ensure that the response to child exploitation remains fluid and appropriate in order to address the changing landscape of risk and vulnerability.

Barriers and challenges

- Staffordshire Police are undergoing an operational transformation to increase resources to investigate crimes involving victims of child exploitation with maximum resource to be in place by 2026. Staffordshire Police have reviewed their capability and capacity to respond to all public protection matters. The review was carried out by independent consultants and resulted in a recommendation to significantly increase the number of staff working within the child protection area of policing. The delivery of the Public Protection Unit project will see the development of a new team solely focused on the response to child exploitation. The team will take a public health approach to tackling this issue but will also relentlessly pursue those who pose a risk to children, using all tools and opportunities at their disposal to seek perpetrators out and disrupt their harmful behaviour.

- Whilst safety plans are developed with children and their families, there remains the challenge in capturing the voice of the child. Further work next year will seek to understand why these barriers exist and how we can overcome them in order to understand the lived experience of children.

- Utilising audits and feedback to ensure that the response to child exploitation remains fluid and appropriate in order to address the changing landscape of risk and vulnerability.

Focus for 2023/24

- A full review of the local MACE process, including the Risk Factor Matrix tool, through consultation with key stakeholders including children and practitioners

- Embedding the specialist single point of contact coordinators for child exploitation within the Districts

- Developing and refining the partnership's performance framework to ensure that we can monitor impact

- The Joint commissioning arrangements that had been in place will come to an end on 31st March 2024. This will require a review of the pathways and processes to ensure that the seamless support is in place.

4.2 Domestic abuse

During 2022/23 there were around 19,700 domestic crimes and incidents recorded in the County by Staffordshire Police which was a 6% increase compared to the previous year with around 6,000 children living in these households (30%). Estimates suggest that around two-thirds of domestic abuse victims remain hidden to the system. Domestic abuse is also one of the most prevalent issues noted in Children Social Care assessments.

Oversight of domestic abuse sits with the Staffordshire and Stoke-on-Trent Domestic Abuse Commissioning and Development Board (DACDB) who are responsible for ensuring delivery of the domestic abuse strategy and accompanying action plan for 2021-24 which was informed by a strategic needs assessment and consultation with key stakeholders.

The domestic abuse action plan has four priority areas:

- Prevention of violence and abuse
- Provision of services
- Perpetrators
- Safe accommodation

There are separate working groups who lead these priority areas and report progress to the DACDB with representatives from professionals who work to safeguard children to ensure that the needs and voices of children are represented. There are several representatives from the DACDB who sit within the SSCB sub-group structure although this relationship needs to be strengthened.

What difference have we made?

- Development and implementation of a domestic abuse performance framework has been undertaken by the DACDB, which monitors the impact of the strategy

- Re-commissioning of domestic abuse support services for those affected by domestic abuse has been undertaken by DA Commissioners, whilst also recognising that support for children affected by DHRs has been conducted by the County DHR Lead

- Early discussions on the identification and support for children affected by domestic homicide reviews (DHRs) and how learning from DHRs where children are involved is disseminated through safeguarding communication and engagement channels

Barriers and challenges

One of the significant changes in the Domestic Abuse Act 2021 was that children witnessing domestic abuse should be treated as victims in their own right, which is included in the action plan. There is some ambiguity however in relation to this element which defines that children affected by domestic abuse should be treated as victims in their own right.

Interpreted to the letter, this could effectively mean that children identified at an incident should be independently directed into domestic abuse services, as opposed to being identified along with the parent/carer victim as is currently the case both locally and across the Country.

If this approach was adopted, there could be a potential increase in the number of victims identified by the Police in Staffordshire and Stoke-on-Trent of 10,000 per annum. Clearly there are a number of implications of interpretation of the Act in this way including: determination of the parent with care able to provide consent for the child to be directed into domestic abuse services; whether the child is able to give consent themselves (Gillick principles relating to age appropriateness apply); process pathway development; and resources within policing and commissioned services to meet the increased demand.

Policing colleagues across the County have been advised to retain current arrangements whilst awaiting clarification from the Government on this element of the Domestic Abuse Act 2021.

This matter was raised with the national Domestic Abuse Commissioners Office initially in Autumn 2022, who have affirmed the ambiguity and confirmed their intention to take this issue forward with central government. The national Domestic Abuse Commissioner's Office will be holding a series of events across the Country to discuss this further during 2023/24. The DACDB will refine and review the action plan depending on the outcomes of discussions with the Government.

Focus for 2023/24

- Develop through partnership engagement and participation, a refreshed 3 year DA Strategy and Action Plan and ensure delivery of same

- Refresh the Domestic Abuse Needs Assessment and Safe Accommodation Needs Assessment

- Strengthen the relationship between the DACDB and SSCB to ensure there is a child-centred lens and that learning from safeguarding system are translated into improvement

- Continue to develop and strengthen partnership relations between existing governance arrangements and pathways between DA services and other support

4.3 Early help

Early help was identified as a quality assurance priority for the Board in 2022/23. Early help is governed by an Early Help Partnership Board who report to the Family Strategic Partnership / Health and Wellbeing Board who this year developed a new early help strategy which was heavily informed by the views of children, young people and families as well as local data and intelligence and national developed evidence base and frameworks. The Early Help Partnership Board will continue to implement and monitor the success of the Early Help Delivery Plan and Strategy and are linked to SSCB through representation on various sub-groups of the Board as well as through the local protocol.

Key deliverables during the year included:

- Early Help Launch Event undertaken and local sessions delivered in each district/borough to bring commitment and partnership action
- Development of a delivery plan for early help to accompany the strategy
- Completion of a self-assessment for early help
- Being selected as one of two local authorities to promote system maturity of early help supporting ten other Local Authorities.
- Overachieved targets for number and outcomes of families worked with in 2022/23
- Learning from the system through a 5% sample of families we work. The outcomes are used to inform the training plans for our eight districts
- Feedback from children, young people and families evidences the impact of our support (large majority say it is positive)
- Information Sharing Agreement between the County Council and health has been agreed and signed which will mean we will get real-time data on children, young people and families accessing early help

What difference have we made?

During the year we saw:

- Over 1,000 children and families supported by voluntary sector providers
- A 58% conversion rate for families worked with to successful and sustained outcomes which is higher than the national average
- More families in work, children attending school and not committing crime
- Reduction in the need for children and families needing support later
- Children and families telling us that whole family working supports them in a better way

Case study: A young man was regularly missing school and getting into trouble when he did attend.

His situation worsened when he connected with a peer group engaging in anti-social behaviour within the local community. A local youth charity reached out to the young man and got him involved in their after-school football club, which he attended regularly. His attitude and behaviour improved and in recognition of this, he was given coaching responsibility. This coaching role improved his confidence and self-esteem. After three years, this young man is a part time coach and working full time. He is kind, respectful and a great role model to other young people

Source: Early Help Strategy

Barriers and challenges

- Capacity of the partner agencies to embed the work into all aspects of support. Partnership performance information reports that over 90% of Early Help is completed by Staffordshire County council or people acting on their behalf.
- Reduced funding for partners outside of the County council for early help
- Recruitment and retention of staff
- The quality of assessment, plan and outcomes varies across the partnership

Focus for 2023/24

- Embed learning across a wider range of support
- Sharing the learning and way of working to scale up
- Thinking about Family Help and Stable Homes Built on Love to ensure sustained impact of outcomes
- Better demonstration of whole family working
- Better use of data and information sharing to inform learning

5 Ensuring effective multi-agency safeguarding practice

As part of our core business, the focus of this overarching priority continues 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.

5.1 Listening to children and families

A key objective is to seek assurance that the voices of children and families are being 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.

Some examples of the work we have done this year include:

- Findings from the **Section 11 peer assessment** found that most agencies met this standard. There was evidence of good practice from all agencies at a strategic level of consulting with children and young people when commissioning and/or designing/redesigning services and visible signs of improvement at operational level, for example in quality of child protection reports where the voice of the child was now included and increasing proportions of contacts where the child was seen alone. A number of agencies identified a need to improve how they capture the voices of children and use this during decision-making.

- During 2022/23, Staffordshire Council of Voluntary Youth Services (SCVYS led the work on a **Staffordshire Co-production Promise** with a launch date scheduled for September 2023. Once launched, the aim is that the Promise will result in a better experience for families who need to access support, but often must fight every step of the way to get any kind of help which will result in better outcomes for children. It will also help improve practice and drive a much-needed culture change where those receiving the support are continually placed at the heart of all decision making. The work has three main strands:

    - Communicate and align with all other co-production work streams across the system to ensure consistency of approach
    - Co-produce with children, young people, parents/carers and professionals a visually appealing one page easy to read co-production promise which includes a local definition and locally identified principles to inform our approach
    - Creation of a toolkit for local professionals to support them to choose when co-production is the best tool available and how to do co-production well, and to use a local co-production kitemark for any piece of work meeting the criteria

- From January to April 2023, SCVYS undertook an engagement exercise to gather the voices of young people in relation to their concerns around violence in their local community and online. Over 1,600 young people from Staffordshire and Stoke-on-Trent completed the survey or were involved in qualitative conversations around the subject (facilitated by SCVYS). The final report has now been compiled with the findings and recommendations informing the new priorities within the local **Violence Reduction Strategy** due to be signed off by partners during 2023/24.

During 2023/24, partners are committed to undertaking the self-assessment quality assurance tool developed by Staffordshire Council of Voluntary Youth Services (SCVYS) which will assess how well we listen and engage with children.

5.2 Listening to practitioners

In light of national challenges relating to workforce issues, and as an action from a child safeguarding practice review, the Board is working together to ensure practitioner's voice is solicited across the partnership, and improvements made in a planned manner and services for children and families in Staffordshire remain of a high standard.

There are also some forums and drop-ins for designated safeguarding leads. Partners at the Section 11 peer assessment day provided examples of how they collect and use practitioner feedback to improve their part of the system. Opportunities to collect feedback included supervision, team meetings, regular practitioner forums and drop-ins. Examples included feedback with Police Officers to shape their new operating model; changes to the missing person procedure; 'Was Not Brought' policy/template within primary care and change to the Section 175/157 audit survey tool in response to feedback from schools. Following learning from the peer assessment day, we also initiated the Early Year Safeguarding Forum as previously described in the Neglect section.

However, this is an area where we have collectively not made as much progress as we would have liked during the year and we have recently developed an action plan to progress this. Therefore during 2023/24 we will be:

- undertaking a stakeholder analysis for their own organisation to understand the mechanisms that exist to engage practitioners and seek their views
- holding practitioner events
- launch our practitioner survey to see how embedded safeguarding is across the wider workforce

The independent chair and scrutineer also has a planned roadshow programme with practitioners.

We are also planning to pilot a 'Learning Hub' model based on the Bexley model. This will build on existing work done by safeguarding partners in their individual organisations and our approach to child safeguarding practice reviews. The model will improve our line of sight to front-line practice and allow learning and improvements to be practitioner-led and provide opportunities to learn, share and reflect as a multi-agency group.

We are committed to developing internal mechanisms whereby practitioner feedback is consistently included within improvement plans which are clearly communicated and progressed with transparency and impact.

5.3 Statutory Partner transformation

Staffordshire County Council

During 2021/22 the local authority went through a transformation process to align their resources by district, bringing together Early Help, social care, education inclusion and special educational needs and disabilities (SEND) together in place-based teams to join up services. These district teams are supported by central functions that work across the county and support consistent ways of working. The overarching principle for the district model is to deliver services to children and families and support permanence for children at the earliest possible opportunity. Embarking on a transformation of this size has been challenging, so the Council are pleased to report that they are now starting to realise the benefits and have seen some positive feedback from our workforce.

The performance and quality assurance information from the local authority continues to evidence strengths in partnership working across the board:

- Partnership working leading to effective support plans for children being supported within early help, children in need and child protection plans processes.
- Our low re-referral rates demonstrates that support provided is enabling families to achieve independence within community settings.
- For our most vulnerable children and families such as children subject to education, health and care (EHC) plans and those who are cared for by the Local Authority, through co-production with all partners including parents/families, we are able to support the majority of children and young people through local resources and/or within their local area. When required, support from independent settings, or out of county resources are deployed, with a strong partnership focus to ensure services remain consistent and effective.

We are aware of the challenges that exist, and we work together to identify solutions such as the need to improve our offer of support for children with complex emotional wellbeing needs.

Staffordshire and Stoke-on-Trent Integrated Care System (ICS)

The ICS are developing a Safeguarding Provider Collaborative between key health agencies in Staffordshire, namely:

- Staffordshire and Stoke-on-Trent Integrated Care Board (ICB)
- Midlands Partnership University NHS Foundation Trust (MPFT)
- North Staffordshire Combined Healthcare NHS Trust (NSCHT)
- University Hospitals of North Midlands NHS Trust (UHNM)
- University Hospitals of Derby and Burton NHS Foundation Trust (UHDB) (as a partner)

The Safeguarding Provider Collaborative are committed to fulfilling their statutory and regulatory duties and responsibilities in relation to safeguarding by promoting the welfare of children, young people, adults and their families or carers within our communities who encounter our services. Acting as one health voice allows us to have a shared set of standards and outcomes across the system to provide consistency and improve quality whilst working collaboratively towards the safeguarding agenda across the Staffordshire and Stoke on Trent Integrated Care System.

What the provider collaborative will mean:

- One voice for health (authority to speak for all organisations)
- Improved prevention through shared learning and sharing of best practice
- Reduced duplication
- Consistent set of standards in safeguarding practice

Each organisation will maintain their individual organisational accountability in relation to safeguarding that in turn reports into the Health Safeguarding Forum, Quality & Safety Committee and then into the Integrated Care Board through the Senior Responsible Officer of the ICB. It is important we ensure collaboration, quality, safety, efficiency, and personalisation, with value, benefit, and success.

Staffordshire Police

During 2022/23 Staffordshire Police have carried out significant improvements in their approach to Child Protection. His Majesty's Inspectorate of Constabulary and Fire and Rescue Services (HMICFRS) carried out a thematic Child Protection inspection of Staffordshire Police in the autumn of 2021. The outcome of this inspection led to the force receiving 15 recommendations for areas of improvement.

The Board has received regular updates from the force on its plans for improvement, along with the progress being made.

The force was re-inspected in April 2023 and was pleased to have achieved sign off on 6 of the recommendations, these being in the following areas:

- The way the force uses Information Technology (IT)
- The strategic governance and access to performance information
- The training of its workforce
- Attendance at Initial Child Protection Case Conferences
- The use of the Child Abuse Identification Database and the appointment and utilisation of a Victim Identification Officer.
- The effectiveness of the Sex Offender Management Unit (SOMU)

The force continues on its journey of improvement in the outstanding areas, and the Board will continue to interrogate progress against the plans going into 2023/24.

During 2023/24 Staffordshire Police has undergone a full review of its Public Protection function by independent consultants. This has led to the distinct alignment and ownership of Child Protection work under the leadership of one Detective Superintendent. The Chief Constable has committed to a significant increase in police officer numbers into the Public Protection Unit. This increase will see the implementation of a brand new Child Exploitation Team in early 2024. The new team will be closely aligned to partners seeking every opportunity to respond to child exploitation concerns in a co-ordinated multi-agency approach reducing risk and bringing to justice those who seek to cause harm to children for their own gain. The team will work closely with the Violence Reduction Team and the Youth Offending Service.

5.4 Safeguarding in education

The County Council's Education Safeguarding Advice Service (ESAS) continues to be key in providing a voice for educational settings to the safeguarding partners. They work in partnership to provide effective support and challenge to early years and education settings in their decision-making. As well as representation on all the Board's sub-groups, ESAS colleagues attend multi-agency meetings/groups to act as a voice for school practitioners. This also means that ESAS can disseminate learning back to schools based on local needs and ensure schools are routinely invited to relevant multi-agency meetings such as MARAC. The ESAS team are also responsible for ensuring that the Section 175/157 safeguarding audit is completed and provides appropriate qualitative and quantitative information to safeguarding partners and schools with a robust self-evaluation of policy and practice.

During the 2022/23 academic year ESAS have handled over 4,200 calls as well as almost 50 individual safeguarding reviews to those schools that are identified as vulnerable. School visits and safeguarding reviews allow for continual improvements to safeguarding arrangements, highlight good practice which can be disseminated to other settings and identify areas of focus for drop-ins. This also ensures settings are Ofsted-ready and support the mental health and wellbeing of Designated Safeguarding Leads (DSLs).

ESAS also deliver Level 3 training and refresher courses to large numbers of DSLs. They also hold termly safeguarding briefings to DSLs and provide bespoke training and/or support to new DSLs. DSL drop-in sessions continue to be popular and provide additional support and guidance on a variety of current topics such as listening to the voice of children; neglect; sexual abuse; domestic abuse and mental health) and allow for both sharing of good practice and learning. As a result of findings from last year's Section 175/157 audit which identified a development need for PREVENT, over 170 practitioners from schools attended three Synergy events with West Midlands Counter Terrorism Police colleagues which has had positive impact.

Following the Synergy Events, the West Midlands Counter Terrorism Police stated:

"I've had numerous referrals of excellent quality come in after the events, so I think it was very much a success"

The education safeguarding page of the Staffordshire Learning Net (SLN) has been reviewed and updated and now provides educational settings with a live central bank of resources of training materials; PSHE resources; information on referral pathways and newsletters as well as signposting to relevant local tools and resources for example on the SSCB website. It also allows for one of the means of timely dissemination of learning from local child safeguarding practice reviews. During the year ESAS also published a template for safeguarding and child-on-child abuse policies based on KCSiE (2022) and Working Together (2018).

Barriers and challenges

- IT issues which have prevented access to the SLN to some staff
- School engagement, for example not all identified vulnerable schools accepted the offer of a safeguarding review; academies choosing to complete their own S175/157 assessment rather than the ESAS team's S175/157 audit template which allows for consistent assessment across the County
- ESAS capacity, during the year team vacancies were recruited to. However, the size of the team still provides a challenge to support over 400 education settings as well as early years settings and childminders

Focus for 2023/24

- Improving ESAS systems so they are more efficient and effective in order for us to analyse and share and analyse this information more easily through development of an education safeguarding dashboard
- Developing wider mental health support for DSLs
- Developing an education risk register of schools
- Continuing to improve the quality of safeguarding resources available to schools

5.5 Multi-Agency Safeguarding Hub (MASH)

Our MASH arrangements remain safe, strong and contribute to timely information sharing to achieve robust decision making for children particularly at the statutory level. We are however, committed to making MASH arrangements more robust, engaging partnership information sharing and decisions at the earliest opportunity including through family hubs.

The finding of a joint peer assessment review in November 2022 highlighted a number of areas to ensure we have the best possible outcomes for children and families including:

- A MASH structure with clear governance and leadership. Purposeful strategic and operational meetings that are continually striving to progress, strengthen, and unite partnership safeguarding arrangements
- A new performance framework with input from all partners to demonstrate how effective the MASH is and the difference it makes. Provision of clarity to all partners 'what good looks like'
- Branding and vision, a new dynamic MASH. A clear and easily recognisable logo with a key mission statement that states the prime purpose of the MASH
- Co-location of MASH partners and building a wider network of partners across the County to build and strengthen relationships; enhance information sharing and intelligence gathering
- Appropriate representation from all agencies and equal status in leadership
- A thematic multi-agency audit programme that results in training and refreshing skills base of all staff
- New technology, replacement, or upgrade of current Information Sharing Log (ISL) that incorporates a performance dashboard including demand
- Retention and recruitment of staff across all partnerships, making the MASH a desirable location to work within
- Shared documents and processes that are produced through a MASH threshold document; adapt a more critical/problem solving approach

Following last year's review of our joint MASH arrangements with Stoke-on-Trent, the main priorities for this year were to explore a Staffordshire MASH for children, independent from previous MASH all-age safeguarding arrangements.

Barriers and challenges

- Technology - need to ensure we have an IT system that allows us to share information effectively and efficiently that is fit for purpose
- Police Public Protection Unit (PPU) transformation - ongoing process, models and staff reorganisation taking place
- Workforce - staffing levels and turnover seen across the partnership
- Finance - need to ensure that agreement is made though a revised service level agreement across all statutory partners to ensure equity
- Confusion on information sharing agreements which had delayed progress with our planned multi-agency audit programme

Focus for 2023/24

Our expected impact of our proposed arrangements will lead to a more efficient information exchange process which will reduce demand on staff within the current MASH and more early conversations and information exchange through existing structures at a district level such as early help and Family Hubs model and harm reduction hubs. As part of this a number of priorities for 2023/24 have been identified:

- Developing and agreeing a future vision for local MASH arrangements
- Developing and monitoring the implementation of the transition plan through the MASH Project Board
- Agreeing a robust and effective project plan with clear timescales for implementation which will be delivered through an operational group with the Board having overall oversight
- Exploring and agreeing on a new system that will facilitate meaningful performance data
- Implementing our performance and multi-agency audit programme
- Reviewing and updating our existing Information sharing agreement (ISA)
- Engagement with wider range of non-statutory partners to join the proposed new arrangements to provide richer picture of safeguarding arrangements and true multi-agency working

5.6 Scrutiny and Assurance

The Scrutiny and Assurance (S&A) group oversees the delivery of the Board's business plan and ensures there is multi-agency oversight of service and programme areas delivered to children across the partnership landscape. Whilst the S&A group has maintained a focus on the priorities as set out in the 2022-25 business plan, it has also reacted dynamically where there have been areas of concern identified through inspection outcomes.

The S&A group meets monthly and therefore provides regular oversight of the board's priorities. The group regularly invite members of the wider partnership to present on service or programme areas for children. Over the last 12 months the group have tried to focus their work on the desired outcomes for children. We want to ensure that whilst capacity is a challenge in the public sector, that all efforts are going into making certain that we are making a difference to children and their families. The group recognise that oversight is sometimes too wide and therefore doesn't provide the opportunity to delve deeper into specific agreed quality assurance priorities such as child exploitation and domestic abuse. The group also agree there needs to be a far greater understanding of the services and programmes from the perspective of children and practitioners. This needs to be understood as a whole system approach so that agencies do not seek to solely understand the impact of the service they are providing.

Plans are in place to develop and pilot a learning hub model based on good practice from Bexley. This will provide more clarity on what good outcomes look like for children and use performance and multi-agency audit activity and feedback from children, families and practitioners more effectively to gather tangible evidence as part of our learning and improvement and provide us with an improved line of sight to front line practice.

Section 11 assurance

During 2022/23 we held a Section 11 peer assessment focussing on four key areas: listening to children and young people; professional challenge and escalation; information sharing and staff training and development. Our findings were generally positive with most partners able to evidence how they were meeting the Section 11 requirements that were assessed on the day with some organisations partially meeting some standards. This was particularly apparent for agencies within the criminal justice sector which may have reflected their respective inspection outcomes. Whilst partners were able to demonstrate their individual organisations impact one of the key challenges was our collective ability to evidence the impact of multi-agency working.

Most partners also evidenced how their organisations had aligned their strategic and operational plans to the Board's priorities as well as learning from the system. They provided evidence of how key messages from learning had been disseminated to practitioners through a variety of methods. Organisations were able to evidence how they had made changes to policies, procedures and practice in respond to learning with the impact of these monitored through audits as well as feedback from children, families and practitioners. However, the overall impact on child and family outcomes, particularly at a multi-agency level were more difficult to evidence.

The peer assessment approach was mostly welcomed by partners. Having a face-to-face event, following the pandemic, gave colleagues an opportunity to get together and network as well as collaboratively come together to share good practice and come up with solutions.

The key challenges for the partnership identified throughout the day were:

- Maintaining a consistent and trained workforce due to ongoing challenges with staff recruitment and retention
- Ability to evidence the collective impact of multi-agency working

Inspections

During 2022/23 we have had a number of inspections: Children Social Care focussed visit (May 2022); Probation (June 2022); HMYOI Werrington revisit (November 2022) and Staffordshire Police revisit for child protection (January 2023).

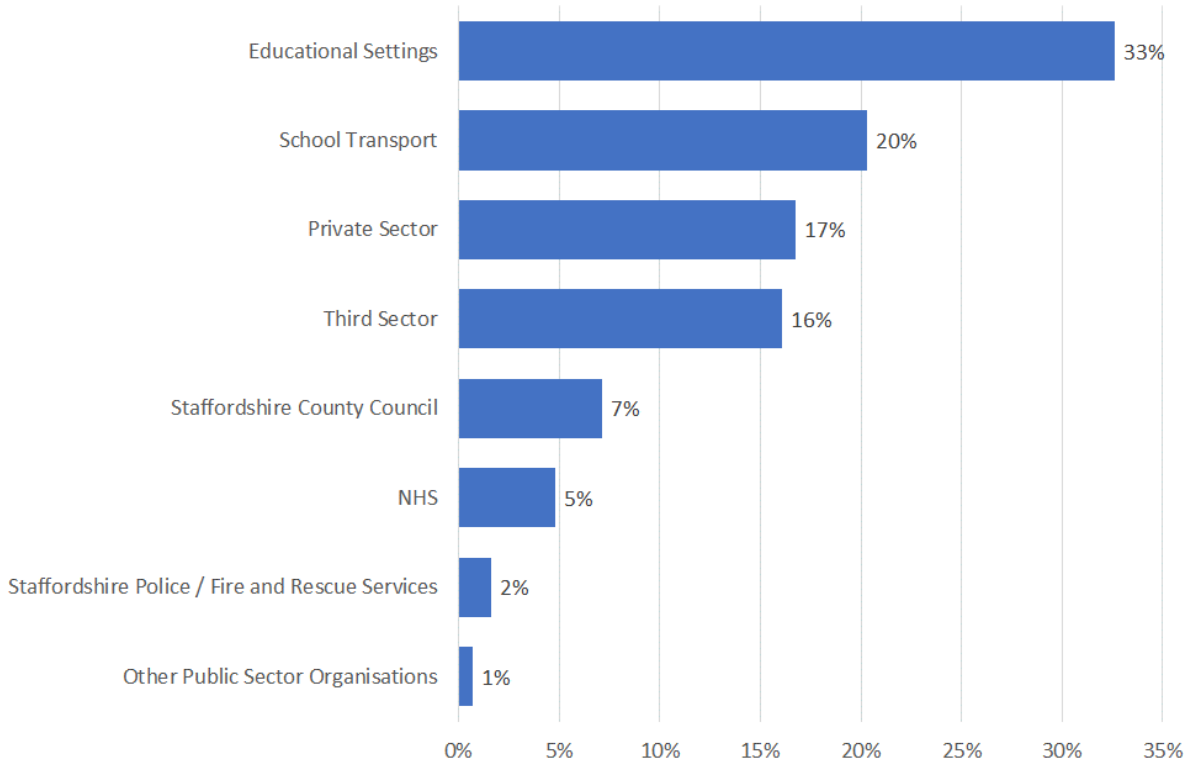
The findings from these inspections identified a number of improvement areas for either individual or across a number of organisations: staffing capacity and pressures; listening to children, young people and practitioners; leadership, management and governance; professional challenge and escalation; effective assessment of risk and need; quality of contact time; management oversight and supervision; staff training and development; record management and information sharing; and performance and quality assurance processes. Many of these improvement areas were not a surprise to safeguarding partners and are recurring themes seen from Child Safeguarding Practice Reviews.

Staff training and development

The Section 11 peer assessment day provided assurance that workforce training and development programmes, including induction, for safeguarding were in place across the County.

During 2022/23, the Board commissioned and delivered multi-agency training to complement single agency training to almost 8,000 colleagues from a range of agencies (Figure 1). The Board's training programme is based on a combination of mandatory and thematic training based on evidence from performance and quality assurance as well as learning arising from local reviews. The Board also offer a number of additional learning resources to the workforce.

Figure 1: Attendance at SSCB training and e-learning courses by organisation type



Following a move to online training during the pandemic, the Board have continued to offer the benefits of flexibility, reach and scale of online training and e-learning courses but also offer some face-to-face training in response to colleagues valuing this approach and in particular the opportunity to share expertise and network.

Feedback post training

"I will be more confident now, knowing that what we are doing is grounded by the information gathered on the course as well as previous experience in a different authority. It will give me the confidence to professionally challenge any circumstance in which children, young people and their families may be needing support"

"The knowledge accrued yesterday will ensure I have the tools to look out for signs to ensure children are safe and supported in education"

"I think that I will be even more mindful of the restorative approach, in order to maintain, create or improve relationships with those parents and children that I am dealing with"

Some of the challenges and barriers identified for partaking in training and development include: staff capacity and training costs.

6 Learning from the system

6.1 Child safeguarding practice reviews

The Child Safeguarding Practice Review (CSPR) sub-group is a multi-agency group, comprising of the statutory partners as well as education, probation, youth offending service 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.

Involvement with statutory processes including rapid reviews, child safeguarding practice reviews (CSPRs) and domestic homicide reviews continues, constituting a significant volume of reactive workload. As a result of the review process the learning trends and themes shape the proactive work and form the basis for the Board's business plan. We also share best practice and learning from national reviews and annual reports published by the National Panel including Child Protection in England (the national CSPR into the murders of Arthur Labinjo-Hughes and Star Hobson).

During 2022/23 Staffordshire have completed six Rapid Reviews of which four have resulted in the commissioning of local CSPRs. Three of those CSPRs are in the final draft stage whilst one is due to commence. In addition, there are four CSPRs that have been completed and awaiting publication due to ongoing criminal proceedings. Children and family members involved are given the opportunity to meet with the lead reviewer to discuss their views.

Neglect and associated non-accidental injuries in babies under one year remain thematic and there have been three cases of inter-generational and intra-familial child sexual abuse. CSPRs awaiting publication involve children subjected to potential forced marriage, non-accidental injury in babies under one and intra-familial child sexual abuse.

In partnership with Stoke-on-Trent Safeguarding Children Partnership the thematic review of under ones executive summary was published this year. Learning from this review has been embedded and the action plan continues to have assurance oversight from both Safeguarding Boards/Partnerships.

Learning identified include some recurrent themes as well as some new findings: professional curiosity (critical thinking and good risk assessment); professional challenge and escalation; multi-agency approach to managing risk (significant men); recognition and response to intra-familial child sexual abuse where the threshold for criminal intervention is not reached; exploration of historical offences, voice of babies and children and understanding their lived experience; cultural bias; understanding and responding to potential forced marriage; Whole Family; information sharing; family norms accepted and overruled with little challenge or enquiry; cross border working; and the impact of the coronavirus (COVID-19) lockdown for families. Many of these themes are similar to recurrent themes/ learning within the National Panel's annual report. There are plans to provide assurance through the Board's sub-group structure and the learning hub approach to ensure that the activity identified are leading to positive improvements in the system.

Key messages from learning are disseminated to the workforce through a system-wide approach, for example, directly from the Review Team; 7-minute briefings; single agency / Board newsletters, social media, organisation and/or Board's website and intranet; team meetings; staff or member briefings; mandatory training; development sessions or learning events such as the local authority and ICS's lunch and learn events or reiteration through learning and development events during national safeguarding awareness week. Many of the messages are also reiterated during individual or group supervision.

The SSCB's Business Team support partners in their duty to disseminate learning. Some creative and innovative work has commenced with the development of a learning from reviews video (under development) and through a refreshed website hosting a variety of media opportunities to learning from reviews, including links to newsletters, webinars, guidance, training and 7-point briefings. Learning from reviews are also fed into relevant strategic partnership groups such as the MTB, EYAB and DACDB through members of the CSPR sub- group who sit on these groups/sub-groups although there is recognition that this area needs further strengthening.

Following rapid reviews and CSPR processes, practitioner events are facilitated by the SSCB supporting additional learning and an opportunity to discuss and debate outcomes from applying changes to systems and processes across the partnership. Individual agencies also support frontline staff through training programmes, workshops and forums enabling ongoing learning and discussion, required for continuous reflection. The weaknesses of the processes/functions is having the capacity to reflect and being able to monitor and collate the difference we have made to improve practice and children outcomes at a multi-agency level.

What difference have we made?

The SSCB have clear principles for learning and improvement and the CSPR sub-group monitors the progress of actions and requires evidence of embedded learning. It is the expectation that safeguarding partners will put in place arrangements to monitor and challenge the quality of their own and other agencies' work in relation to children's safety and welfare. By doing this the SSCB can be assured that partners have been enabled to identify and understand the reasons for systemic strengths and weaknesses that relate to safeguarding practice. **The focus remains on the 'so what' factor and how do we know things are improving for the children and young people of Staffordshire.**

- Updated the local guidance and flowchart for bruising in non-mobile babies' which is held, on the Board's website as well as key points accessible to practitioners, at a glance, through a seven-minute briefing
- Improved the training uptake and application of neglect and the GCP2 assessment tool, in particular with GPs ensuring think family is well embedded
- Improved the content of local domestic abuse training according to the Domestic Abuse Act 2021, as such, the child is a victim; coercion and control being criminal offences and increasing recognition of the impact on the unborn, baby and child

- Set up a task and finish group to review and improve our process for Domestic Homicide Reviews so that they clearly include the impact on the child, when involved, ensuring the child's lived experience, wishes and feelings are captured and recorded
- Improved child protection medical processes which now also include family history information
- Improved the response rate, timeliness and quality of GP conference reports and virtual attendance
- Revised the strategy discussions protocol to invite key partners to enable an expert health voice and provide opportunity for professional challenge
- Implemented an alert on the child's, parents / carers and significant family members records (e.g. Health, Children Social Care and Police) when there has been a serious incident notification submitted to the National Panel. There is also ongoing work continuing to improve the information attached to the Integrated Care Record.
- Developed a multi -agency audit panel and tool to evidence the quality and impact of multi-agency working and learning
- Increased focus on postnatal period contacts and ICON (programme to reduce abusive head trauma) which has been rolled out across Staffordshire. Early recognition of adverse behaviour in infants and its distress meaning.
- Raised awareness of the National Forced Marriage Unit and its ability to support investigations in an advisory capacity
- Improved understanding of the need to information share when managing a person who poses risk to children (PPRC)
- Implemented a robust governance structure within policing to ensure that lessons are learned
- Delivered comprehensive training to understand the need to capture the child's voice
- Provided training for all child protection staff on the Child Safeguarding Review Process and the need for them to engage
- Improved staff understanding how to escalate when disagreements between partner agencies occur
- Shared briefings explaining the risk of domestic abuse and parental neglect to unborn babies

Barriers and challenges

During the Section 11 peer assessment day there were discussions that learning from both local and national reviews have remained consistent for many years and the challenge was to assess whether we are identifying the right themes, root causes and actions to embed learning at a local level.

One of the key barriers to embedding learning identified during the peer assessment day was staffing pressures. Sickness, turnover, unfilled vacancies and redeployment (during the pandemic) meant there were time and work constraints to complete and keep up-to-date with training. Staffing pressures was also thought to reduce the likelihood of staff having time to read and digest relevant learning. It has been recognised locally that organisational transformation has also had an impact on staff morale leading to difficulties with staff retention and productivity and therefore safeguarding practice could be affected. The CSPR sub-group welcomes the opportunity to raise these macro level issues with the National Panel that are beyond the control of the partnership and whilst present in some recommendations, are less likely to lead to positive impact.

In terms of monitoring and measuring impact, this has proven the most challenging to robustly obtain, especially long-term sustained change and measuring cultural change. Findings from single-agency/multi-agency audits, surveys, compliments and complaints, feedback from children, families or practitioners and self/peer assessments are often cited by partners as evidence to demonstrate the impact of embedding of learning. However, there remains a challenge in our collective ability to evidence that learning is being embedded to improve outcomes particularly at a multi-agency level.

Focus for 2023/24

- Further work to understand better the recurrent themes and how systemic they are within Staffordshire

- Ensure that our connections with strategic groups is developed further so that learning is communicated and understood more clearly so that it can be embedded into respective delivery plans

- Improve the way we monitor and measure impact of our embedded learning across the partnership

6.2 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 2022/23 we saw a small reduction in the number of notifications of child deaths (79 compared with 93 notified the previous year) with neonatal deaths (deaths within 28 days of life) continuing to account for the largest proportion. Children from a white background had the highest proportion of deaths, reflective of the population. Of these notifications, 17 (22%) were categorised as unexpected requiring a joint agency response (JAR).

During the year 107 child deaths were reviewed in Staffordshire and Stoke-on-Trent. Of these 28 were considered to have modifiable factors with the most frequent themes being smoking and maternal obesity.

Our priorities for the year were to:

- Ensure that learning from child deaths is communicated to the workforce through a range of channels and used to inform training events
- Increase voice of parental feedback to inform learning
- Ensure reoccurring modifiable factors highlighted in reviewed deaths are raised and targeted locally
- Ensure there is a consistent death review process in place for low gestation babies.
- Ensure that recommendations from the suicide thematic review that was completed last year are embedded into relevant mental health workstreams.
- Seek assurance that the care and treatment of asthma for children and young people are compliant with NICE recommendations as a respond to local asthma child deaths.
- Ensure consistency across the hospital trusts in relation to the obtaining of the Kennedy samples as part of the rapid review process.

Owing to the regional and national trend following the relaxation of the clinical rules regarding “pills by post” this presents a significant safeguarding concern for the board due to the increasing impact on our communities. Staffordshire recently saw the first criminal conviction for such an offence which has been high-profile and heightened the political awareness of the issue. The Board are monitoring the impact of this national trend, raising awareness seeking to ensure professionals understand the shifting landscape, upskilling the workforce and ensuring fast time learning is shared timely as these incidents are reported and ideally prevented due to positive partnership engagement and increased awareness.

What difference have we made?

Some of the service improvements we have seen from recent learning includes:

- Use of an interpreter (e.g. language line) during booking or antenatal care. Awareness around language barriers and need for specialist services have also been promoted with staff
- Earlier intervention and recognition and response to a ‘grey’ baby . Learning has been shared with emergency services such as NHSEI (who are responsible for 111) and WMAS as well as the National Child Mortality Team in order to review pathways and processes
- Relaying of resuscitation status to family highlighted for service improvement

- Bereavement midwives are now informed and involved in implementation of the Advance Care Plan (ACP)
- Mothers for a subsequent pregnancy referred to the pre-term birth prevention clinic; advised for high dose folic acid pre-conception and monitoring of high BMI. They are also given advice on weight loss before pregnancy to improve outcomes for both mother and baby
- Discussion with the palliative care team whether it is possible for ventilator dependent children in PICU to be managed at home after discharge

Barriers and challenges

- CDOP identifies learning and improvement areas. However, as implementation often falls to another partner/partnership this poses challenges and risks to achieving desired outcome
- Some risk / procedural barriers to support out of area suicides
- Understanding the health inequalities and health disparities of those with individual characteristics and societal factors such as vulnerable or inclusion[4] health groups or those with protected characteristics[5]

Focus for 2023/24

- There is a healthy desire across CDOP for innovation, development, and learning. The CDOP co-ordinator is designing the Panel's first immersive child death training course that seeks to give all key CDOP members (and beyond) the opportunity to learn in a controlled immersive hydra experience. This will strengthen our response to child death. This will be the first course of its kind designed around the child death themes identified in the annual data to ensure relevance.

6.3 Review of Restraint

The **Review of Restraint Group** was established under the previous Local Safeguarding Children Board arrangements and have continued under the new safeguarding partnership arrangements to ensure compliance with Working Together 2018 in providing scrutiny of restraint. The group reviews whether staff in HMYOI Werrington are trained in behaviour and de-escalation techniques and ensure that appropriate monitoring arrangements are in place to oversee restraints of children, which ultimately provide assurance to the safeguarding partners that children are safe.

[4] for example, vulnerable migrants, Gypsy, Roma, Irish Traveller and Boater communities, people experiencing homelessness, offenders or former offenders, and sex workers

[5] under the Equality Act 2010 – the 9 protected characteristics are: age, sex, race, sexual orientation, marriage or civil partnership, pregnancy and maternity, gender reassignment, religion or belief, and disability

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 20 incidents of restraint for scrutiny focussing on three types of restraint: pain-inducing, group assaults and passive non-compliance. All of those incidents demonstrated a sound knowledge of applying restraint appropriately and within the expected standards. The viewing of footage evidence that staff are competent and confident in their knowledge and skills in these types of restraint with no concerns raised by techniques or excessive force used in any restraints viewed.

The viewing of this footage has however raised some questions around staffing levels as it is evident that in some cases there has not been the facility to swap staff during extended restraints. Furthermore, it has been noted that a lack time out of their rooms may be a factor in many cases where restraints are used. These issues have been noted and form part of HMYOI Werrington's feedback to the Safeguarding Board's Scrutiny and Assurance group.

The Review of Restraint Group are also keen to invite representatives from local authorities whose children are involved in restraints to meetings in the future. The logistics of this are currently being devised. As a minimum the chair of the task group will contact the identified manager within the home local authority to inform them a restraint on a child from their area has been viewed by the task group and any factors/issues identified by the group will be shared.

What difference have we made?

In addition to the independent review of restraint, HMYOI Werrington have a number of other ways in which they provide assurance and learning opportunities to promote the safety of children. This includes:

- Daily triage of all uses of Minimising and Managing Physical Restraint (MMPR) and within 36 hours by a multi-disciplinary team. 40% of MMPR paperwork requires improvement to be of a reasonable or good standard. The MMPR team offer support and guidance to staff when completing use of force paperwork.
- Weekly risk management meetings (RMMs) where all uses of force are screened with good practice and/or learning identified and shared with staff to drive improvement. There is video evidence of instances where MMPR de-escalation techniques have been used to avoid the use of force, and the MMPR team have begun to compile and share examples of good practice.
- Monthly Use of Force meeting where trends and themes from data analysis of force data is shared. The number and rates of incidents have reduced significantly since the His Majesty's Inspectorate of Prisons' (HMIP) visit in September 2022. A new process to improve timescales for receipt of use of force paperwork is due to be introduced from June 2023.
- Weekly MMPR training with 78% of staff up to date
- Safeguarding Masterclasses
- Introduction of safety meetings

- Introduction of a Weapons Reduction Strategy in October 2022, which has proved to be effective and is understood by staff and children
- Training in personal protection techniques which delivered to all staff (operational and non-operational)

Staffordshire County Council and HMYOI Werrington have also developed a document that outlines responsibilities and practice guidelines for keeping children safe in custody which has been approved and published by SSCB.

The new Youth Custody Service (YCS) Safeguarding Policy is in the final stages of being ratified and from HMYOI Werrington, alongside all establishments will be required to produce their own Safeguarding Local Operating Procedure (LOP) during 2023/24.

Barriers and challenges

- Dedicated Social Workers (DSWs) - long-term absences and provision of cover has affected workload including delays in processing child protection referrals

Focus for 2023/24

- Children will be invited to become members of the core group so that their voices can be heard to inform learning and improvement

- Undertaking a training needs assessment, produced by the YCS and piloted at HMYOI Wetherby, to understand where staff are in terms of their safeguarding knowledge and confidence in undertaking their safeguarding duties. HMYOI Werrington staff have previously reported a lack of confidence in knowing these duties, including understanding of processes in making a referral and in what circumstances.

7 Summary

The Board's structure provides an effective mechanism for partners to raise constructive challenge, seek suitable assurances and work on agreed plans. We will continue to learn improve our safeguarding system and reflect any changes to our arrangements in line with Working Together 2023.

Despite the challenges of being a large and diverse County, partners have continued to work hard to deliver aspects of the business plan to improve outcomes for children and families. The greatest challenge that all agencies are facing is workforce capacity and therefore during 2023/24 the business plan will be reviewed and simplified to ensure all professionals engaged in the delivery of it are clear around the expectation and believe and own the content. As a partnership we will ensure the content of the plan is focusing us in on the parts of the system that we know are under the most pressure in relation to need for service and capacity to deliver and ensure there is a balance between the current issues with delivering against long-term priorities.

We have seen a number of improvements in areas identified through independent inspections of which some were similar to our CSPR findings across the system. However, we recognise that there are some areas which still require further improvement.

We also recognise that there is more work to improve how we use and share wider performance data within the partnership with a need to strengthen our multi-agency performance scorecard to ensure that it helps us monitor the progress we are making towards achieving our outcomes.

We also need to further increase our understanding of the child's journey and experience across the multi-agency system and how we assess and addressing inequalities. Further works is also needed to improve how we evidence impact and outcomes.

Staffordshire County Council

Safeguarding Overview and Scrutiny Committee - Thursday 04 January 2024

Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board (SSASPB) Annual Report 2022/2023

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:

NA

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. 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. 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 2022 to 31st March 2023:

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

a. **Concerns reported:** There have been 15,680 occasions when 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 2,543 from 2021/22 which was reported as 13,227. Following initial assessment it was determined that the duty of enquiry requirement was met in 17% of those reported concerns, a decrease of 4% from 2021/22 reflecting a downward trend, a further 4% fewer than the figure of 25% in 2020/21.

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.

The number of people who meet the threshold for a Safeguarding enquiry under Section 42 is broadly unchanged. It is the increase in the total number of concerns that has contributed to the reducing conversion rate.

Safeguarding concerns range from the very serious to the relatively trivial. The information gathered from audits indicates that the variance could be related to the type of concerns raised, for example, there are a significant number of concerns arising through quality or assessment processes.

Audits indicate that 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, when no other actions are 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.

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 and to ensure that referring thresholds are understood with the aim of ensuring proportionate ongoing management to protect resources to deal with the more serious cases.

b. **Age:** Of the people subject of a Section 42 enquiry, those aged 75 to 84 years (26.9%) represent the largest cohort followed by 85 to 94 years (25.1%). Last year these age groups were reversed with 85 to 94 being the most prevalent at 25.2% compared to 24.9% for 75 to 84 years.

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. Around 12% of the adult population in Staffordshire are aged 75 and over, however, 56.8% of safeguarding enquiries are related to this age group.

c. **Gender:** Females represent the majority of adults subject of a Section 42 enquiries with 63% over the year. This is disproportionately above the population average for females in Staffordshire which is 50.3%. Females over the age of 75 years are consistently found to be most at risk of abuse or neglect.

d. **Ethnicity:** The majority of adults involved in a Section 42 enquiry are white – 91.9%, an increase from 87.8% last year. The percentage of the population of Staffordshire who self-identified as white is 90.2%. There has been an improvement of 'Not Recorded' reduced to 2.2% from 6.2% last year.

e. **Primary Support Reason (PSR**): Physical support continues to be the most common PSR in Staffordshire at 48% the same percentage as last year. This is followed by mental health support at 20% reflecting a 6% increase from last year. It is of note that there is a significant decrease in the category of 'not recorded' which is down to 0% from 17% last year.

f. **Type of Abuse:** Neglect and Acts of Omission continues to be the most prevalent type of abuse at 37% and is the same figure as last year. Financial Abuse remains similar at 20% compared to 19% last year. Physical Harm has reduced to 13% from 17% last year.

g. **Location of Abuse:** The most reported location of abuse in Staffordshire was the adults' own home at 70% compared to 62% in 2021/22. The next most prevalent locations were nursing home 17% a slight increase from 16% last year and independent residential home 12% a slight increase from 11% last year. Put into context the adult may consider their care/residential or nursing home as their 'own home'.

h. **Expressed Outcomes met:** 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 the same figure as last year.

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 either move away from or stay with the family, but the risks are too high and there is a need for appropriate proportionate action to reduce the risks.

i. **Strategic Priorities:** During the reporting period the SSASPB Strategic Priorities were:

   i. Ensuring Effective Practice. This is a new priority arising from a revision of the SSASPB Strategic Plan and in response to five themes of significant importance and recurring concern arising from a combination of learning events. Pages 18 – 32 of the Annual Report provide a comprehensive overview of the collective activities of safeguarding partners that evidences the changes in practice in response to learning experiences.

   ii. Improving engagement with adults with care and support needs, their families, carers, members of the public, professionals and volunteers. Pages 32 – 33 of the Annual Report set out the range of methods that have been utilised to raise awareness, including commissioning Rockspur working with adults with autism or a learning disability to produce a more accessible version of the Annual Report.

j. **Learning from experience:** The SSASPB's commitment to learning from experience is outlined in pages 11-16. As required by the Care Act 2014, a summary of the Safeguarding Adult Reviews (SAR) undertaken in 22/23 is presented. A total of five referrals were received. Following assessment, two met the criteria for a SAR, two did not meet the criteria and one is being considered as a Domestic Homicide Review.

Arising from the learning from the SAR of Andrew, the SSASPB has facilitated extensive training for practitioners to help in responding to self-neglect and in trauma informed practice collectively attended by around 1,200 practitioners during the past year. This section of the report concludes with a summary of the other work that is being done through the SSASPB to support strategic priorities.

Link to Strategic Plan

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

   a. Encourage good health and wellbeing, resilience and independence

Link to Other Overview and Scrutiny Activity

9. Deprivation of Liberty Safeguards

Community Impact

10. 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 2022/23

Contact Details

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Staffordshire and Stoke-on-Trent
Adult Safeguarding Partnership Board

Abuse must stop

Annual Report 2022 to 2023

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

1. Independent Chair Foreword

This Annual Report is longer than previously for good reason. Once again it illustrates the enormous amount and range of safeguarding activity done in partnership, much of which builds on learning from good practice as well as where things have gone wrong. The constant challenge – it is a big one - is to demonstrate and evidence that the necessary changes in practice needed in response to the learning have been implemented by safeguarding partners to mitigate the potential for future recurrences.

Accordingly, the SSASPB has adapted its approaches to seeking assurances and these are reflected in the revisions to the Strategic Plan to include a new strategic priority of Effective Practice. As you will read there are five themes to Effective Practice and the updates of actions and, where available, their positive impacts have lengthened this report. A key element in responding to the challenge of breaking the cycle of recurring themes and issues is to continuously raise awareness of the learning points from adults who have had adverse experiences.

A significant theme has been identified in relation to adults who self-neglect and the practical difficulties that this sometimes presents for practitioners. This was illustrated with the 'Andrew' SAR in last year's Annual Report. Over a period of 18 months Andrew was seen on 308 occasions by 11 organisations but sadly died at the age of 37 years. This was a 'watershed' moment for safeguarding partners locally and in the last 12 months a total of 1,193 practitioners have attended training or learning events emanating from the learning from 'Andrew'.

The case studies in this report illustrate the positive differences being made and what can and is being achieved by reflective practice and determination to go the extra mile. What is still missing, however, is a greater sense of safeguarding partners being able to better evidence what local communities and people who have experiences of using the multi agency safeguarding services say.

I again take this opportunity to acknowledge the commitment and enthusiasm of all our partners and supporters including the statutory, independent, and voluntary community sector who consistently demonstrate a strong clear focus on doing their best for those adults we are here to protect. Through the extension of an inclusive approach to safeguarding I extend a welcome to new partners who have recently joined the Board and bring a particular focus and a wider perspective to the work on recurring themes.

As always, I am immensely grateful to all who chair the Board Sub-Groups as well as the Board Manager Helen Jones who works so hard behind the scenes to ensure that our business programme works efficiently. On behalf of the Board, I record here thanks and good wishes to Rosie Simpson who, after 4 years, left her valuable role of Board Administrator in November 2022 to re-locate to another area. We look forward to working with Lorraine Hudson in the Administrator role.

John Wood QPM

2. About the Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board

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:

1. It must publish a Strategic Plan that sets out its objectives and how these will be achieved.
2. 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.
3. 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:

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 center of planning to meet support needs to ensure they are safe in their homes and communities.

[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

3. 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 on page 5 of the SSASPB Adult Safeguarding Enquiry Procedures.

4. What have we 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.

The Board

Independent Chair:	John Wood
Vice Chair:	Lisa Bates, Designated Nurse for Adult Safeguarding, Staffordshire and Stoke-on-Trent 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 every quarterly Board meeting the Chair reminds 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 and assurances that agencies are working together effectively. The Chair goes on to say that constructive challenge, as always, is welcomed and encouraged.

During 2022/23 the Board has:

- Approved the 2022/2025 SSASPB Strategic Plan with Effective Practice, focusing on 5 key themes, and Engagement as its two Strategic Priorities.
- Held a Development Day Workshop in June 2022 at which pledges were made by Board partner organisations in support of the 5 themes within the Effective Practice Strategic Priority. The Board has received reports on the progress of priorities at each of its quarterly meetings.

- Approved Safeguarding Adult Reviews 'Heather' (April 2023) and 'Frank & Elsie' (January 2023), Safeguarding Adult Reviews (SARs) (ssaspb.org.uk).

- Received a presentation from the chair of the Staffordshire and Stoke-on-Trent Quality, Safeguarding and Information Sharing Meeting. QSISM examines quality and safeguarding matters in care settings and aims to support providers through challenges aiming to prevent escalation. Themes and trends from the meetings in 2022/23 were discussed. The Board sought assurances on recurring themes and reaffirmed alignment on mutually relevant work.

- Examined annual assurance reports regarding Large Scale Enquiries and constructively challenging reasons for recurring themes.

- Examined annual assurance reports regarding Deprivation of Liberty Safeguards including reasons for and responses to the increasing number of DoLS applied for.

- Received a presentation on the refocus of the LeDeR (Life and Death Mortality Review) programme noting the changes to the programme which now includes 'autistic people' in its remit. The presentation included the main themes and trends outlined in the LeDeR Annual Report. Reaffirmed alignment on work on mutually relevant themes.

- Continued to contribute to the review of the arrangements and working of the Multi-Agency Safeguarding Hub (MASH) and received updates on the review.

- Received a presentation by Dr Laura Pritchard-Jones, Keele University, on the key findings from the Insight research into the impact of COVID on Adult Safeguarding. One area of focus was the reduction of Mental Capacity Assessments undertaken during the pandemic. The SSASPB hosted a learning event presented by Dr Laura Pritchard-Jones, covering Mental Capacity and Adult Safeguarding in response to this.

- Received an update on the progress of the Stoke-on-Trent City Council Multi-agency Resolution Group (MaRG) and the Changing Futures programme. The chair of the MaRG, a lead officer from Changing Futures, and one of the Expert Citizens attended the Board meeting to discuss strategic and operational links on matters of mutual relevance and the key contribution of Expert Citizens. The discussions helped to further strengthen the links between the work of the Changing Futures programme and the SSASPB Effective Practice priority.

- Received a presentation from the Staffordshire County Council lead officer for the Integrated Co-occurring Needs (ICON) project. The project is about the response to adults with vulnerabilities and multiple needs whose personal circumstances don't meet the eligibility criteria for support through the Care Act 2014 or other eligibility. The plan is for the project work to result in a forum similar to the MaRG in Stoke-on-Trent but bespoke to the needs of a multi-tiered Local Authority.

- Promoted and supported the Ann Craft Safeguarding Adult week, hosting multi-agency awareness raising and learning events and encouraging partners to run events within their own organisation. One example was the 'Safeguarding's Got Talent' event arranged by the Integrated Care Board. Several connected partners showcased multi-agency adult safeguarding work. Congratulations to North Staffordshire Combined Healthcare Trust for receiving the highest scores in a very closely contested event. The practitioner networking was also appreciated by those attending.

- Received and considered the publication of a report 'Addressing Violence against Older Women; Learning from practice' sponsored by Comic Relief. Staffordshire Women's Aid were one of 7 areas contributing to the research. An update on actions arising was received from the Chief Executive, Stafford Women's Aid.

- Considered the impact that the 'Cost of Living crisis' and other winter pressures was having on Adult Safeguarding and sought and received assurances that risks were being mitigated as far as possible and that partners were ready to respond to increases in demands upon resources.

- Contributed to the funding and supported the Alcohol Change led research into 'Cognitive Impairment in Dependent Drinkers'. One of the key reasons for participation in this research was as a response to the findings of the Safeguarding Adult Review of 'Andrew'.

- Discussed the impact of the increase of 'quality' concerns currently being reported into Safeguarding and actions needed to help practitioners to identify which process should be used.

- A standing agenda item on matters arising from links with others partnership boards and fora enables visibility and alignment on matters of safeguarding relevance.

- Cross partnership working is being strengthened through the development of a protocol with Safeguarding Children Board, Health and Wellbeing Board, Integrated Care Board and the Police and Crime Commissioner.

- A standing agenda item for inspection, organisational review and peer review updates from partners that facilitates constructive discussion about areas of good practice and offers of support to meet organisational challenges. Subjects have included CQC readiness assessments in preparation for the forthcoming Adult Social Care inspections, this included participation in a peer assessment of Staffordshire County Council and focus groups (both tactical and strategic) with Stoke-on-Trent City Council.

Internal Audit of the SSASPB

In August 2022 Staffordshire County Council and Stoke-on-Trent City Council jointly commissioned an internal audit of the SSASPB to seek assurance that the Board was fulfilling its role as outlined in the Care Act 2014.

The aim of the audit was to provide assurance on the governance and performance of the SSASPB to ensure that the Adults Safeguarding Partnership Board continues to operate in accordance with its terms of reference and statutory requirements of the Care Act 2014 including roles and responsibilities of the Board and representation by partner organisations.

The terms of reference for the audit were to ensure that:

- adequate governance arrangements are in place, which are robust and effective;

- a performance management framework has been established, against which performance is reviewed and reported routinely;

- SSASPB members are trained appropriately to ensure that they can carry out their membership duties;

- financial support is provided to assist with achieving the aims and objectives of adult safeguarding and to ensure that strategic risks have been identified and are being monitored periodically.

The auditors spoke to the Independent Chair and Board Manager and scrutinised key SSASPB documents. The overall findings were that Internal Auditors were able to offer adequate assurance as most areas reviewed were found to be adequately controlled.

The following control weaknesses were identified with 3 medium risks and 1 low risk resulting in associated recommendations:

Medium priority

1. Officers should ensure that Terms of Reference and business plans are approved/ratified within the required timescales.

2. Budget information should include complete information to show a clear picture of the account of the Board.

3. The SSASPB should produce a statement to record the Board's new approach in respect of how risk is going to be managed.

Low priority

1. The Board should ensure that sub-group meetings are held in accordance with their frequency stipulated within their corresponding Terms of Reference.

Actions in response

All recommendations were completed and finalised by Internal Audit by 31 July 2023.

Executive Sub-Group

Chair:	Lisa Bates, Designated Nurse for Adult Safeguarding, Staffordshire and Stoke-on-Trent Clinical Commissioning Groups August 2020 to present.
Vice Chair:	Sharon Conlon, Head of Strategic Safeguarding, Midlands Partnership Foundation Trust.

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;
- ensuring 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 Integrated Care Board); the Midlands Partnership Foundation Trust (MPFT) and North Staffordshire Combined Healthcare NHS Trust (NSCHT).

During 2023/23 the sub-group has:

- Co-ordinated the work undertaken to review the strategic priorities in preparation for the Board approval of the 2022/2025 Strategic Plan. Monitored progress against the SSASPB strategic priorities (Engagement and Effective Practice).

- Monitored the progress of all Safeguarding Adult Reviews raising constructive challenges around practice where appropriate. Used several of the challenges to inform the new Strategic Plan 2022/25 – these have formed the basis of the Effective Practice Strategic Priority.

- Heard a case study of Predatory Marriage and as a consequence sought and received assurances that Registrars in Stoke-on-Trent and Staffordshire receive adult safeguarding training.

- Received a presentation on the main themes arising from the Learning from Lives and Deaths Programme (LeDeR).

- Examined assurance updates from both Local Authorities regarding Large Scale Enquiries (LSEs) and Deprivation of Liberty Safeguards (DoLS) authorisation backlogs, linked to Effective Practice Theme 2.

- Discussed the work of the Stoke-on-Trent Multi-Agency Resolution Group which is a multi-agency forum to discuss adults who have multiple needs and at risk of abuse or neglect, particularly self- neglect linked to Effective Practice Themes 3 and 5.

- Received an update on the work which is looking at the response to 'vulnerable adults with multiple, complex and co-occurring needs' in Staffordshire. In particular, those who are not in safeguarding processes. This has links with Theme 5 of the Effective Practice Strategic Priority.

- Received the feedback from the Joint Local Authority Internal Audit of the SSASPB and initiated actions to respond to the 4 recommendations.

- In response to challenge raised at SSASPB meeting received assurance from SCC that there were no instances of safeguarding concerns connected to prison releases (medication prescription).

- Agreed support for the National Ann Craft Adult Safeguarding week. The SSASPB hosted 3 learning events covering Mental Capacity, Adult Safeguarding Awareness and the Role of Advocacy in Adult Safeguarding. From the subsequent local evaluation acknowledged the excellent work done by many partners to support the awareness raising initiative.

- Considered several Board membership requests in accordance with the SSASPB Board membership procedure.

- Continued to strengthen alignment of working on mutually relevant themes working with leads/chairs of Safeguarding Children Boards and Health and Wellbeing Boards in accordance with the Staffordshire Strategic Partnership Protocol.

- Confirmed that links with the MAPPA governance and procedure were in place. Several Board members sit on both MAPPA and SSASPB meetings and can share learning from reviews through standing agenda item on links with other fora.

- Made links to two new Independent Domestic Violence Advocate roles specialising in Older People and Disability facilitating information sharing on matters of relevance.

- Considered the Whorlton Hall findings (SAR) the seeking of assurances locally.

- Received assurances from partners that there had been individual agency activity in response to the SAR Andrew action plan.

- Tasked the Audit and Assurance sub-group to consider Discriminatory Abuse as a theme for a Tier 3 audit arising from the finding of extremely low numbers in the annual data capture (it was noted that this finding was replicated nationally).

- Received updates from Regional and National Adult Safeguarding fora through membership at various meetings.

- Sought assurances that any safeguarding issues from the welcoming of Ukrainians to the Stoke-on- Trent and Staffordshire area are recognised and addressed.

- Received updates from the links with the Domestic Abuse Commissioning Board with shared partners reporting matters of relevance to each Board.

Safeguarding Adult Review Sub-Group

Chairs:	Staffordshire Police Superintendents Nicky Furlong to March 2023. Victoria Lee from March 2023.
Vice Chair:	Lisa Bates, Designated Nurse Adult Safeguarding Stoke-on-Trent and Staffordshire Integrated Care Board (ICB).

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 learned from any reviews conducted by other SABs.

During 2022/23 a total of five SAR referrals were received. Following assessment, two met the criteria for a SAR, two did not meet the criteria and one is being considered as a Domestic Homicide Review. Information is provided on the referrals meeting the criteria.

'Frank and Elsie': A SAR conducted under Section 44(1) Care Act 2014 – Mandatory Review (Staffordshire)

Brief overview of the circumstances and how the criteria for a SAR was met:

A referral was received in July 2022 and involved a white British male (81yrs) and a white British female 72yrs, neither of whom had capacity and resided in a nursing home in Staffordshire. The names Frank and Elsie are not their actual names have been used to protect their identities.

There were concerns that there was insufficient focus and multi-agency working with regards to the risks presented by Frank to Elsie and others. There were numerous incidents of both physical and sexual violence to other residents and physical assaults/sexualised behavior to staff. There were concerns about the lack of clarity on the funding for the extra supervision of Elsie via one-to-one support. Frank was a Stoke-on-Trent resident (initially funded by Stoke) who then was assessed as having eligibility for NHS funded care (Funded Nursing Care). Staffordshire County Council were involved in a Section 42 safeguarding enquiry into one of the sexual assaults and it is believed that a more proactive stance to prevent re-occurrence may have been required.

This SAR was conducted by an Independent Reviewer supervised by the Social Care Institute for Excellence (SCIE) using their Review in Rapid Time model. The review commenced on 25 October 2022 and the final draft was presented to the SSASPB where it was approved on 26 January 2023. This model focuses on systems findings and seeks to identify the key barriers and/or enablers that make it harder/easier for good practice to flourish and that need to be tackled to see improvements.

Systems Finding 1:
Staffordshire safeguarding policies and procedures recognise sexual abuse as a category however there is no local policy or procedure about how sexual safety can be maintained specifically in residential care settings, including how to respond to incidents, assess and manage risk. This is despite recognition of the extreme vulnerability of residents and problematic sexualised behaviour of some residents being acknowledged as common. This leaves disparate and sometimes contradictory efforts by different agencies to support the individual and protect others, with no effective multi-agency working or effective oversight of risk management within a home, or of placement decision making, whether routine or in emergencies following evictions.

Systems Finding 2:
Staff in residential care are not adequately equipped to distinguish consensual sexual activity from sexual assault, based on an assessment of an individual's capacity to consent. This is reflected in unclear language to describe sexual activities and increases the chances of downplaying both the risks an individual may pose, and the needs of others for protection.

What the SSASPB has done in response to the findings

The Board responded by developing an action plan to address the above findings. It was agreed that a practical toolkit or resource pack would be produced making use of guidance and help available from National bodies including the Local Government Association (LGA), SCIE and the Care Quality Commission (CQC).

In response to Finding 2 the SSASPB will be facilitating a learning event 'Mental Capacity and Sexual Safety' with a presentation and workshop to be delivered by Doctor Laura Pritchard-Jones, Senior Law Lecturer, Keele University, timed to contribute to associated learning events during the Ann Craft Adult Safeguarding Week.

Clive Treacey: A SAR conducted under Section 44(4) Care Act 2014 – Discretionary Review (Staffordshire)

Brief overview of the circumstances and how the criteria for a SAR was met:

A referral was received on 8 November 2022 about Clive Treacey a 47-year-old white British man

from Staffordshire who died in January2017. Ordinarily, the identity of a person subject of a review would be anonymised but his family wish the circumstances of his lived experiences to be widely known and communicated.

Clive had a learning disability and diagnosis of autism and epilepsy. He grew up within a loving and supportive family. At the age of 18 years he attended a residential college and went on to reside in a variety of residential settings as an adult. It was alleged by Clive that he was sexually abused whilst in one of the placements in Cheshire. It is then reported that the source of risk followed Clive into subsequent placements.

Clive had been detained under the Mental Health Act 2005 (MHA) for a decade. He gained an unwarranted reputation for being complex and challenging, and someone for whom a community setting was only properly considered during the later years of his life. A LeDeR (Learning from Life and Death review - formerly known as a Learning Disability and Mortality Review) was conducted on behalf of NHS England which identified that there were financial and systemic barriers that thwarted Clive residing in community settings and remained in settings that were poorly equipped to meet his needs.

Concerns have been raised that the safeguarding alerts that Clive's family and professionals raised over the course of his life through community and specialist hospital settings were not adequately responded to. It has been raised that these were missed opportunities to intervene and had these matters been responded to more effectively, this may have altered the course of events that followed.

Clive was not kept safe from harm, and it is believed that he experienced sexual abuse whilst in the care of some providers. Questions have been raised regarding the effectiveness of his safeguarding and the police response to this. The reviews by NHS England and LeDeR were not able to ascertain what safeguarding and police actions followed these serious incidents.

It was decided that a Safeguarding Adult Review would be conducted jointly by Staffordshire County Council and Cheshire East Council. The focus of the SAR is to be how policies, procedures and practice have changed since the early 1990s when the abuse is alleged to have taken place and to seek assurances that future risks for others can be mitigated. The review is ongoing at the time of writing and will be authored by Professor Michael Preston-Shoot. An update will be provided in the 2023/24 Annual Report.

Update on the 'Andrew' SAR from the 2021/22 Annual Report

The SSASPB approved the final report of 'Andrew' in April 2022. Briefly, the SAR was about the learning from the death of a 37 years old white British man who was living in social housing in Stoke-on-Trent. Andrew had multiple needs arising from mental ill health, substance misuse, grief following the death of his mother, poor health generally and indifference to whether he lived or died and fluctuating engagement with service providers.

Over the last 18 months of his life Andrew was seen on 307 occasions by 11 service providers. Andrew died from gastrointestinal bleeding with self-neglect as one of the key contributory factors. There were concerns as to how agencies worked together.

The published report can be accessed from the link to the SSASPB website Safeguarding Adult Reviews (SARs) (ssaspb.org.uk).

What the SSASPB has done in response to the findings

The Andrew SAR has provided significant and extensive learning that is continuing. The findings and lessons learned are a regular focus of discussion.

During the review of the SSASPB Strategic Plan 2022-25 the themes from the SAR of self-neglect and adults with multiple needs who don't meet the eligibility criteria under the Care Act 2014 were specifically included within the themes of a new strategic priority to seek assurances of Effective Practice.

The SSASPB has initiated and facilitated several events focusing on themes from the learning attended by a total of 659 practitioners. These include:

- Three interactive learning events (facilitated through Microsoft Teams) presented by the Independent Reviewer, Patrick Hopkinson, which focused on the findings from the review attended by 336 practitioners and supervisors/managers.

- An interactive learning event presented by Patrick Hopkinson on the theme 'Trauma Informed Practice'. A total of 169 practitioners attended this event which was open to anyone whose work includes engagement with adults with needs for care and support.

- An interactive learning event presented by the Prevention and Engagement sub-group on 'Self Neglect'. This was attended by 134 practitioners.

- A learning event to focus on 'Mental Capacity and Self-Neglect' has been planned to take place in the autumn of 2023.

The SSASPB contributed to the funding of a national project undertaken by Alcohol Change on the theme of 'Identifying and Addressing Cognitive Impairment in Dependent Drinkers'. The project included research using local case studies and a focus group with practitioners who work with dependent drinkers. The findings of the project were communicated through a multi-agency training event led by the clinical researchers which was offered to practitioners from the Board member organisations to whom the theme was relevant. Key learning points from the training and key messages for practitioners were subsequently included in the SSASPB Newsletter which prompted positive feedback.

The SSASPB has reviewed its representation and invited Humankind to become a member to meet a need for a perspective on substance misuse by adults with care and support needs to be better recognised.

Audits have been conducted to examine reported safeguarding concerns that were not considered to have met the requirement for a Section 42 enquiry. The audit in Stoke-on-Trent identified that two referrals should have been categorised as Section 42 enquiries because a significant amount of protective work was described in both. Three cases were closed without the person referred being seen in person and the inherent risks of managers agreeing closure without the referee being seen were followed up with managers by the auditors. In two cases seen, there appeared to be an absence of clear descriptions of actions undertaken and the rationale for closure. Auditors concluded that overall the adult had been seen, protective factors had been put in place and risks mitigated.

The SSASPB has actively promoted the benefits of the appointment of a Lead Professional for multi-agency responses, recognising that Andrew had been in contact with 11 different services but there was no effective co-ordination of intervention or support. Messages have been conveyed through a combination of Newsletter articles, Social Media messages, learning presentations as well as amendments to the Section 42 multi-agency procedures.

The SSASPB has received a presentation from the Independent Chair of the Multi Agency Resolution Group (MARG) in Stoke-on-Trent and the programme lead for Changing Futures to seek assurances on the effectiveness of the partnership work to help adults with multiple needs typically including homelessness, drug and alcohol misuse and self-neglect.

The Board has encouraged preventative work, especially with those adults who don't meet the Care Act 2014 criteria for 'care and support' and received a presentation from Staffordshire to seek assurances on the response to inadequate care for people with co-occurring needs (ICON).

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.
- Incorporated the National SAR Quality Markers into the local SAR Guidance.
- Promoted the Olive Branch training made available by Staffordshire Fire and Rescue Service, to support fire risk reduction at home.
- Engaged with Community Safety Partnerships that are managing Domestic Homicide Reviews (where they involve adults with care and support needs).
- Promoted the use of advocacy services in SARs to support the adult involved (where appropriate).
- Tasked the Audit and Assurance sub-group with auditing how lessons are being embedded in organisational practice from the recurring findings in SARs.
- Provided detailed assurance against the 29 improvements recommended by Professor Michael Preston-Shoot in his academic analysis of SARs nationally (2020)
- Continued to actively raise awareness amongst practitioners 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 as early as possible to resolve professional disagreements.

- Appointment of a lead professional to drive multi-agency resolution in complex cases.
- The need for better understanding of the application of the Mental Capacity Act 2005 particularly in relation to self-neglect.

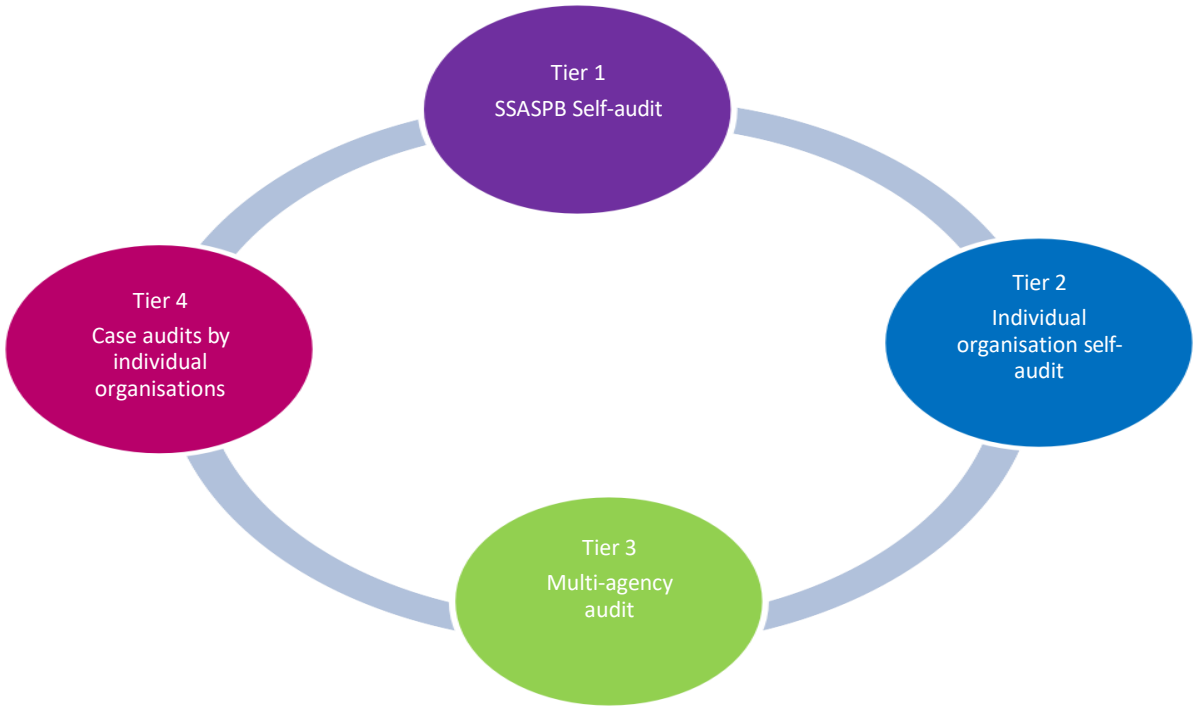
➢ Promoted to practitioners' webinars made available nationally that are relevant to SARs.

Audit and Assurance Sub-Group:

Chair:	Sharon Conlon, Head of Strategic Safeguarding, Midlands Partnership Foundation Trust
Vice chair:	Laura Collins, Named Nurse for Safeguarding, North Staffordshire Combined Healthcare NHS Trust

The SSASPB 4-tiered audit framework:

Overleaf 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.

- Selected specific standards from the Tier 2 audit data capture to request further assurances and evidence to support the self-awarded RAG (Red, Amber, Green) ratings. The standards chosen were bespoke to each partner's submission to provide detailed assurance on their Workforce Development section of the audit (Training).

- Conducted Tier 3 (Multi-agency) audit on the subject of 'Appointment of Lead Professionals in multi-agency responses to safeguarding activity'. Key findings and actions were:

  - There was evidence in some cases that a lead professional had been appointed but there were more cases where this would have been beneficial; there was often a perception that the appointment of a lead professional would impact on that person's capacity.

  - It was agreed that the benefits of appointment of a Lead Professional should be further promoted through the SSASPB Newsletter and Practitioner Forum.

- Conducted Tier 3 (Multi-agency) audit on the theme of Discriminatory Abuse. Key findings and actions were:

  - Where Discriminatory Abuse is recorded this was an accurate assessment of the abuse presented.

  - Limitations on recording systems mean that Discriminatory Abuse may be recorded as other categories of abuse leading to under representation in data; the Police often record discriminatory abuse as a Hate Crime and this type of crime is a rich source for further research (understanding that Care and Support needs is often difficult for Police to categorise separately); two partners who expected to find Discriminatory Abuse referrals had none recorded, a further check is to be done following this audit to examine if there is an increase.

  - Awareness of discriminatory abuse was included in the SSASPB newsletter and learning presentations.

- Conducted Tier 3 (Multi-agency) audit on the subject of online abuse. Key findings and actions from the Online Abuse Tier 3 audit: This audit was conducted following a query by Staffordshire County Council's Overview and Scrutiny of the SSASPB Annual Report 2021/22. This type of abuse isn't one of those identified in the Care Act 2014, consequently the research had to identify cases through free-text research where that was possible.

  The lack of a facility to identify the online abuse of adults with needs for care and support is a barrier to understanding this type of abuse; this type of abuse mostly affects adults under 60 years of age who have a learning disability or mental ill- health, most adults affected by online abuse don't have care and support needs as identified by the Care Act 2014; there was evidence of good awareness of this type of abuse and positive action to prevent impact, seen especially by banks when unusual activity on an account was identified; there were many links

to so-called 'romance-fraud' i.e. people from oversees approaching others using dating apps requesting money; many did not believe that they were being exploited and gave the money willingly.

Following the audit contact was made with both Local Authorities' Trading Standards teams and an article written for the SSASPB Newsletter which included links to more information and help available.

Prevention and Engagement

Interim Chair:	Helen Jones, SSASPB Business Manager.
Vice chair:	Laura Collins, Named Nurse for Safeguarding, North Staffordshire Combined Healthcare NHS Trust.

This sub-group was formed to drive the work of the Engagement Strategic Priority. For an update on progress please see the Strategic Priority section on page 32 of this report.

5. Performance against 2022/2025 Strategic Priorities

Strategic Priority 1: Effective Practice

This is a new priority arising from a revision of the SSASPB Strategic Plan. It was developed with the engagement of the Board and sub-groups in response to five themes of significant importance and recurring concern arising from a combination of learning events. At the SSASPB Development Day in June 2022 Board partners made a series of pledges and commitments to action. The updates are summarised below.

Theme 1:
That Making Safeguarding Personal (MSP) is meaningfully implemented and embedded in practice by all partners, (other than in exceptional circumstances when it may be less appropriate) and that its effectiveness is measured to give confidence.

The Board has sought assurances that adults are supported to make choices that balance risks with positive choice and control in their lives.

Stoke-on-Trent City Council

- Case file audits in relation to 57 safeguarding cases were undertaken during October and November 2022. Findings were that overall, there was good social work practice, however, the rationale for decision making was not always clear and therefore MSP is not always visible. Arising from the findings a series of workshops were convened with all qualified Social Workers, Senior Social Workers, Team Managers and Senior Managers to provide feedback and to improve recording and practice in line with MSP.

- Case note practice guidance was issued to staff to support person centered and consistent case note recording following the above audit and workshop.

- A new training package for practitioners has been developed which includes legal duties under the Care Act 2014 and responsibilities in relation to Making Safeguarding Personal.

- A new feedback loop is under development. Each month safeguarding assistants contact people who have been involved in a Section 42 enquiry and seek information on their experiences, this helps to inform practice and development of communication/feedback methods.

- In complex cases where high risk individuals cannot access all mainstream services there is access to support and representation through Expert Citizens to enable the person's thoughts, feelings, goals, and strengths to be articulated at the meeting.

Staffordshire County Council

- Quality audits generally demonstrate that safeguarding is person centred and Making Safeguarding Personal can be demonstrated. The quality audit on safeguarding found that 69% of people subject of the enquiry agreed that it had been completed in a timely way and the good practice timelines had been met.
- Staff responses identified variances in terms of approach, but there was agreement about keeping the person at the centre through practice, personalisation, proportionality, and with sensitivity. One team identified this as one of their services strengths by supporting people to balance risk with positive choice and control.
- It is recognised that there is a need to further improve to ensure that MSP is consistently embedded in practice. The safeguarding training has been redesigned and with the principles of MSP at the centre of it.
- A feedback form has been produced for adults who have been subject to a safeguarding enquiry completed by the Adult Safeguarding Enquiry Team (ASET). A feedback form has also been produced for carers and providers. At the time of this Annual Report the arrangements are subject to an evaluation.

- A process to seek feedback from adults where a concern may not have progressed to a Section 42 enquiry is being developed.

- Health and Social Care are committed to co-production and have a co-production network to support colleagues with information and resources about doing it well.

Midlands Partnership Foundation Trust (MPFT)

- Produced a Making Safeguarding Personal information leaflet that is available to all staff and patients through MPFT intranet.

- Produced a seven-point briefing on MSP that is of helpful practical relevance during safeguarding supervision discussions.

- An audit to examine compliance with MSP guidance was completed. This will be repeated to take account of the updated guidance issued to practitioners.

Staffordshire Fire and Rescue Service (SFRS)

- A quarterly safeguarding report is produced that provides details on the number of staff who have completed mandatory training. In the report for the period January to March 2023, Adult Safeguarding Awareness Level 1 – 92% completed (7% increase from previous quarter).
- Different levels of safeguarding training commensurate with roles and responsibilities have been developed and are being rolled out across the service.
- Information is produced in the quarterly Safeguarding Report and shared at SFRS Safeguard Board and SFRS Prevent and Protect Board.

Trent and Dove Housing

- There is a reflective practice approach used in the supervision of staff involved in safeguarding settings.
- Enhanced reporting of relevant information to the quarterly meeting of Safeguarding Forum.

Healthwatch

- Healthwatch has reviewed the use of its approach to 'Enter and View' with partners to be more effective. Enter and View is now consistent with Making Safeguarding Personal. All staff have a focus on Safeguarding in their work. All safeguarding concerns are raised with relevant parties to ensure good practice.

Theme 2:

The assessment and reviews of mental capacity and Deprivation of Liberties Safeguards (DoLS) are of a good standard and includes the perspective of service users/carers, with appropriately skilled advocacy accessed where appropriate.

Stoke-on-Trent City Council

- The Advocacy contract has been renewed to support adults needing representation. Management information on Deprivation of Liberties Safeguards and safeguarding data is produced monthly. Team Managers and senior social workers meet to scrutinise it and respond to issues arising.
- Audit cycle to check quality of assessments is overseen by quality assurance officer.
- Group supervision is on a bi-monthly cycle to discuss new case law and any relevant cases that may require peer support.
- Work has been commissioned to tackle the backlog of assessments. At the time of this Annual Report working with three separate providers to complete assessments and quality assurance work.

- Options being examined to identify longer term plans to sustainably address the assessment backlog.
- DoLS authoriser training completed via 'Edge Legal' with four more training places on Best Interest.
- Assessor course being offered to current workforce to increase assessment capacity.
- Transitions team in discussions to have a multi-agency approach to assessing capacity where appropriate involving Adults, Children and Health services (at the time of this report going through governance processes).

Staffordshire County Council

- Monthly audits examine how the person's voice is heard and this includes the use of advocacy. It is recognised that this is an area that needs more attention. Strength based training will cover aspects of this.
- In practice it is not easy to distinguish between when independent advocacy has been used or when family members have been involved. This is currently being reviewed by performance and systems teams so that the data can be more easily collected.
- There is a need to develop a specific audit in relation to the application of the Mental Capacity Act that will better capture the use of advocacy. This will be done once the updated statutory guidance which is awaited has been produced.
- Practitioners have been provided with training in relation to advanced mental capacity as well as the overview of mental capacity that has been available previously. These resources are now part of the role related training programme.
- Part of the preparation for CQC assessment has included how adults are supported when they experience transitions/moves between settings. Guidance is being produced and will include the use of advocacy when a person lacks capacity.

MPFT

- MPFT has worked with the Trust's Mental Health Law Team to produce learning materials and prompts to help practitioners to adhere to the requirements of the Mental Capacity Act.
- Completed a safeguarding confidence and competency survey across the Trust with responses from over 700 practitioners.
- Plan is to include Mental Capacity Act considerations in the next Trust wide safeguarding survey of staff.

SFRS

- SFRS was a partner in the Fireside Study Project lead by Keele University resulting in the production of a paper: Optimising Fire and Rescue Service "Safe & Well" visits to support detection and signposting for mental health problems in older adults. This report was submitted to the National Institute for Health and Care Research.

- Further project work is to be carried out to develop this area further primarily researching if, by providing more training in this area, it will help staff to recognise the signs of early mental health concerns and equip the staff with the knowledge and understanding of how to access help and advice.

- As partnership working continues to expand, there is further work required regarding signposting to relevant partners regarding Mental Capacity and DoLS. It is expected that awareness will be raised through the work of the Fireside Project and the wider work in this area that is being conducted by the National Fire Chiefs Council.

Healthwatch

- Staff are being trained around DoLS to be actively looking out for patients and resident feedback on their experiences.

Theme 3:

Safeguarding partners commit to improve our response to self-neglect, including that we will explore what experiences led, and sustain, a person to live in this way rather than judge self-neglect and substance use to be a lifestyle choice and we will consider wider social, physical and mental health factors rather than over rely on substance use to explain a person's circumstances. We will recognise the impact of trauma, substance use, and the coercive and controlling effects of addiction, on a person's mental capacity to make decisions about their self-neglect and substance use.

Stoke-on-Trent County Council

- Changing Futures and Public Health have co-commissioned the enhancement of the services of the Multiple Disadvantage Team which is delivered by North Staffordshire Combined Healthcare Trust. The aim is to understand and address underlying trauma, whilst individuals may still be in active substance addiction. The approach of the service is to be flexible with outcomes that evidence the impact of addressing co-occurring needs.

- The Changing Futures programme is currently funded until 2025.

- Attendance at Trauma Informed training and Safeguarding training is mandatory for all social care practitioners who are engaged with making assessments. The training input is co-produced with Insight Academy and people with lived experiences.

- Safeguarding audits where self-neglect has been identified are scrutinised. Examples of trauma informed approaches being used in practice have been found in case file audits.

- Making Safeguarding Personal feedback arrangements are being developed to add value and understanding of people with lived experience.

- People with lived experience are increasingly engaged to inform commissioning strategies. Current engagement includes Learning Disability and Autism Panel and Direct Payments.

- Principal Social Worker, Adult Social Care practitioners and Expert Citizens are actively engaged in the Multi Agency Resolution Group where the circumstances of adults with multiple needs are examined with the aim of improving outcomes.

- Research into a practice model for self-neglect is being conducted from an academic and practitioner perspective in partnership with Keele University.

Staffordshire County Council

- The Integrated Co-Occurring Needs (ICON) and Bullseye projects are in place. The projects are a multi-agency approach currently involving Public Health, Commissioners, Midlands Partnership Foundation Trust and Humankind/STARS. There is an ongoing expansion of the projects to include Adult Social Care and Housing. The aim and approach is to provide: one team for people with drug/alcohol and mental health needs; preventing 'bounce' between services and long waits for trauma therapy; focusing on the client not their 'conditions' in isolation supported by psychologists and overcoming significant data-sharing and governance hurdles.
- The ICON and Bullseye projects have been independently reviewed with a positive endorsement of the approaches.
- Training in Trauma Informed Practice has been introduced and provided to practitioners conducting assessments. More training is to be provided in Autumn 2023.
- Training to respond to and help adults in situations of self-neglect has been provided as well as forums to support staff.
- It is recognised that there is a need to review the self-neglect pathways from a multi-agency perspective and arrangements are being made for this be done.

MPFT

- Safeguarding practitioners recognise the challenges when dealing with adults who self-neglect. A self-neglect tool kit is being produced to provide staff with practical support.
- Ambition is to recruit a self-neglect navigator who can support staff with complex cases and ensure that multi agency actions are overseen and completed.
- Training in Trauma Informed Practice is available for staff. This is not currently mandatory training.
- An audit into the practical application of the Mental Capacity Act has been undertaken. It had not been published at the time of this Annual Report.

Integrated Care Board (ICB)

- All ICB safeguarding staff completed the training arising from learning from 'Andrew' SAR.
- There is a plan to work on shared understanding of risk across partner agencies especially in relation to self-neglect.
- Work is underway on the Safeguarding Collaborative approach across the health system.
- Further work to done across the health system and with SSASPB partners to review the self-neglect pathway.

SFRS

- Improved the Olive Branch offer, making it more accessible, and users can do the training at a time that suits them. Olive Branch Training is aimed at people who visit vulnerable members of communities in their own homes within Staffordshire. It helps them to identify potential fire hazards, including self-neglect (hoarding) and other risks in the home. It will also advise how to refer vulnerable people for a Safe and Well Visit.

- The number of referrals that are made regarding self-neglect are recorded and examined to identify the outcomes arising from the referral. The number of referrals received from partners following Olive Branch training are also recorded to identify outcomes.

- SFRS Prevent Teams attend relevant meetings to discuss concerns raised by partners and our teams as required.

- Learning events are regularly shared with relevant staff who are encouraged to attend to help to enhance understanding.

Healthwatch

- Working with commissioners around Drug and Alcohol contract designs to reflect the impact these are having on the users of the services. Constructive feedback provided that, from experience of users of services perspective, drug services need to be more person centred and not so data driven.

Case Study 1: North Staffordshire Combined Healthcare NHS Trust

A female patient 'Sarah' (name anonymised) was referred to North Staffordshire Combined Healthcare NHS Trust following repeated attendances at University Hospital of North Midlands Accident and Emergency Department related to alcohol misuse.

Sarah has been known to misuse alcohol since she was a child and lives with her elderly mother who also has care and support needs. The relationship between Sarah and her mother appears to be dysfunctional. Staff at the University Hospital of North Midlands experienced difficulties when trying to follow up the Sarah's non-attendance at outpatient appointments. Sarah's mother would inform staff that her daughter did not need services and that she did not need any follow-up care. It appeared that the mother was preventing her daughter from accessing services.

There were concerns for both the mother and daughter as they both had their own vulnerabilities and they lived at home together. North Staffordshire Combined Healthcare NHS Trust High Volume Users Team made a referral to the Olive Branch due to the risks presented around alcohol and smoking. Arising from a professionals meeting Sarah was referred to the Community Mental Health Team within North Staffordshire Combined Healthcare NHS Trust (NSCHT).

As there was a high risk for both women, who both appeared to be avoiding or unable to access support, further meetings of professionals were arranged by the High Volume Users Team to engage Staffordshire Police, University Hospital of North Midlands and NSCHT Safeguarding

Team to establish what additional help could be offered. A social worker was allocated to the case and a joint visit of partner agencies arranged.

This is an illustration of effective multi-agency working. Meetings were arranged quickly, with appropriate information sharing, safeguarding referrals and risk mitigation with all relevant agencies involved.

Case Study 2: Stoke-on-Trent City Council Adult Social Care

'Ken' is a 56-year-old white British man. He has had a variety of physical health issues and suspected cognitive impairment.

Ken was self-neglecting. He was not looking after his personal care; not meeting his nutritional needs; not taking prescribed medications; not maintaining his home environment and was experiencing significant deterioration in his physical and mental health. Adult Social Care was contacted arising from concerns that he was being subjected to physical and financial abuse, was alcohol dependent and was 'rough sleeping'.

Continuous communications between the Rough Sleepers Team and Adult Social Care resulted, after several attempts, a meeting between all relevant agencies which was the start of Ken receiving the support that he needed.

A Section 42 Safeguarding Enquiry was commenced in response to concerns for self-neglect. There were difficulties in engaging with Ken and his living environment was not conducive to completing an accurate assessment of need. A series of Multi-Disciplinary Team Meetings were convened to involve the relevant services including Housing, Health Services, Occupational Therapy, Memory Clinic, Police, Drug and Alcohol Services, Changing Futures and support workers through charities including Reaching North Staffordshire.

Ken's circumstances presented challenges to the safeguarding partners particularly in relation to the differences in value bases between professionals. Service gaps were also a challenge - the most notable of these between housing and the limited services that are willing to work with adults who are actively misusing alcohol.

The processes included completing mental capacity assessments, risk assessments and regular reviews of Ken's needs. A key aspect was managing the co-ordination of relevant services to address each specific area of need. These included completing health checks, supporting Ken to make, remember and attend appointments. Supported living was eventually sourced and implemented with an appropriate care package that promoted Ken's independence and sustains his safety. Police supported Ken to examine previous incidents of abuse through the appropriate channels. The Community Drugs and Alcohol Service (CDAS) completed ongoing work around Ken's misuse of alcohol and the trauma-based factors underlying this.

Six months after the referral to Adult Social Care Ken has stability in his life. He is thriving in supported accommodation; engaging well with support services for his mental health and alcohol dependence; receiving proportionate daily support; building social networks; establishing new relationships and is no longer self-neglecting.

Case Study 3: Staffordshire County Council, Adult Safeguarding Enquiry Team (ASET)

"Violet" is an 82 years old woman with a number of physical health needs. She lives in her own home with a care package in place. Violet is known to use alcohol to excess which resulted in recurrent falls.

Several safeguarding concerns about the risk of self-neglect were raised by Violet's domiciliary care provider and social worker. It was noted that Violet was choosing not to engage with the recommendations from professionals and it was considered that Violet was at high risk of harm due to self-neglect. It was agreed that a Multi-Agency Planning Meeting (MAPM) would be convened under the self-neglect protocol and chaired by one of the Practice Leads from the Adult Safeguarding Enquiry Team (ASET).

A MAPM was arranged with all involved agencies which included Violet's Social Worker, District Nursing Team, GP, Domiciliary Care Provider, Day Care Provider and the Fire and Rescue Service. Although Alcohol Services were not involved at the start of the process, and Violet had initially declined their support, it was recognised that their involvement was required in terms of sharing knowledge and they were invited to meetings. The meetings enabled consideration of the measures that could be put in place to reduce the risks.

Violet had clearly identified that she wanted to remain in her own home, but it was noted that her family felt that she would be safer in a residential setting. Given the differences of opinion it was agreed that a referral to advocacy services would be made to help Violet express her views and wishes throughout the process. Violet attended safeguarding meetings supported by her advocate.

A safeguarding plan was developed with input from all involved agencies and agreed by Violet. Following a hospital admission Violet returned to her home address with a new package of care in place. Violet continued to attend the day centre which she appeared to gain significant benefit from. Violet had also agreed to measures to reduce the risk of falls at home such as an additional handrail on her stairs and the removal of a rug identified as a trip hazard. Violet had also agreed to the gas cooker being disconnected and had purchased an electric hob.

Violet was involved with her needs and wishes being heard throughout this process. It was recognised that it would not be possible to remove all risks, but professionals were able to work with each other and Violet to reduce the risks. Violet was able to remain living in her own home in accordance with her wishes. At the time of writing the safeguarding plan remained in place and was being monitored by the local area team.

Theme 4:

There is awareness and understanding that there can be an increased risks in relation to safeguarding when a person moves between services, such as when a person is discharged from hospital to their home or other community settings

Stoke-on-Trent County Council

- Adults with Multiple Disadvantages are identified and provided with case co-ordination, aware that many self-neglect, with an approach to enable services to identify gaps and work effectively. Weekly Multiple Disadvantages Team meetings to review progress and address service barriers, so individuals do not 'slip through the net'.

- Social Care staff are based at the Acute Hospital to support discharge planning. Daily calls are undertaken with all partners across the system to facilitate safe planning. If required, a personal budget may be provided for quick solutions to mitigate risks following hospital discharge.
- Homeless Healthcare Service in the community enables treatment to continue post discharge (co- commissioned by Changing Futures and Housing Department in LA).
- Feedback from young people transitioning to adulthood and their carers/advocates is that transitioning requires further attention and resourcing capacity.

Staffordshire County Council

- Pathways have been reviewed and there is working towards a 'One Adult Social Care' approach.
- Training to staff around effective recording has been provided with guidance updated. The focus is on ensuring that a person's records are reflective of their current circumstances including where they live, if they are at a temporary address or in hospital.
- There is an ongoing project in relation to Preparation for Adulthood. This is focusing on meeting the needs of young people where multiple agencies are involved to ensure that agencies work better together at an early stage to prepare for the transition from children's services to adult services. It has been recognised that adult safeguarding had not been considered as part of this but is now to be included.
- Guidance to staff in relation to how to approach transitions between services and teams is being reviewed. This includes how people transfer between settings, such as leaving prison or hospital.

Integrated Care Board (ICB)

- The Safeguarding Team has contributed to the pan health digital design group and worked with IT providers to support the visibility of patient information pertinent to safeguarding and risk.
- Collaborative work will continue to promote the value, and use of, the Integrated Care Record (One Health and Care) across Health and Social Care.
- Multi-Disciplinary Team (MDT) risk assessment is completed before complex discharges from hospital/care setting.

MPFT

- One Health and Care record is now available across Staffordshire and Stoke-on-Trent and accessible by all NHS Trust primary care and social care staff. This innovation allows all those who have a legitimate purpose to access the information to have sight of a person's health journey, including discharge from hospital and community support.

UHNM

- The vulnerable patient team has been invited to become a member of the Trust's Patient Experience Group. This will provide a direct source of feedback from patients and carers experiences at the acute trust. Any learning pertaining to safeguarding will be then shared via the Safeguarding Working Group.

- The Head of Patient Experience and the Corporate Governance Team are now members of the Trust's Safeguarding Working Group and the Vulnerable Patient Steering Group. This will enable the team to triangulate information, reviewing themes and trends.

- Work has commenced on developing and implementing a carers strategy which the vulnerable patient team support and cross reference to safeguarding.

- The audit programme will identify good areas of practice and areas of learning in relation to discharge arrangements where there was an identified safeguarding concern.

Healthwatch

- Is involved in Integrated Care Board meetings to ensure processes are being followed with a focus on ensuring that the patient voice is being heard.

- Through attendance at meetings of the Health and Wellbeing Board reported the concerns around delays in hospital discharges and the impact of safeguarding when moving people at a later stage than is beneficial to the person which is leading on occasions to a greater need for care.

SFRS

- Arrangements have been agreed with the Hospital Discharge Teams throughout Stoke-on-Trent and Staffordshire to ensure there is a robust pathway in place for clinicians to sign post for a Home Fire Safety Visit for patients that pose a fire risk. This is on-going work and will be shared with the relevant Prevent Leads.

Trent & Dove Housing

- Person centred risk assessment is an operational focus for new applicants for social housing and where existing customers with an identified need wish to move to alternative accommodation.

Theme 5:

That amongst connected partners professionals and leaders are alert to the sources of risk of abuse and neglect for adults with care and support need in communities and residential settings particularly the hidden voices and people 'falling between the eligibility gaps'.

Stoke-on-Trent County Council

- Changing Futures programme provides a prevention strategy and practical support to people with multiple disadvantages.

- There are 15 Community Lounges in Stoke-on-Trent that provide a 'Front Door' to offer early help to prevent further need. These facilities are well used.

- Two new posts for Locality Connectors are at the recruitment stage. One of these is for hospital discharge planning based in Accident and Emergency and the other is to meet need for Ukraine/Asylum seekers working across the City at Community Lounges.

- Insight Academy is providing training on Care Act, Safeguarding and Trauma Informed Care.

- Case Managers provide bespoke support to social care staff. Multi-Disciplinary Team meetings are convened to provide bespoke solutions to prevent escalation to full care package requirements.
- Work is ongoing to upskill the workforce to professionally challenge and respond when people are deemed to be 'falling through the gap'.
- Social Worker in post to work with people on the Homes4Ukraine Scheme and other people seeking Asylum in Stoke-on-Trent.

Staffordshire County Council

- The developing work of the Multi Agency Risk Collaboration group will seek to address those who currently fall between the gaps of support services. There is a working group examining how to work differently and more effectively with people with multiple needs and complex personal circumstances. This work is still in its early stages but over the next 12 months will make progress.
- There is improved support from an administrative perspective in relation to our approach to People in Position of Trust risk so that we can monitor individuals and risk assess. This approach is being reviewed to seek further improvements.

MPFT

- The term professional curiosity has been used in relation to safeguarding for some time, however, the meaning and purpose of it does not seem generally to be well understood. MPFT safeguarding service has developed guidance on professional curiosity and this is included in staff briefings and forms part of the safeguarding supervision offer. Encouraging staff to think beyond the care and treatment being offered provides an opportunity to intervene and prevent adults at risk from falling between the gaps of service eligibility.

Integrated Care Board (ICB)

- The Safeguarding Team continuously monitor to ensure statutory reviews are completed.
- Plan to work on shared understanding of risk across partner agencies especially in relation to self- neglect.
- Multi-Disciplinary Team (MDT) risk assessment is completed before complex discharges from hospital/care setting.

Healthwatch

- Working more closely with Adult Social Care and ICB to discuss eligibility gaps and to ensure the voices of those who would otherwise be missed is being heard at all levels.

SFRS

- Through its activities within communities SFRS staff fulfil a valuable role as the 'eyes and ears' in identifying neglect and abuse. The Service has developed many single referral pathways with partners across the Stoke-on-Trent and Staffordshire.
- The SFRS safeguarding report provides a record of actions and outcomes. Referrals into Mental Health services is an area for further development and improvement.

Staffordshire Humankind

- Using links with the safeguarding board to identify shared learning and disseminate this learning across our Staffordshire services.
- We will ensure that all staff are trained to recognise and respond to abuse and will support this by developing safeguarding champions who will lead on a rolling programme of training which includes identifying risk factors for self-neglect and financial abuse.
- We will roll out a new programme to upskill staff to work in a trauma informed way from first point of contact.

Trent & Dove Housing

- Has completed a review of its approach to safeguarding and introduced a safeguarding forum that meets quarterly. From this an assurance statement is provided to Executive Management Team.
- Safeguarding is a mandatory training requirement for all staff.
- Safeguarding referenced in Strategic Risk Register.

VAST/Support Staffordshire

- Has disseminated safeguarding information through bulletins, social media and website in line with the pledge made by Support Staffordshire.
- Has supported its members by providing awareness events:

    - 4 Adult Safeguarding awareness training courses attended by 37 VCSE organisations.
    - 3 Bitesize Supportive Communities training sessions attended by 29 community-based staff/volunteers.
    - 1 - 1 information, advice and guidance on Adult Safeguarding policy and practice to 15 VCSE organisations.

Case Study 4: North Staffordshire Combined Healthcare NHS Trust

This case concerns 'Matthew' (name anonymised) a male who was referred to North Staffordshire Combined Healthcare NHS Trust Early Intervention Team with first episode psychosis. The approach of the team was to engage with and treat Matthew using the least restrictive approach in the community.

At the beginning Matthew was engaging well and his partner was fully involved and supportive. Over time Matthew developed and expressed fixed beliefs about his partner and he made persistent accusations about her which were unfounded. The couple separated and Matthew left the family home, but he continued to contact his ex-partner which became distressing. His ex-partner reported the matter to the Police.

Police concluded Matthew's illness was the reason behind his persistent harassment of his ex-partner. The ex-partner had contacted a range of services for advice and support and had been told by each organisation there was nothing that any of them could offer to help her. The situation was getting worse and risks to her were increasing.

The Early Intervention Team concluded that the risks to the ex-partner could not be ignored. Mental illness could not be an excuse for Matthew's behaviour. The Early Intervention Team escalated their concerns and contacted North Staffordshire Combined Healthcare NHS Trust Safeguarding Team for advice.

The Safeguarding Team arranged a meeting with the Stalking and Harassment Lead Officer for Staffordshire Police and the case was reviewed. Arising from the review Police confirmed that the case did meet the threshold for a Stalking Protection Order and the appropriate steps were taken to safeguard the ex-partner.

This case highlights the importance of escalation and professional challenge particularly in situations when people are adjudged not to meet the threshold for support services.

Case Study 5: Stoke-on-Trent City Council Adult Social Care

'Isaac' is a black man of Afro Caribbean heritage aged around 60 years. Adult Social Care was contacted by Isaac's tenancy support officer due to concerns about his deteriorating personal health and the increasing risks of physical, psychological and financial abuse that he was experiencing from 'cuckooing' at his home.

A Changing Futures worker and the local Police Community Support Officer (PCSO) would visit daily due to the significant risks identified with the aim of dispersing the people who were cuckooing Isaacs property. A deep clean was completed at his home but within a week it was back to the condition it was before the clean. At that time Isaac wanted to remain at his home to decorate and to make it a safe and nice environment to live but his living situation deteriorated and the risks to him escalated. A Section 42 safeguarding enquiry was subsequently commenced.

Changing Futures worked closely with the Police and the Local Authority Anti-Social Behaviour Officer. A warning marker was put on Isaac's home address, ensuring that in the event of any calls to the Police relating to him or his property a Police Officer would attend as a matter of urgency.

One day Isaac was assaulted whilst walking in the street near his home. Arising from this Isaac agreed that he was no longer safe and he wished to move home. However, none of the housing providers locally would rehouse Isaac. This was due to his previous criminal convictions and his reputation. All involved in offering support considered that he was being unjustly disadvantaged and this became a major difficulty.

Arising from the persistent approach of the Changing Futures team, the consistent approach of the local PCSO and a housing provider being prepared to give Isaac a chance where no one else would he moved into a supported tenancy.

The safeguarding risks to Isaac have been significantly reduced. He has maintained contact with his support team. He is happy, able to communicate effectively with his key worker and feels safe, eating regular meals and has plans to pursue his hobbies which include art and music. He now has access to benefits, he is registered with a GP, is engaging with Community Drug and Alcohol Service (CDAS) and attending appointments and his drug use has significantly reduced.

Case Study 6: Stoke-on-Trent Adult Social Care

Steven is a 35-year-old white British man living in council tenancy.

Adult Social Care was contacted due to concerns about significant self-neglect and substance misuse accompanied by Schizophrenia. His associates were financially and emotionally exploiting him, selling him substances at inflated rates, threatening violence to intimidate him and cuckooing his flat.

Following a Care Act Assessment, a Section 42 safeguarding process engaged agencies in developing a safeguarding strategy. Many attempts were made through multi-agency approached to support and engage Steven including providing regular food parcels, contacting utility providers as his services had been disconnected, frequent visits from Police Community Support Officers, support from the Community Mental Health Team and Housing Officers to alleviate the risks he was known to be subjected to. Steven did not sustain his engagement with services which diluted the impact of the support offered. During this time Steven had to move out of his home.

However, the allocated Changing Futures worker was able to offer the consistency of contact and approach that is the unique added value of Changing Futures workers. Through the repeat visits, perseverance and dedication of the Changing Futures worker, Steven began to engage.

Changing Futures was able to utilise a budget to safeguard Steven in bed and breakfast accommodation until a Social Worker eventually sourced a supported living flat. Steven began to access and sustain community support for his substance misuse addiction and remains substance free. He has been provided with new clothes and has regular meals. His relationships with his family have healed.

The willingness to 'go the extra mile' in multi-agency working coupled with Changing Futures working intensively beyond the usual challenging time constraints of Social Workers has helped Steven to work to his potential and shine. He is engaged with Expert Citizens and developing a peer mentor role for himself and currently working towards becoming a volunteer as a peer member with lived experience.

Strategic Priority 2: Engagement

Lead: Helen Jones, SSASPB Business Manager

The activity around this priority is managed and co-ordinated by the Prevention and Engagement sub- group which meets bi-monthly and is chaired by Laura Collins (North Staffordshire Combined Healthcare Trust). This is a sub-group with a broad membership and attended by partners with a good knowledge and insight into operational practice.

For the purposes of the work of the Board during 2022/23 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

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

- Hosted 3 events for the Independent Reviewer of the Safeguarding Adult Review of 'Andrew' to present the findings and learning. The three events were attended by 336 practitioners.

- Hosted a Trauma Informed Practice learning event in support of the findings of SAR 'Andrew' attended by 169 practitioners.

- Hosted Practitioner Forum events to discuss topics arising from audit findings, SARs, or at the request of practitioners. Topics have included cuckooing; hoarding; self-neglect; Advocacy in Adult Safeguarding and Mental Capacity.

- Supported the Ann Craft Trust National Safeguarding Adults Week in November 2023.

- Hosted a learning event covering Adult Safeguarding Awareness pitched at practitioners including District and Borough councils and housing groups for whom adult safeguarding is part of their work but not a full-time element.

- Supported the inclusion of Advocacy services and Drug and Alcohol Services to the SSASPB membership in recognition of the findings from SARs locally and nationally.

- Produced the autumn newsletter which was distributed widely. Topics included: contributions in support of the Adult Safeguarding Week; the work of the Board partner Asist who provide advocacy services; how to raise a safeguarding concern; key messages to practitioners from SARs and audits and introduction to new Strategic Priority 'Effective Practice.'

- Enhanced awareness raising of Adult Safeguarding Week by promoting partner organisations to host their own organisational events.

- Provided a variety of online learning events that were attended by a total of 1193 practitioners in 2022/23.

- Commissioned Board partner Rockspur to produce a more accessible version of the 2021/22 Annual Report. This was produced by adults with autism or a learning disability. It is the second to be produced and reflects the positive feedback from the report produced for 2020/21.

- Facilitated the gathering of information for a refresh of the SSASPB website that is accessed on a monthly average of more than 3,000 occasions.

- Produced a power point presentation for partner organisations to use on the subject of 'Learning Lessons from SARs'. The presentation highlights the recurring themes and encourages effective practice.

- The Board has decided to continue with Engagement as a Strategic Priority for 2023/25 and will continue to focus on how to better engage with care and support needs who have experienced abuse or neglect.

6. Staffordshire and Stoke-on-Trent 2022/23 Performance Report Overview

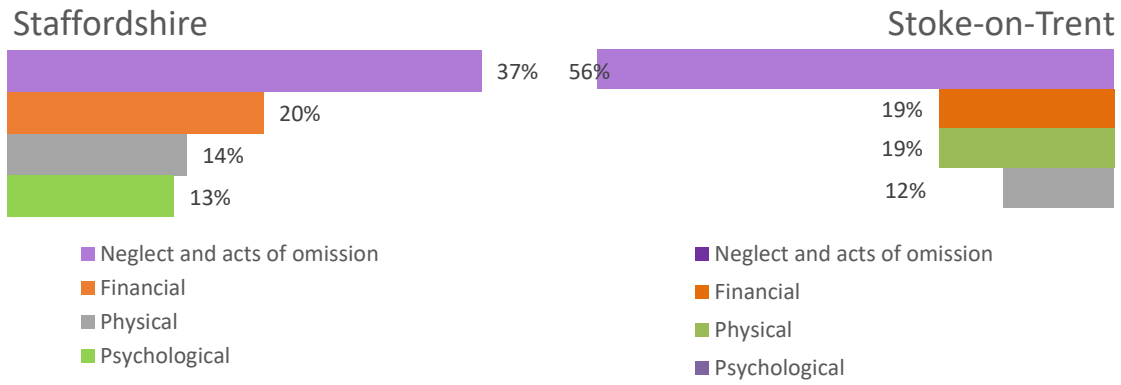
Number of safeguarding concerns received by the

15,680	5,226
Staffordshire	Stoke-on-Trent

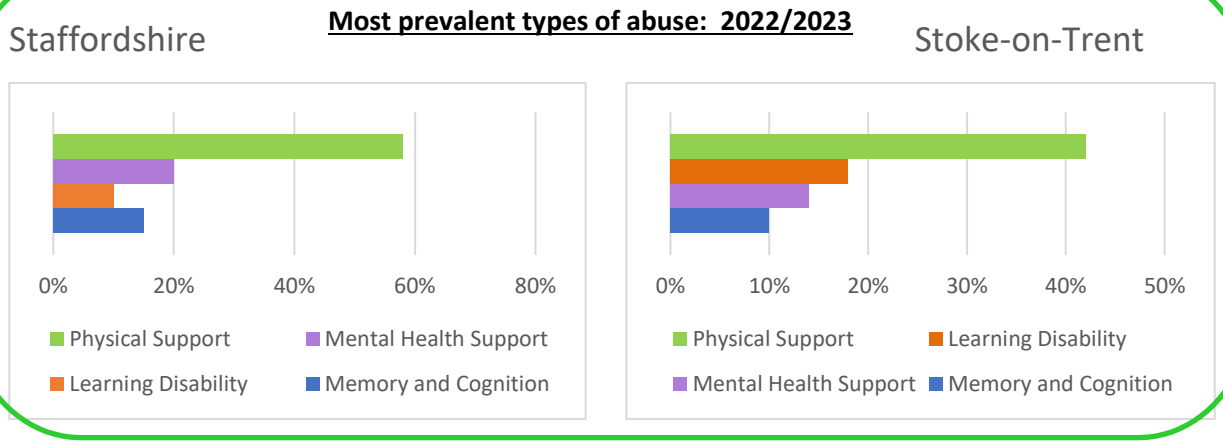
Staffordshire	Stoke-on-Trent
57%	42%

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

Most prevalent primary care and support need for the adult



Most prevalent types of abuse: 2022/2023



Top 4 Locations of Abuse

	Own Home	Residential Home	Nursing Home	Hospital
Staffordshire	70%	17%	12%	1%
Stoke-on-Trent	37%	22%	15%	4%

7. Analysis of Adult Safeguarding Performance Data

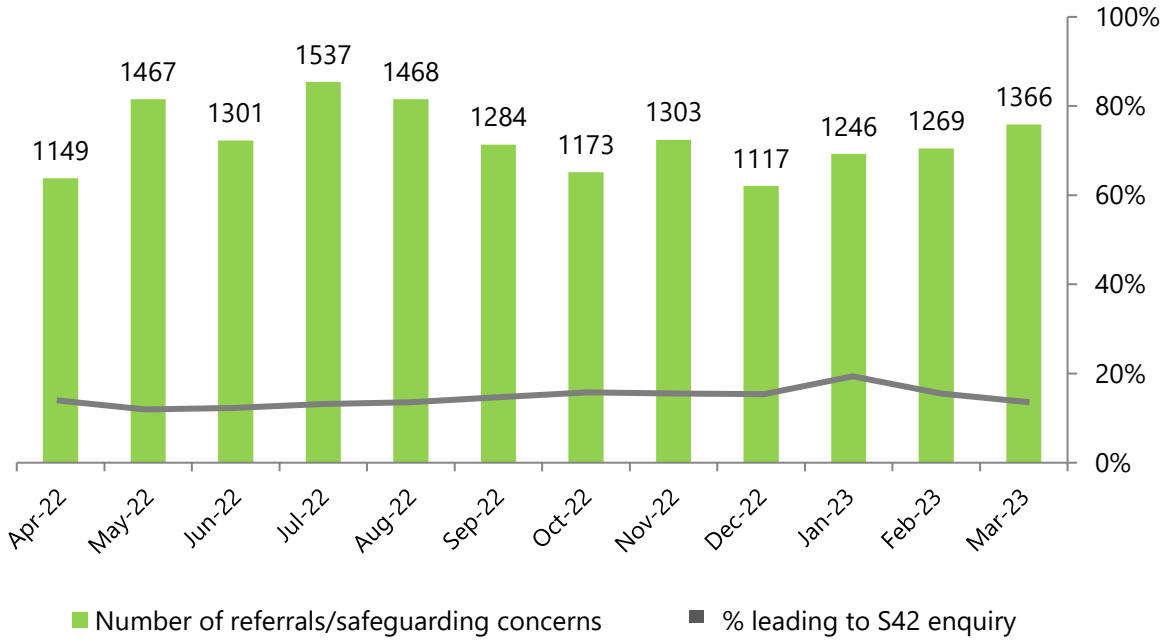
This section provides commentary and analysis of safeguarding data from Stoke-on-Trent and Staffordshire. Please note that in many sections the percentage has been rounded to the nearest whole number and therefore not all percentages will add up to 100%.

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. It should be noted that there is a difference between how both LAs capture and report this data. In cases where a statutory response is not required the SSASPB continues to seek assurances that local arrangements ensure signposting and engagement as necessary with appropriate support services.

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

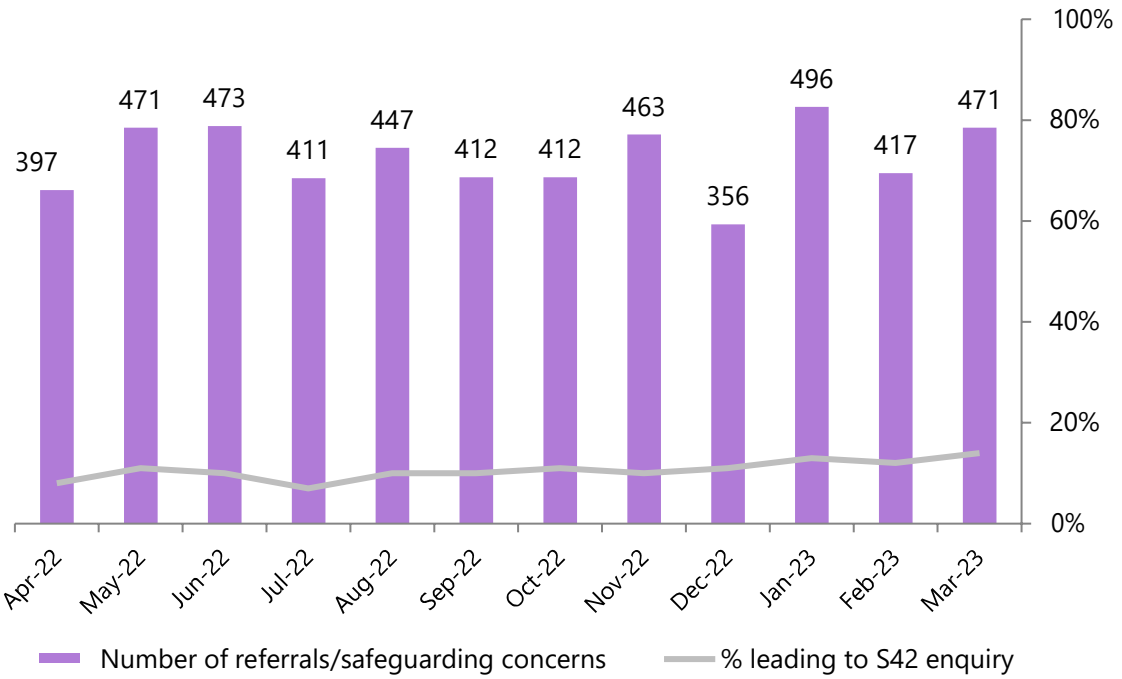


During 2022/23 in Staffordshire there have been 15,680 occasions when concerns have been reported that adults with care and support needs may be at risk of or are experiencing abuse or neglect. The total figure has increased by 2,543 occasions from 13,227 in 2021/22 which is an increase of 19.2%.

This year the duty of enquiry requirement was met in 17% of reported concerns, a decrease of 4% from 2021/22 (21%) reflecting a downward trend, a further 4% fewer than the figure of 25% in 2020/21. The reasons for the percentage decrease in concerns meeting the duty of enquiry threshold have been explored. The number of people who meet the threshold for a Section 42 enquiry is broadly unchanged. It is the increase in the total number of reported concerns that

has contributed to the reducing conversion rate. The information gathered from audits, indicates that the variance could be related to the type of concerns raised, for example, there are a significant number of concerns arising through quality or assessment processes. Audits indicate that there is rarely 'no activity' following the submission of a concern and whilst a formal enquiry may not commence there is a benefit to the person subject of concern. Staffordshire has been examining the reported concerns and is working with referring partners to ensure that thresholds are understood.

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



In Stoke-on-Trent there were 5226 reported safeguarding concerns in relation to adults with care and support needs during 2022/23. This is an increase of 636 (13.8%) from 4590 during 2021/22.

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 Section 42 enquiry or takes an alternative route. 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 11% of occasions when a concern was raised. This is an increase from 9% in 2021/22.

Stoke-on-Trent has been conducting audits to explore the outcomes for adults whose safeguarding concern does not progress to a Section 42 enquiry. This is part of a quality assurance process with the aim to examine decision making and rationale for the actions taken. Referrals made to the local authority are subjected to a scrutiny process to ensure that these meet threshold criteria. The findings of the audits provide assurances that it is rare that no action at all is taken following receipt of a safeguarding concern.

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).

At the request of the SSASPB both local authorities have re-examined their approaches to seek better alignment in recording practices. This review has illustrated that both authorities are following the same procedures to ensure adults are safe and risks minimised and both comply with the recording guidelines. In essence the preferred recording systems is an internal decision for each authority.

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.

Fig. 3 Staffordshire Age Breakdown of the County

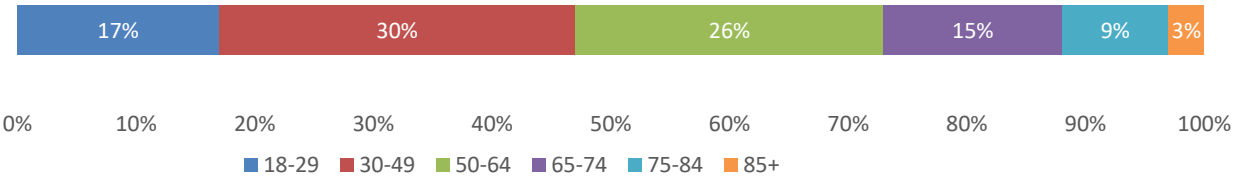
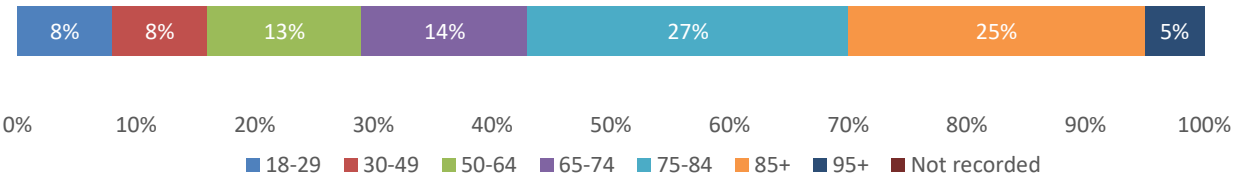


Fig. 4 Staffordshire Age Breakdown (Section 42)



Staffordshire:

Of the adults who have been the subject of a Section 42 enquiry, those aged 75–84 (26.9%) represent the largest cohort followed by 85-94 (25.1%). Last year, 2021/22, these age groups were reversed with 85–94 being the most prevalent at 25.2% compared to 24.9% for 75-84yrs.

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 12% of the adult population in Staffordshire are aged 75 or over, however, 56.8% 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.

Fig. 5 Stoke-on-Trent Age Breakdown (Section 42)

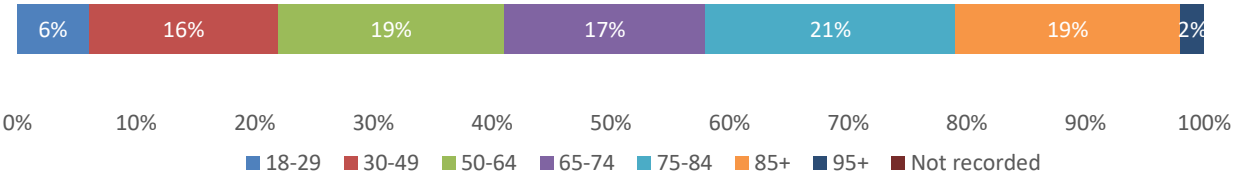
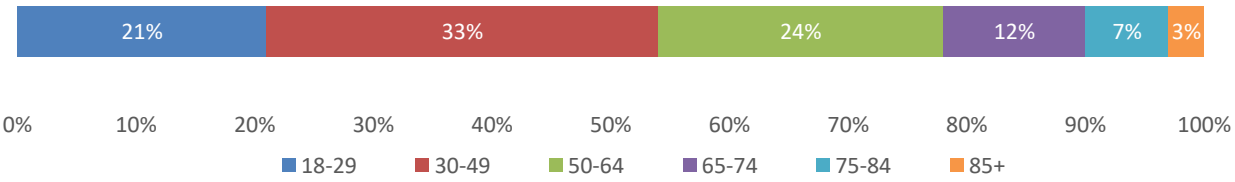


Fig. 6 Stoke-on-Trent Age Breakdown of the City



Stoke-on-Trent:

For Stoke-on-Trent there is a fairly even spread of ages of adults who have been involved in a Section 42 Enquiry. The largest cohort is adults aged 75-84 years (21%) an increase of 1% from last year. The second largest cohorts both represented 19% of Section 42 enquiries. These adults aged 85-94, a reduction of 8% compared to 27% in 2021/22 and adults aged 50-64 years. For the younger cohort this is an increase of 5% from last year. There was a decrease from 27% to 19% for those adults aged 85 to 94. Due to the relatively small number of Section 42 enquiries small changes in numbers can significantly change the percentages.

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, 22% of the population are over 65 but 59% of adults subject of a Section 42 enquiry are in this age category.

Men in Stoke-on-Trent have a life expectancy of 76.5 years and for women 80.2 years. There are again 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.

Gender

Fig. 7 Staffordshire: Gender Breakdown (Section 42)

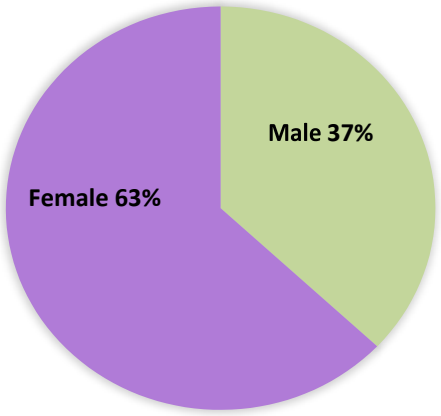
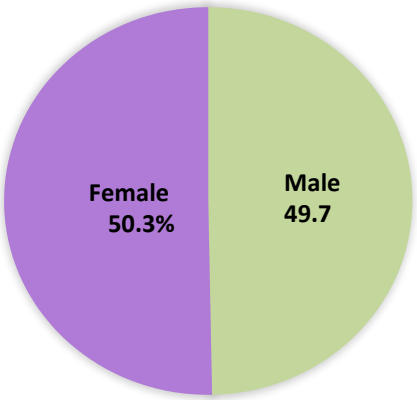


Fig. 8 Staffordshire: Gender Breakdown of the County



Staffordshire:

Females represent the majority of adults subject of a Section 42 enquiry with 63% over the year. This is in very similar proportions to those seen in previous years.

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

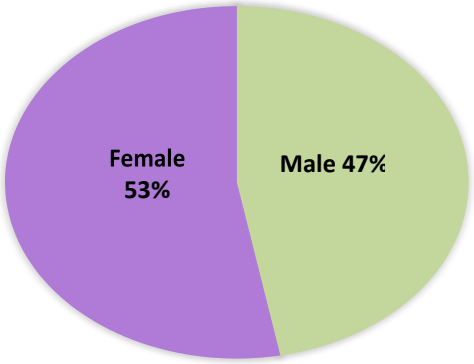
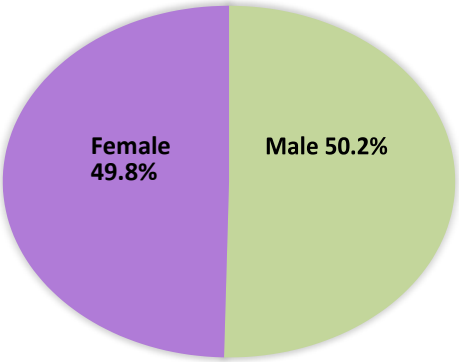


Fig. 10 - Stoke-on-Trent: Gender Breakdown of the City



Stoke-on-Trent:

Stoke-on-Trent has broadly remained the same for the number of males and female who were subject of the Section 42 enquiry process (last year females accounted for 55%). It is of note that women have a higher average life expectancy 3.7 years more than men and as a population is more elderly and accordingly 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 Local Authorities with a request that there is a 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	87.9	78.5	91.9	90.2
Not Recorded	4.5	-	2.2	-
Pakistani	1.9	6.0	0.4	1.3
Any other mixed background	1.6	1.5	0.2	0.0
Black Caribbean	1.0	0.4	0.5	0.3
Not Stated	1.0	-	2.3	-
Other White	0.6	4.5	0.8	2.9
Any other ethnic group	0.6	1.8	0.3	1.4
Any other Asian Background	0.3	1.8	0.4	0.8
Indian	0.3	1.1	0.3	1.1
Mixed White/Caribbean	0.3	0.8	0.2	0.8
Black African	0.0	2.0	0.1	0.4
Bangladeshi	0.0	0.6	0.0	0.1
Any other Black Background	0.0	0.4	0.0	0.1
Arabic	0.0	0.3	0.0	0.1
Gypsy /Roma	0.0	0.3	0.0	0.1
White Irish	0.0	0.2	0.4	0.4

Stoke-on-Trent:

The majority of individuals subject to a Section 42 enquiry are recorded as 'White British' at 87.9%, an increase from 83.1 % last year. There has been an improvement of 'Not Recorded' which has been reduced to 4.5% from 9.8% in 2021/22.

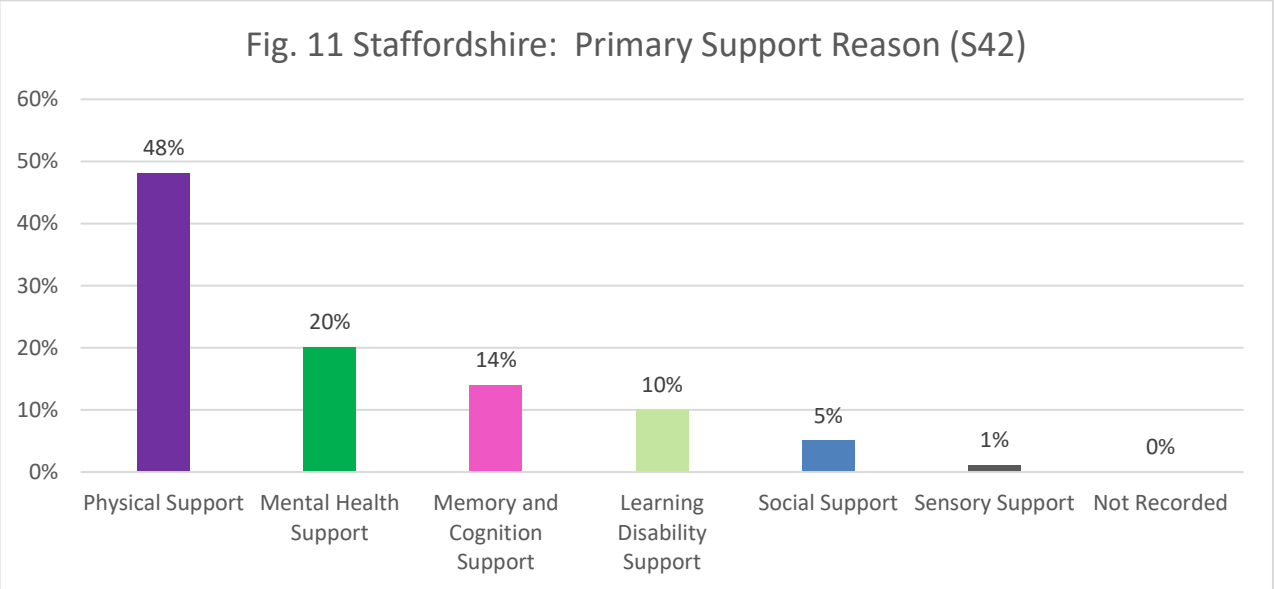
Staffordshire:

The pattern is similar in Staffordshire with the majority of declared ethnicities as 'White British' 91.9%, an increase from 87.8% last year. There has been an improvement of 'Not Recorded' reduced to 2.2% from 6.2% last year.

Note: The Board has promoted the importance of accurate ethnicity recording in 2022/23 through its Practitioner Forums, learning events and Newsletter. This coincides with the more accurate recording reflected in this years' data and the progress is acknowledged.

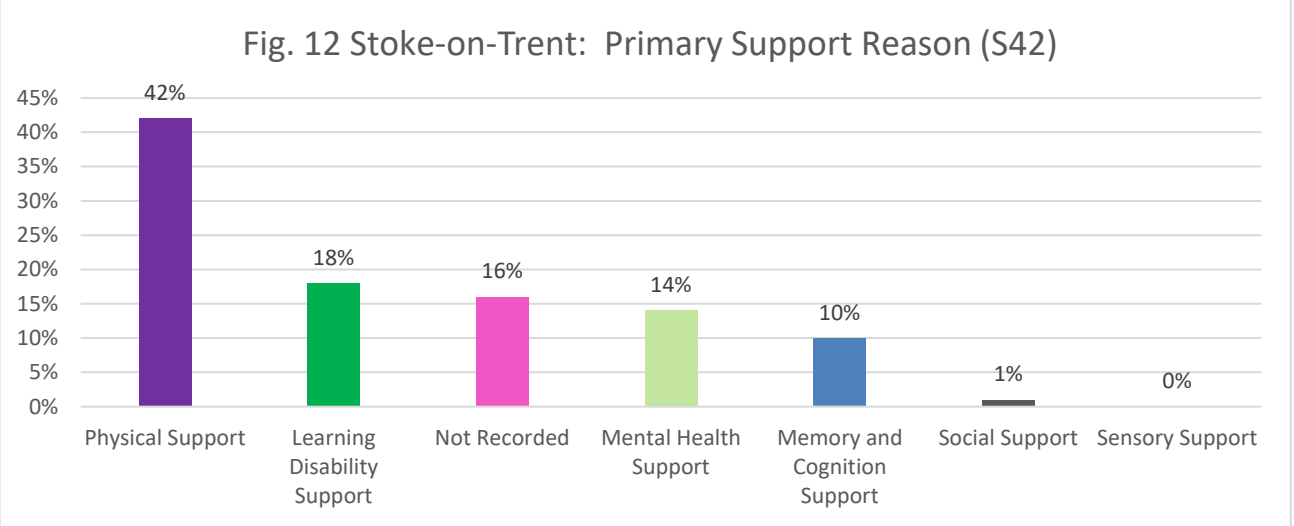
Primary Support Reason

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 2022/23 (48%) exactly the same percentage as reported last year. The second most prevalent primary support reason is Mental Health Support at 20% reflecting a 6% increase on last year. It is to be noted that there has been a significant decrease in the category of 'not recorded', which is down to 0% compared to 17% in 2021/22.



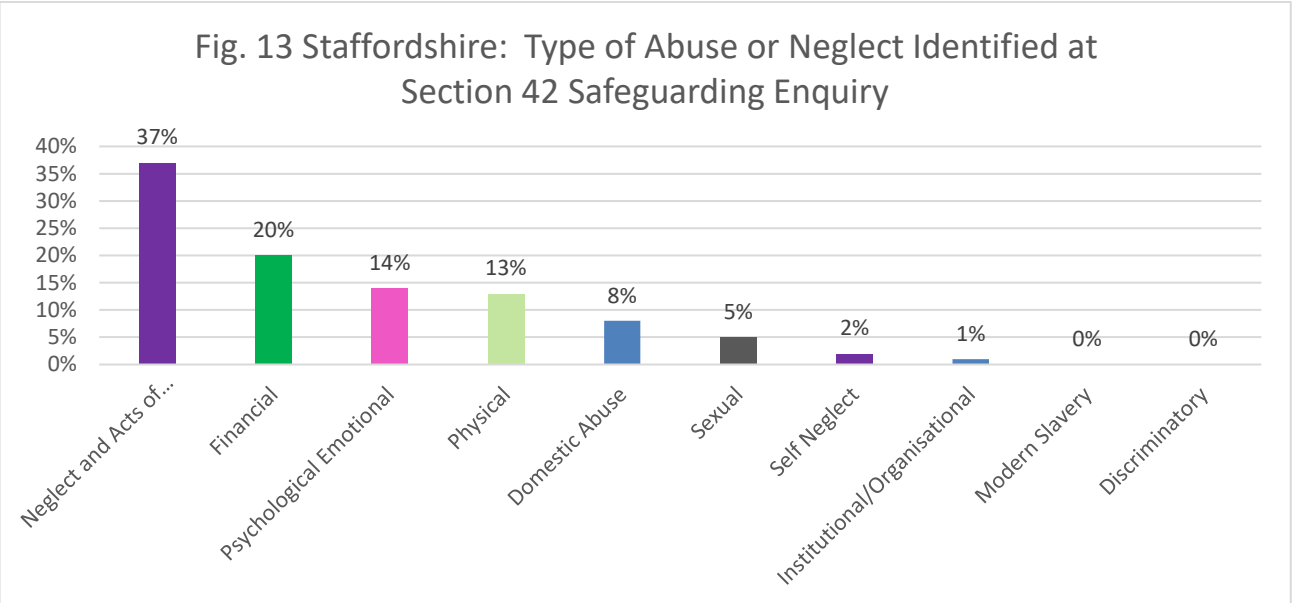
Stoke on Trent:

Physical Support similarly represents the largest proportion of primary support reasons recorded in Stoke-on-Trent at 42%, an increase from 39% last year, followed by learning disability support with 18% which is a reduction from 24% compared to last year.

The 16% shown as not recorded in the chart above is better explained as 'not known at the point of recording' as the adults were not known to Adult Social Care and, at that time, their needs not assessed. There are plans to move the recording of this information to later in the safeguarding process.

Types of Harm or Abuse identified at Section 42 Safeguarding Enquiry

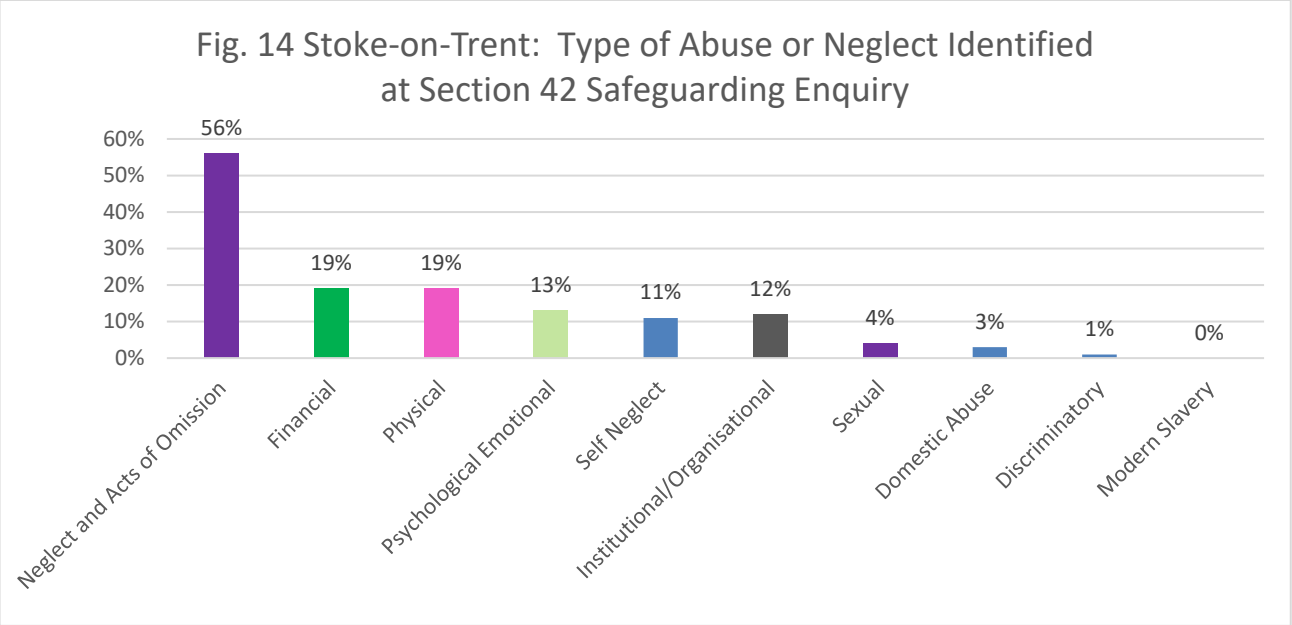
The below information shows the types of abuse and neglect reported in comparative proportions:



Staffordshire:

There are no significant changes to the percentages reported in 2021/22. Neglect and acts of omission continues to be the most prevalent type of abuse at 37% and is the same as the figure reported in 2021/22. Financial abuse remains similar at 20% compared to 19% last year. Physical abuse has reduced to 13% from 17% last year.

It is believed that organisational abuse remains under-reported at 1%. This is believed to be owing to there being only one type of abuse that can be recorded in Staffordshire case management systems and other categories are selected at the point of recording to describe the abuse e.g. physical abuse.



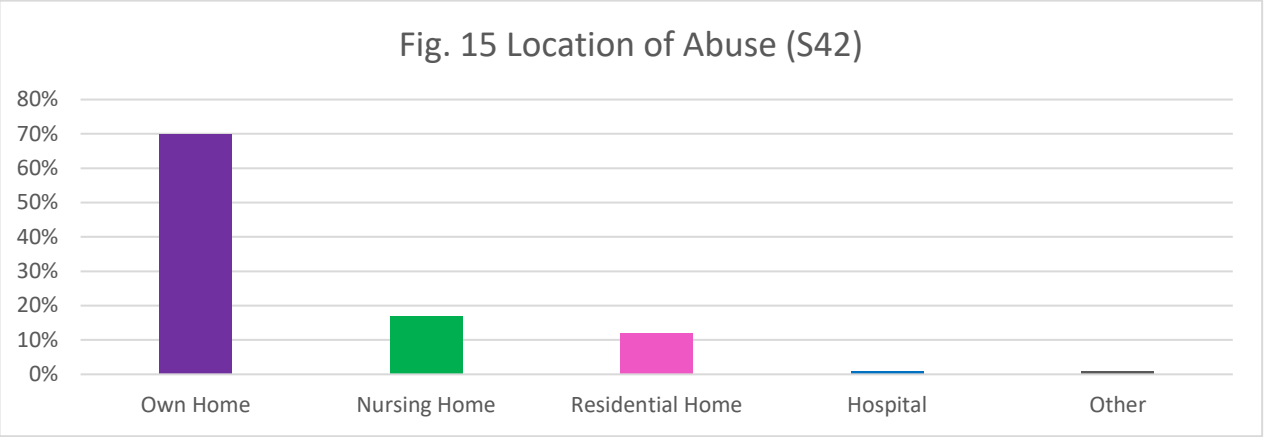
Stoke-on-Trent:

The percentage of neglect and acts of omission cases has decreased to 58% from 61% last year. Financial abuse has increased to 19% from 12% last year. Self-neglect concerns continue to increase to 11% this year. This compares to 7% last year and 2% in 2020/21. It is believed that this may be attributable to the awareness raising of self-neglect as a category of abuse following the well-attended learning events that followed the Safeguarding Adult Review of 'Andrew'. The increase in practitioner recognition of self- neglect should be seen as a positive development.

Organisational abuse, where more than one category of abuse can be recorded, is better reported in Stoke-on-Trent than Staffordshire where the recording arrangements are different.

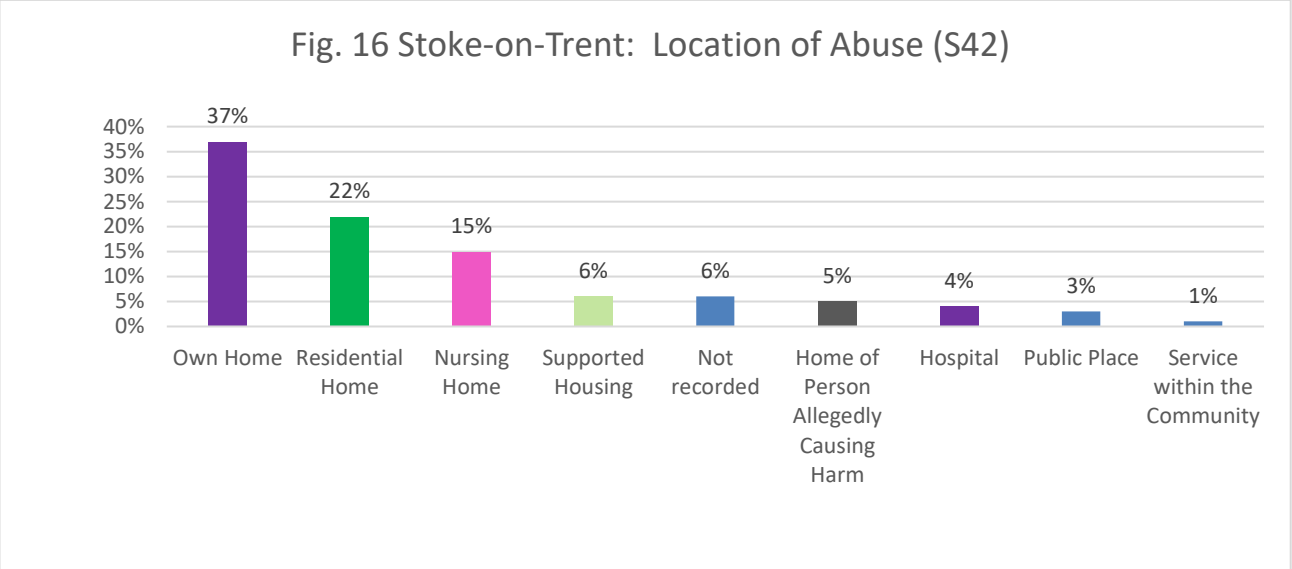
It should be noted that there can be relatively small numbers of adults in types of abuse which can cause a percentage change to appear more pronounced. In Stoke-on-Trent more than one type of abuse may be reported for a single case, as illustrated above in relation to organisational abuse. The total cases therefore total 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 (70%) compared to 62% in 2021/22. The next most common locations in Staffordshire were Independent nursing home at 17% a slight increase from 16% last year and residential home at 12%, an increase from 11% last year.



Stoke-on-Trent:

The most prevalent location of abuse in Stoke-on-Trent is in the person's own home 37% an increase from 26% the previous year. This was followed by 22% in an independent residential home and 15% nursing home. Stoke-on-Trent's recording system allows for a broad type of location, for example, public place, supported housing etc.

Through audit it has been identified that some practitioners record a care home as a person's own home. Work continues to improve consistency in recording standards. For this report "own home" also includes the categories of supported accommodation whilst hospital also includes those locations recorded as mental health inpatient setting or community hospital that are recorded separately on the Stoke-on-Trent local authority recording system.

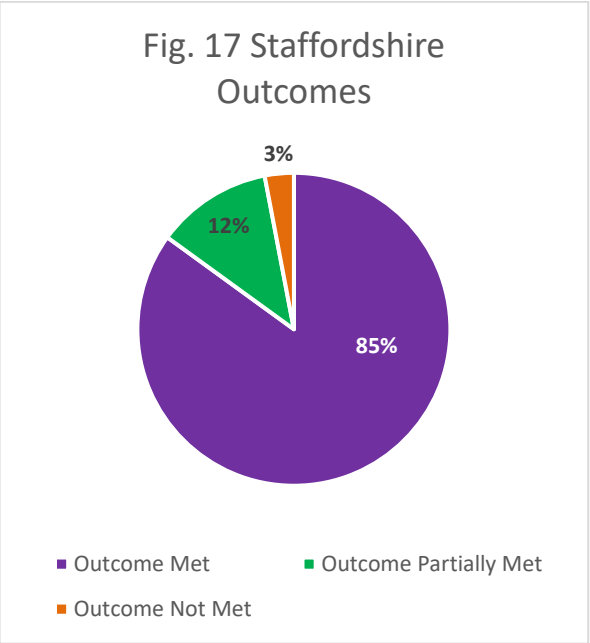
Findings of Concern Enquiries

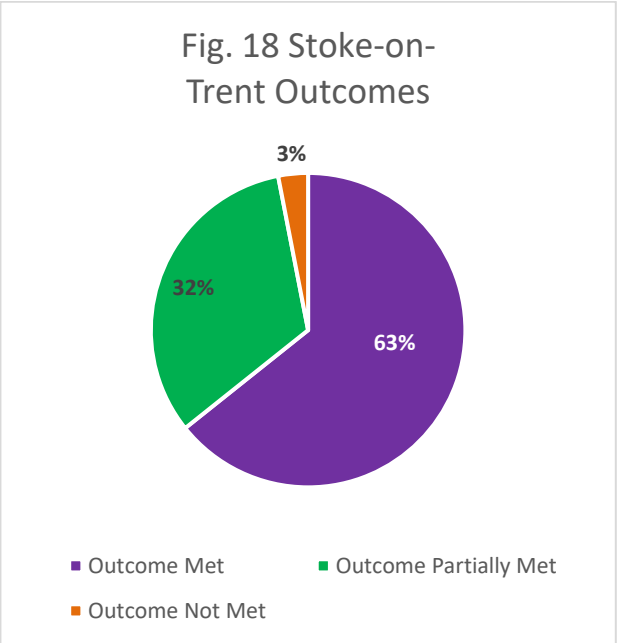
The following section provides an overview of the findings of Section 42 enquires showing what is happening to referrals with a comparison to previous years.

Staffordshire**:** 17% of adults involved in a Section 42 Enquiry had previously been involved in an enquiry in the past 12 months. This compares to 19% in the previous year.

Stoke-on-Trent: 11% of adults involved in a Section 42 Enquiry had previously been involved in an enquiry in the past 12 months. This is an increase compared to 4% last year.

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





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 whether 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 the same figure as reported 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 54% of adults subject of a Section 42 enquiry provided a response, an increase from 44% in 2021/22. 95% of these stated that desired outcomes were fully met or partially met. This is a slight decrease from 96% last year.

There is a continuous focus on accurate data capture of adults expressed desired outcomes and whether these have been met. Quality assurance audits explore the relevance and accuracy of information recorded within the Section 42 enquiries focusing on whether the outcomes identified by adults adhere to the principles of Making Safeguarding Personal.

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 remit includes proactive visits to care homes that may be on the verge of going into Large Scale Enquiry (LSE), proactive investigations on behalf of the Coroner and problem solving at repeat locations.

Whilst many 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 team has wider links to safeguarding partners, the Care Quality Commission (CQC) and Her Majesty's Coroner.

The table overleaf lists the types of incidents the Team has investigated (1 April 2022 to 31 March 2023).

Offence Type	
Non Crime or Blank	44
Care worker ill-treat/willfully neglect an individual	25
Assault occasioning actual bodily harm	30
Common assault and battery	15
Theft if not classified elsewhere	12
Rape of a female aged 16 or over	10
Sexual assault on a female 13 and over	10
Care provider breach duty of care resulting in ill treatment/neglect of individual	11
Action Fraud	5
Sexual assault on a male 13 and over	4
Sending letters etc. with intent to cause distress or anxiety	3
Theft in a dwelling other than from automatic machine or meter	3
Temporary Code – Third party report – waiting for victim confirmation	2
Wounding with intent to do grievous bodily harm	2
Engage in controlling/coercive behavior in an intimate/family relationship	2
Assault on a female 13 and over by penetration	2
Other criminal damage to other residential building £500 - £5000	2
Malicious Wounding: wounding or inflicting grievous bodily harm	1
Stalking involving serious alarm/distress	1
Non-fatal strangulation and suffocation	1
Rape of a male aged 16 or over	1
Rape of a male aged 16 or over – multiple undefined offenders	1
Burglary – Residential	1
Care workers: sexual activity with a person with a mental disorder – male person	1
Care workers: causing or inciting sexual activity (person with mental disorder) no penetration	1
Care workers: sexual activity in the present of a person with a mental disorder	1
Cause of incite the sexual exploration of a child – child 13 – 17	1
Take/make/distribute indecent photographs of a pseudo- photographs of children	1
Exposure	1
Ill treatment or neglect of a person lacking capacity by anyone responsible for that persons care	1
Fear or provocation of violence	1
Harassment	1
Total	**187**

Examples of investigations include:

- Carer convicted of ill-treatment of care home resident

  An investigation was commenced following a report was made to police that a carer had been witnessed assaulting a 78-year-old male resident at a care home. The witness reported that the carer has pushed the resident onto the bed banging his head against a wall before punching and slapping him several times around his head causing cuts and bruising. The carer then forcibly removed the resident's shirt causing him further distress.

  A joint investigation was conducted by police and adult social care as the resident lacked capacity. The carer was interviewed and denied ill-treating the resident. Following the

investigation which was challenging due to the resident not having mental capacity the Crown Prosecution Service brought criminal charges against the carer for ill- treating the resident. Following a trial at Stoke-on-Trent Crown Court in March 2023 the carer was found guilty of ill treatment and sentenced to eight months in prison. On sentencing the carer the Judge commented:

"The Court of Appeal has made it clear that cases such as this almost always require custodial sentences…….not only did you maintain your innocence but you accused at least two of your colleagues of lying…….you were in a trusted, responsible position working with vulnerable people and you lost your temper."

This is an example of effective team working between police and safeguarding partners to protect adults with care and support needs from abuse by people in positions of trust.

➢ <u>Responding to Modern Day Slavery</u>

The care co-ordinator for 'Paul' contacted the Safeguarding Team at North Staffordshire Combined Healthcare Trust with concerns that Paul wasn't fully engaging but was accepting his medication. The care co-ordinator reported not being able to see Paul but, family members with whom he was living temporarily had concerns about his welfare and requested a visit.

When Paul was seen he disclosed that over the previous four weeks he had been kept hostage at an unknown address and had been made to complete tasks in return for drugs. The care co-ordinator observed that Paul's hands were injured and dirty.

An adult safeguarding referral was made to Adult Social Care and a report to Staffordshire Police. An investigation was commenced and several arrests were made on charges of assault occasioning Grievous Bodily Harm and Modern Day Slavery with the outcome that the source of harm to Paul was removed.

The case illustrates the effectiveness of the multi-agency working to respond to abuse that is often hidden.

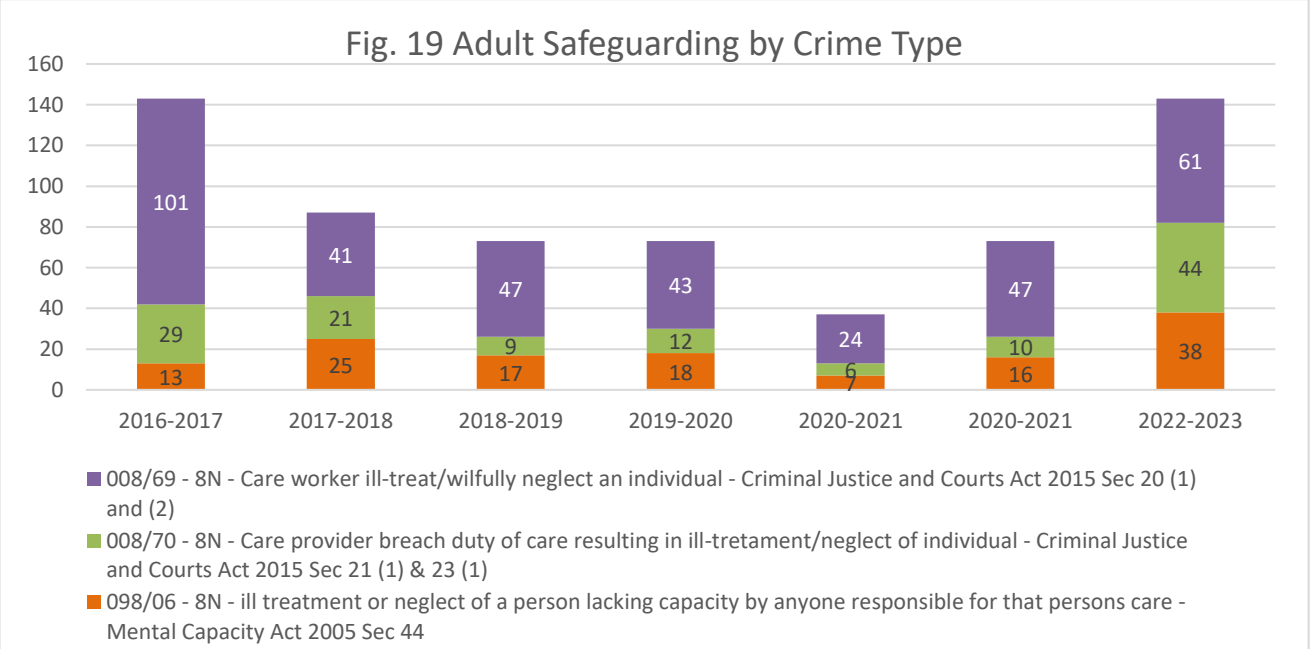
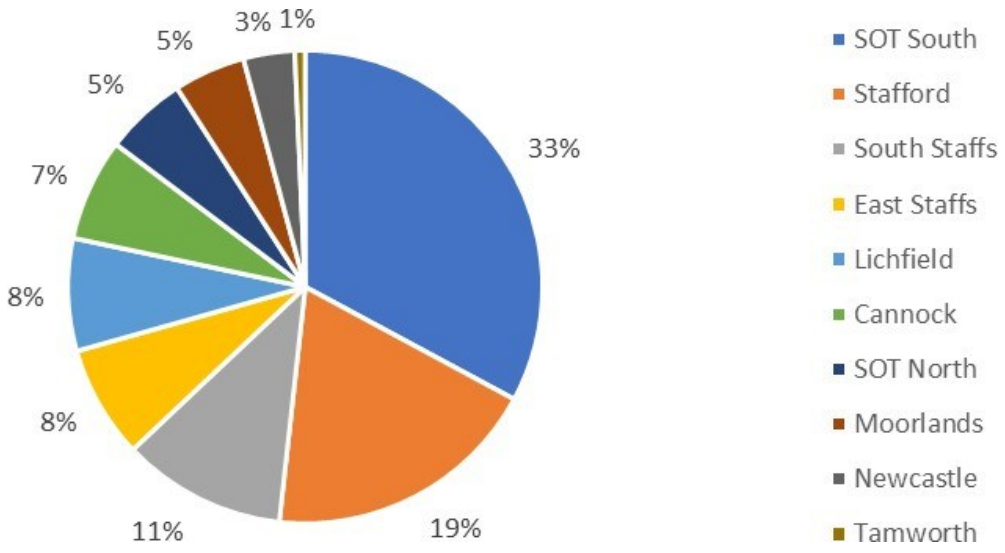


Figure 19 illustrates that there were a total of 143 offences reported for criminal investigation in the 12 months to 31 March 2023. The year is contrasted with previous years to indicate reporting rates over time. From analysis of 2022/23 reports:

- Of the Neglect offences, there are 9 repeat victims in the last 12-months period; none had been a victim in the previous 5 years.
- 1 victim has 3 associated occurrences
- 8 victims have 2 associated occurrences
- 5 out of the 9 victims had all offences occur at the same address.
- There are 6 repeat suspects in the last 12-month period, none had been a suspect/offender in the previous 5 years.
- 2 repeat offenders are linked to the same 3 crimes.
- There are 17 repeat locations in the last 12-month period. Of these 14 are care homes with 3 residential addresses.

The analysis is used operationally in conjunction with safeguarding partners to target preventative actions. The location of the crime types are illustrated below.

Fig. 20 Location of neglect type crime by Local Policing Team Area 2022/23



8. Finance Report (Draft)

The Board is supported by a part-time Independent Chair, a full-time Board Manager and a full-time Administrator. There was a period of 9 weeks when there was no administrator and so employment costs were slightly less than anticipated.

Income: This was year 1 of a 3-year budget agreement which was approved by the statutory partners in July 2022.

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

Spend:	Staffing/Employee costs	£121,369 *note (i)*
	Consultant fees	£3,738 (SAR costs)
	Training resources/catering	£252
	Website costs	£2,500
	Insurances	£2,102
	TOTAL:	**£129,961**

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

WORK PROGRAMME
Safeguarding Overview and Scrutiny Committee – 2023/2024

This document sets out the work programme for the Safeguarding Overview and Scrutiny Committee for 2023/2024.

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 2023/2024			
Date of Meeting	**Item**	**Details (Background)**	**Action / Outcome**
15 June 2023 10.00am	**'Living my Best Life': Report on the Joint Strategy for Disabled and Neurodivergent people in Staffordshire 2023-2028** Cabinet Member: Julia Jessel Lead Officer: Andy Marriot & Nicola Day	Pre-decision scrutiny – postponed from last municipal year	The Committee supported the Strategy and look forward to seeing the action plan that will give more detail on how the vision and strategy will be implemented and how success will be measured. A decision on the Strategy adoption will be taken at the 19 July Cabinet meeting.
	Safeguarding Overview & Scrutiny Focus for the Future Cabinet Members: Julia Jessel, Mark Sutton, Jonathan Price, Victoria Wilson Lead Officers: Richard Harling, Neelam Bardwaja, Catherine Mann	Cabinet Members and Lead Officers highlight topics within their portfolio to support the Committee's work programme planning	Due to time restraints the Committee deferred hearing from the Cabinet Member for Communities & Culture. An extra informal meeting has been arranged for 10 July where this detail will be covered. Members will then use the combined information from 15 June and 10 July meetings to inform their work programme planning.
	Work programme Planning Lead Officer: Helen Phillips	Within the remit of the Overview & Scrutiny Committee, begin planning the work programme for 2023-24.	
27 July 2023 10.00 am	**Customer Feedback & Complaints Annual report – Children's Social Care**	Report brought annually	The Annual Report was welcomed.

Staffordshire County Council

Work Programme 2023/2024			
Date of Meeting	**Item**	**Details (Background)**	**Action / Outcome**
	Cabinet Member: Mark Sutton Lead Officer: Kate Bullivant		
	Customer Feedback & Complaints Annual report – Adults Social Care Cabinet Member: Julia Jessel Lead Officer: Kate Bullivant	Report brought annually	The Annual Report was welcomed. Members asked for their thanks to be passed to all Teams for their diligence, professionalism and commitment, and particularly to those responsible for receiving the 68 compliments shown within the report. The Committee made a referral to Corporate Overview and Scrutiny asking them to consider the impact of changes to the financial assessment accessibility and method of charging six months from implementation.
	PSHE Coordinator impact after first 12 months Cabinet Member: Jonathan Price Lead Officer: Phil Pusey	The Inquiry Day report into Sexual Harassment in Schools asked that the O&S Committee consider the impact of the new PFCC funded PSHE Coordinator role after its first 12 months.	The impact of the PSHE Coordinator role after its first year was welcomed and Officers were congratulated for the impressive work completed.

Staffordshire County Council

Work Programme 2023/2024			
Date of Meeting	**Item**	**Details (Background)**	**Action / Outcome**
14 September 2023 10.00 am	**Impact of Cabinet Investment on Children's Services** Cabinet Member: Mark Sutton Lead Officer: Nisha Gupta	Considering the impact of the Cabinet's extra investment into Children's Services, looking at specific elements of investment and the differences made.	The Chairman congratulated the Cabinet Member and Officers on the improvements made through the effective targeted use of the Cabinet investment to date.
	The Children in Care Programme Cabinet Member: Mark Sutton Lead Officer: Nisha Gupta	Item requested by Members during their June/July work programme planning.	Developments through the Children in Care programme were welcomed and supported by the Committee.
24 October 2023 12.30pm Extra meeting	**Early Years Strategy** Cabinet Member: Mark Sutton Lead Officer: Helen Gibson	Item of pre-decision scrutiny.	The Committee were happy to support the strategic vision for the early years' service, welcoming the work to reorganise the service delivery model and the planned budget profile.
24 October 2023 2.00pm Extra informal meeting with the PFCC	**Meeting with the Staffordshire PFCC**	To discuss with the Commissioner: the changes made in response to the PEEL findings and the impact of changes to date; the neighbourhood safety delivery process to enable Members to better understand and reassure their communities; and, the Humberside pilot project "Right Care Right Person", whether Staffordshire is following this	The Commissioner shared with the Committee details of the Right Person Right Care process, rationale and timescales, including partnership working and transition planning. Further discussion was around developments resulting from the PEEL report and monitoring of the

Staffordshire County Council

Work Programme 2023/2024			
Date of Meeting	**Item**	**Details (Background)**	**Action / Outcome**
		method of working with those who have mental health concerns and the potential impact of this.	current situation with regard to possible increased terrorist threats
23 Nov 2023 10.00 am	**Family Hub update and the work of the Family Improvement Boards** Cabinet Member: Mark Sutton Lead Officer: Natasha Moody	Item requested by Members during their June/July work programme planning.	The Committee support the emerging Family Hub model and congratulated Officers and the Cabinet Member for the progress to date. Members agreed to consider becoming advocates and pledge their support for the Staffordshire Co-Production Promise. Details of: the Bump to Toddler Pathway; the Risk register; and the location of the Family Hubs were requested and progress against the performance framework will shared with the Committee at either 6 or 12 months (at the discretion of the Chairman in consultation with the Cabinet Members).
	Trading Standards Cabinet Member: Victoria Wilson Lead Officers: Catherine Mann/Trish Caldwell	Scrutinising the work of Trading Standards in enforcing more than 250 pieces of legislation and its role in maintaining a safe and sustainable marketplace.	The Committee welcomed detail of the successful work undertaken by Staffordshire Trading Standards. They requested detail of enforcement data.

Work Programme 2023/2024			
Date of Meeting	**Item**	**Details (Background)**	**Action / Outcome**
	Vaping Cabinet Member: Victoria Wilson Lead Officers: Catherine Mann/Trish Caldwell	SCCs approach to dealing with vaping non-compliance, the unsafe nature of these products which are marketed at children and young people.	They also suggest the Chairman and Portfolio Holder write to the chairs of the eight district and borough planning committees raising the issue of vaping, and seeking their consideration to include planning restrictions through their Health in all Policies to prevent Vaping premises being positioned near schools and colleges. Members will also consider becoming scam champions.
4 January 2024 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	
	Staffordshire Safeguarding Children's Board Annual Report Independent Chair: Ian Vinall Lead Officer: Lynn Milligan	Report brought annually	

Work Programme 2023/2024			
Date of Meeting	**Item**	**Details (Background)**	**Action / Outcome**
	Family Help Pilot Cabinet Member: Mark Sutton Lead Officer: Nisha Gupta	Item for pre-decision scrutiny	
	Provision of Services for Children and Young People Cabinet Member: Mark Sutton Lead Officer: Karen Coker/Shahid Munir	Item for pre-decision scrutiny (the item covers the placement sufficiency detail requested by the Committee)	
15 Feb 2024 10.00 am	**Adult Safeguarding Early Response** Cabinet Member: Julia Jessel Lead Officer: Ruth Martin/Jo Cowcher	Considering work towards earlier responses to adult safeguarding, considering the process, numbers and seek assurance that these are dealt with in a timely way.	
	MASH Review and adoption of a Staffordshire Children's Front Door		

Work Programme 2023/2024			
Date of Meeting	**Item**	**Details (Background)**	**Action / Outcome**
	Cabinet Member: Mark Sutton Lead Officer: Clive Cartman-Frost		
	The Community Safety Agreement, performance and impact Cabinet Member: Victoria Wilson Lead Officer: Catherine Mann/Trish Caldwell	Looking at the Community safety Agreement, considering its performance and impact. To include any potential impacts identified from the Right Care Right Person initiative.	
18 April 2024 10.00 am	**Domestic Abuse Contract – 6 months in** Cabinet Member: Victoria Wilson Lead Officers: Catherine Mann/Trish Caldwell	Considering the new contract 6 months in, looking particularly at the new refuge and sanctuary duties and how these are implemented in Staffordshire.	
	Adult Vulnerability Hubs Cabinet Member: Julia Jessel Lead Officer: Ruth Martin/Jo Cowcher	Looking at the development of adult vulnerability hubs, their intended outcomes and timescales to achieve these.	
	Adult Safeguarding Assessment Cabinet Member: Julia Jessel Lead Officer: Ruth Martin/Jo Cowcher		
	Hearing the voice of the child	16 February meeting Members requested a better understanding of	

Work Programme 2023/2024			
Date of Meeting	**Item**	**Details (Background)**	**Action / Outcome**
	Cabinet Member – Mark Sutton Lead Officer – Neelam Bhardwaja	how the voice of the child is heard – particularly with respect to early identification of emerging online threats and challenges.	

Items for Consideration – Work Programme 2023/2024		
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: • 24 July – briefing on 14 July SSCSG
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	

Staffordshire County Council

Standing Items 2022/2023		
Item	**Details (Background)**	**Action / Outcome**
	meeting as part of the work programme agenda item. CIB scheduled dates: 23.05.23, 28.06.23, 25.07.23, 27.09.23, 24.10.23, 28.11.23, 20.12.23	
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 2023/2024			
Date	**Item**	**Details (Background)**	**Action / Outcome**
	"Stable Homes Built on Love" Government's response to the Care Review		
	Adult Safeguarding Quality Assurance Framework		

Working Groups / Inquiry Days 2023/2024			
Date	**Item**	**Details (Background)**	**Action / Outcome**

Membership – County Councillors 2022-2023	Calendar of Committee Meetings - 2023-2024
Bob Spencer (Chairman) Gill Burnett-Faulkner (Vice Chairman - Overview) Paul Snape (Vice Chairman – Scrutiny) Ann Edgeller Janet Eagland Johnny McMahon Gillian Pardesi Kath Perry Mike Wilcox Conor Wileman	15 June 2023 at 10.00 am
	27 July 2023 at 10.00 am
	14 September 2023 at 10.00 am
	24 October 2023 at 12.30 pm
	24 October 2023 at 2.00pm – informal meeting
	23 November 2023 at 10.00 am
	4 January 2024 at 10.00 am
	15 February 2024 at 10.00 am
	18 April 2024 at 10.00 am
	Meetings usually take place in the Oak rm, County Buildings